

# CHAPTER THREE

## Recovery

### Overview

#### Topics covered in this section

- **The Emperor's new clothes?**
- **Strategies for Living**
- **Recovery Healing Communities**
- **Commissioning for Recovery, Well-being and a Whole Life**
- **Personal Recovery Stories**
  - **Turning the Circle and Seeing Again**
  - **A Personal Account of Recovery**
  - **Life's a Botch**
- **Recovery and Spirituality**
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  - **BPD or Spiritual Crisis?**
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- **Exercises**
  - **Creating a Climate of Recovery**
  - **Personal Recovery and Change Process**
  - **Recovery and Spirituality**
- **Self Management**
- **'Moving On': A Self-Management Programme for Individuals**

#### Aim

This chapter will outline the key features of what is meant by 'Recovery' and discusses the difference between clinical and personal Recovery.

The essential elements of Recovery will be explored using examples of clinical experiences to highlight some of the tensions of working within environments that struggle to recognise whose Recovery we are working with.

Several stories and perspectives on Recovery will be included to further the perspective from those with personal experience. This section will also explore what is meant by 'self management' and its relationship with Recovery and Well-being.

#### Learning outcomes

By reading these sections and completing the activities included you will begin to understand:

- More about what 'Recovery' means.
- Be clearer about the essential elements of Recovery.
- The starting point for Recovery-based practice or support and how to create a climate conducive to Recovery.
- The relationship between Well-being, Recovery and self management.
- How, when and why to use this approach.
- The difference between self management and care planning.
- Where to find more information about self management and Recovery planning.
- More about the 'Moving on Programme' in Hertfordshire as an example of a programme that supports Recovery and self management.

# The Emperor's New Clothes?

by Tanya Kennard-Campbell

### What is Recovery?

Recovery is a troublesome word to define as it means different things to different people in different contexts.

But for the purpose of this workbook we will refer to the perspectives of Recovery as an outcome and Recovery as a process.

### Recovery as an outcome (outside – in)

These perspectives have been called 'Clinical Recovery' or 'Recovery from' and refer to the process of symptom resolution, absence or even cure, a movement from A to B.

This is often a person's first impression when they hear this word used in the context of mental health services. The dominant belief is that there are mental illnesses just like there are physical illnesses and disorders, and Recovery in this sense means a resolution of the disorder marked by symptom elimination.

Clinical Recovery remains an important perspective and goal as advancements are made in discovering physiological and nutritional implications that promise to offer benefits for health.

Numerous longitudinal studies have supported the Recovery movement by providing evidence that clinical Recovery is not only possible but highly probable from the most debilitating symptoms. This evidence has inspired hope in many.

Many mental health professionals remain uncomfortable with the word Recovery, as they believe it may be giving false hope to an unpredictable process, and members of the public are surprised by the word in relation to mental illness due to the common myth that there is no

cure for mental illness.

I recently asked someone who had no personal experience of the world of Mental Health or Mental Health services what Mental Health Recovery means to them. The answer was very insightful and gives us an important perspective to consider.

*"Recovery is about regaining all your mental faculties in order to live a normal life. Some people meet me and they'll never know. But if people know something is wrong with you, they will look for it and you may end up behaving like they expect. Whether the things that affect you are with you still or in your past, you still have to live with that. So no, you can't ever Recover from that".*

Interestingly, this person does not have a diagnosed Mental Illness, but had experienced what he described as a 'minor social phobia'. This raises the issue that most of us live with some form of challenge at some point in our lives, be that a social phobia, not fitting in with the majority or the loss of a loved one.

These experiences will always be a part of our story or history and this can never be taken away, so from this perspective, Recovery is never clear cut.

In clinical Recovery, it is often seen as a reason to force people to change, (as it is seen as an end place, a having 'got better'), meaning individuals are now 'able' to take on roles not claimed for themselves, such as return to work or no longer needing support or ready for discharge from services.

The difficulty here is that Recovery is defined by others and based on objectively perceived symptom

control, elimination or functional ability. Recovery from this perspective is focused on outcomes, often as perceived or defined by another.

The difficulty with others defining what is successful or effective is that the control and power remains with the person defining the experience.

This has historically been the position of mental health services in retaining the expert role, unintentionally disabling self-determination, self mastery and personal meaning in the process of defining another's Recovery from the outside.

'Whose Recovery' are we talking about in this context?

### Recovery as a process (inside – out)

Personal Recovery has very different origins, intent and meanings and is a process that occurs and is defined from the inside. Recovery in this sense has more of a political purpose, a symbolic reclaiming of control over one's life and Recovery. Personal Recovery has emerged from the voices of many who have experienced mental illness and distress and have survived, or indeed thrived despite it.

There are many definitions of Recovery, but this one by the Scottish Recovery Network captures the meaning well.

*"Recovery is being able to live a meaningful and satisfying life, as defined by each person, in the presence or absence of symptoms. It is about having control over and input into one's own life. Each individual's Recovery, like his or her experience of mental health problems or illness, is a unique and deeply personal process. It is important to be*

*clear that there is no right or wrong way to recover”.*  
Scottish Recovery Network

But the most relevant definition is the one defined by the individual and it bears its true meaning in the moment of definition.

Recovery is not about the absence or eradication of symptoms or about judging one type of approach or treatment as more effective than another. It is about the process that occurs around and within treatment (it's presence or absence). It is not an end place or cure. It is a deeply personal experience of deciding what is important in one's life, finding out how best to achieve this and the choices made to make this a reality.

Recovery is a process led by the individual and comes out of a conscious (or indeed unconscious) decision to 'do differently'. This is a highly creative, and often, initially, quite a clumsy process of learning what works and what doesn't.

One thing is certain in Recovery and that is the control and emphasis continues to come from the individual who is leading the journey and ownership of the journey is sacred. Recovery is about learning, discovering and continuing to grow irrespective of age, gender, culture or ability.

### **The moment of Recovery**

One thing we have learned about the process of Recovery is that for most, there is a moment where Recovery occurs or is initiated. This moment is different for everyone and is stimulated by highly individual things, but what is familiar to all is that this moment creates a fresh insight into people's worlds and for some reason, they no longer see things as they did.

Here is an example of how this looks:

*I was sitting one evening in an inpatient unit with a young woman who had been given a diagnosis of borderline personality disorder. She was aware that they didn't know what to do with her and they had stopped any active treatment. The team was looking into sending her to a therapeutic retreat where she would have to remain for a six month period with little contact from family and friends. She was feeling hopeless.*

*“We got to talking and she*

*shared about how before her illness she had enjoyed her career in teaching and how there were so many things she wanted to change about the way children were educated. She lit up as she talked with passion about the mission she felt she had found in her life. Then quite rapidly her mood sank as she realised that this was no longer possible for her because of her illness. I asked her why she felt she would no longer be able to go back to the career she loved, surely her 'illness' would not be the only thing hindering her?*

*She said that her psychiatrist had told her that those with personality disorders were unable to hold down high functioning jobs and that her disorder would gradually get better over many years, and perhaps in middle age she would not be so tortured. This was the evidence she had to rule out her dreams.*

*I asked her to consider for a moment that he was completely wrong in what he had told her (or what she made of what he told her). She initially resisted this concept, saying she had read so much to support this and met others with the same condition who had remained stuck because of it. But finally she considered the possibility.*

*I asked how different life would look if this wasn't true for her. She immediately saw how different her life would be. She would get back in contact with old university friends who she'd lost contact with because of the shame, she would move to a different area to be close to the schools she wanted to teach in etc, etc, etc. I asked how she would manage her 'flash backs' and low moods, she immediately had an answer to this too. She would seek out a good therapist, as she'd be able to afford one and select the best person for her. She might even set up a support group for herself and others to utilise.*

*As she was talking, once again her mood rose and she became animated and full of life. Somewhere along the line she realised what had happened, she had seen a new way of viewing her life, even if it was through an 'as if?', she realised that the only difference between these two realities was the belief she placed in it. She saw differently.*

When you listen to stories of Recovery and ask the question, can

you remember the moment your Recovery began?, you will hear some very interesting answers. Many people describe an instant or a moment when things changed for them, and if you listen you will hear that this change was because at that moment the person's thinking changed. Recovery happened in an instant.

How we then create a new life out of this new perspective is another story. As we know, Recovery is highly individual, yet there are some overlapping principles and essential elements that appear common to most experiencing this for themselves. These essential elements will be explored further.

### **A process**

Recovery is experienced as a process or journey and many talk about a process of healing from the 'significant event', be that mental distress, loss, trauma, abuse or the secondary effects such as stigma, discrimination, isolation and poverty.

Recovery is an ever changing process of learning new ways of being and finding new ways of living in spite of life's unpredictable hiccups that sometimes seem set to make or break us. This is not a graceful process, there is nothing beautiful or divine about it, this comes later, on reflection. It is a clumsy, fumbling ongoing encounter with our seeming lack of insight and objectivity. Of course it is often an extremely painful process to experience and to watch.

This is not a process you would readily invite, but for some of us, it seems as though we have no choice, as we are plunged into the water and learn how to swim in the process. Sadly, we know this is a process we can truly only experience alone, but the love and care of those around us give us the courage and breath to continue.

As David puts it 'Recovery is a journey of discovery, the thing you learn most about is yourself' (From New Zealand Recovery plan booklet). Recovery is the process in and around the mental distress, the things we learn along the way about us, our processes, our loved ones, the world and our internal sense of meaning and purpose.

Of course what we come back with from these encounters are deeply powerful insights, lessons

and gifts that guide us through our lives with an unchallengeable wisdom.

One does not have to experience mental illness/distress to experience Recovery. Just when we thought we'd figured it all out and have become comfortable with our new realities, life goes and changes again.

You can see why this can frustrate! Don't we all want a little respite? A little security in knowing that life can be simple? Perhaps one of the lessons we learn is that life and our Recovery is constantly shifting, changing and growing.

During a workshop I ran recently, after doing an exercise aimed at exploring the personal nature of Recovery, a staff member commented "isn't this just like the process of life?" I laughed and said she'd revealed the secret that others couldn't quite see yet. Like the Emperor's new clothes! A useful insight. Recovery (as with life) is a full contact sport.

### **Hope**

*“Where there's breath there is life, and where there is life there is hope.”*  
Words of a local Macmillian nurse

Hope is an essential spark that lights the flame of potential and possibility. Individuals on this journey become highly sensitive to its presence or absence. The fear, stigma and discrimination associated with mental illness compounds and accentuates the distress felt during the process of being touched by it.

This is no ordinary illness. There are very few who do not hold powerful negative beliefs about mental illness, its experience and prognosis, these beliefs often being nurtured internally for many years.

Ask a person to imagine being diagnosed with Schizophrenia, or for someone they love going through this and no doubt you will see a flicker of fear run past their eyes. This fear is the disabler, the thing with real power, but alas is often overlooked, or dismissed as not being as important as other pressing issues. But tackle this one and you'll invite in its opponent – Hope.

Hope is talked about a lot in

Recovery and its power should not be underestimated. It is like the light in a darkened room, no matter how small it is you can see it and feel its warmth, take its guiding direction and passionately nurture and protect it, because it is something sacred and pure and made only for you.

The biggest fear for me as a clinician is not working with someone who has no hope but working with someone for whom I have no hope. You can feel, smell and hear fear whispering in the room, it is truly one of the worst experiences, your fear mixed in tight with the despair of another. Not a happy combination, but a very powerful one.

This is where true team work comes in. There will always be someone who holds some hope for this client, no matter how small, it has the power to bring life and light back into the room.

There have been very few clients that I have been unable to connect to and feel hope for, but I remember one girl who I just could not connect with. I did everything to try and find something about her that I could build a relationship with, but there seemed to be absolutely nothing. This meant that I felt irritated by her pain, felt disgust for her behaviours and angry with her refusal to see the cleverness of my suggestions. I beat myself up endlessly about this girl and the way I felt about her, it was eating me up, making me an impostor in my role and a very sad kind of human.

I remember one particular day standing with her in A & E, while she was having sharp objects removed from her body, thinking all kinds of contemptuous thoughts, when a student nurse came over to relieve me. She walked in with tears in her eyes and swept over to her, put her arms around her and set her off crying in relief.

This moment was like electricity, it gave me one hell of a wake up call. The student nurse showed genuine care and compassion (hope) which triggered off a flame of positive feeling in the room, an emotion that felt close to a healing spirit.

I left that room ashamed, but knew what I needed to do. I refused to work with that young girl again until I got my compassion back, the best thing I could ever have done for her.

Three years later I came across her in my work with the crisis team. We connected.

Leah is a young woman who was diagnosed with borderline personality disorder, one of the most offensive diagnoses in terms of staff attitudes.

I got on really well with Leah and nursed her through many a crisis, including ones where self harm was involved.

What I saw in Leah was a bright, warm, intelligent young woman with so much to love about her. She was tortured, being deeply affected by some reality only she could see. She could not lift her head to see other perspectives, especially positive ones about herself.

What I saw in her, what so many others saw too, was her health, potential and possibilities. She would lose her hope so often (not surprising considering what she believed about herself) and no matter how hard she tried to prove herself unloveable or hopeless, I (and others) kept gazing back, never losing sight of all her goodness.

I think it really wound her up, because she saw it reflected in our eyes and she could feel it was real, so she had a choice, believe what she saw reflected in our eyes or believe her own feelings? I know which one paid off in the end.

Leah ended up being a part of the Recovery movement in New Zealand and has now qualified as a nurse. No more self harm and no more diagnosis. Oh, we must have got it wrong because people can't recover so young from that diagnosis. Laughable or outrageous? Either way, this is her own success story as described by Leah:

*“My Recovery journey has been what seems a long one with many ups and downs along the way. I don't expect to ever live without my illness but I have learned to live with it and accept myself for who I am. The most important element in my Recovery has been hope. When I lost hope I was lucky enough to have mental health workers who held my hope for me while I couldn't. They held that hope and believed enough in me to get me out of that dark space. For that I am truly grateful”.*  
NZ Recovery plan booklet

Now this is a story of Recovery, a crooked process, fighting the odds, fighting a system so strong it has the power to take your rights away, with an arrogance that astounds. Leah fought for the right to good support, for good psychological therapies. She was offered one type of therapy and asked to sign a contract committing to what in essence was behavioural modification. There was no 'walking with her journey' or choice here. And when she no longer self harmed or experienced crises and had reclaimed her health, she was told that she should never have had the diagnosis in the first place. An attempt at validating unacceptable behaviour in a system that should know better?

### Personal meaning and understanding

Periods of distress or pain often lead us into a search for the meaning in it all. This search leads us into the depths of our soul in search of the answers. Once touched by the wisdom of our own souls, we will never be the same again.

This process is deeply sacred and of such importance to our sense of self that others' attempts to influence and control it brings a sense of violation and disrespect.

The meaning we make of our lives and our experiences move with us as our lives change and adapt. Wisdom one day can become old news another. When we become hooked on the current conclusions and let them define us, we lose sight of the bigger picture.

Recovery from mental distress or illness involves the process of healing following diagnosis or distress.

Healing, I believe, is the word we are looking for here. Healing from mental distress/illness is not as simple as healing your physical wounds (your poor battered neurochemistry), it's about healing your poor battered self and soul.

The meaning we make of our experiences is of vital importance to our sense of direction and purpose. Drawing on the important lessons and insights gained from our experiences arms us with a sense of our own resilience and strength and invites us to continue the process of becoming who we are.

*“For me, part of my Recovery*

*included realising that this feeling would eventually pass and fighting against it prolonged the experience. I found that my depression would come uninvited and left a bad taste in my mouth. But over time I realised that my body would override what I thought was important at the time and kind of 'pulled the plug' on me. When this happened, there was actually nothing I needed to do to get me out of this state. Knowing that my deeper self often knew better than me helped me find meaning in these times. When I let the process take me and stopped trying to control it, I found I ended up in the right place eventually, even though it didn't go at my pace or fit with my schedule!*

*"In this process, I kind of, relinquish conscious or ego control and trust my higher self to take care of me and know what is in my best interests. I've learnt to be comfortable with my discomfort, even though I do initially go into battle and try to be the one in control".*  
Anonymous

Spirituality is often seen as a natural part of finding meaning in our Recovery:

*"When everything seems so pointless and full of pain, I have to find some kind of comfort if I am to survive. Although I accept the illness, I also need hope. Every time I have had an episode of illness in my life, I have been on some kind of spiritual journey by the time it's over. In the long term, through these experiences, I see myself becoming more and more whole. In fact, I see myself as a mentally healthy person, who is sometimes ill".*

Julie Leibrich, *The Recovery Book*, 'Norwich Mind'

## Support

Support is essential in Recovery and we only need to reflect on our own times of need to realise how important this is to our experience.

Support can come in the form of people and relationships, but also in terms of supports such as medication, talking or complementary therapies, religious or spiritual beliefs and practices and hobbies etc.

'Having just one person who believed in me' was most commonly rated the essential element when asked 'what helps' in Dr Courtney Harding's research with people with long term conditions (1987).

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### Often when we are lost in our distress we lose the perspective and insight that would be available to us when we are in touch with our Well-being

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As highlighted in Leah's story, that one person has the power to bring hope into our lives.

Julian Bareham talks about how important support is in the Whole Life DVD by saying:

*"The one thing that really helped beyond anything was Mack, my biggest support. He was an ordinary man I met in a pub, when I was talking about things nobody understood..... Mack has a sense of humour and that is what got me better, he gave me back my sense of humour and I thank him an awful lot for that".*

Julian Bareham, *Service User/Philosopher*, taken from the Whole Life DVD

Another aspect of support is highlighted in Leah's story. Often when we are lost in our distress we lose the perspective and insight that would be available to us when we are in touch with our Well-being.

This is where gifted, compassionate, loving/caring support and insight from others can show us what it is we are missing in this process. The timely insight of others on our process can often provide us with this 'aha' moment of insight and clarity that accelerates our learning. Others can often see more objectively what it is we can't because we are so 'lost in the moment' of our process. This is where we shout 'this is my process!' and defend it to the hilt. But gentle clarity from others shakes us to the core. This is where support is blessed.

How often do the words of others, when delivered with love or compassion, give us the missing dimension needed to make sense of it all and urge us forward to our own timely conclusions? It's kind of nice to know you're not alone in this

experience, that this is a common side effect of being creative, insightful, and human!

This is where peer support is so valuable to those whose experiences aren't common to us all and where mental health workers are unable to relate this to 'common human experience'. The support and advice given from someone who has similar experiences comes with so much more power and meaning.

I was told this story recently as a means of highlighting our role as supporters.

You meet a man who is isolated from his friends because he believes people are laughing at him and acting strangely around him.

Now you know that inside he has everything he needs to stop people laughing at him, but he just doesn't realise it. At moments he comes close to seeing the answer to his problem, but always just misses the point of insight.

What is your role here? Do you let him work it out for himself? Because eventually he will or do you do the most helpful thing and tell him the reason people are laughing at him is because he has food on his face.

We're all in the soup together with food on our faces.

## Acceptance

Acceptance is the painful process involved in making sense of one's experiences. When mental distress, trauma or loss enters our lives it is rarely invited. The initial process is to fight and struggle to protect oneself from its effects. Common cries include 'It's not fair', 'Why me?', 'It's not my fault' and 'I'm not strong enough'.

As time moves on, we are left with the choice of accepting

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### For some, accepting a diagnosis of mental illness is unacceptable as it means accepting all the fears, myths and stigma associated with it

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what has happened and moving on, or living a life of pain, resentment and anger.

Recovery involves the first choice. Accepting what has happened gives you the release to then do

something about the present and future as a consequence. When we remain stuck in the past, we lose sight of what we may have right now.

But accepting what has happened is a challenging thing to do. It involves first acknowledging what has happened and this is not something we choose easily.

*"Acceptance was a big part of my Recovery. Initially it was something clearly wrong, but I didn't want to accept that, because by accepting there was something wrong meant I had to then acknowledge my feelings of failure and that I really needed to take action to turn this around. It seemed safer initially to deny what was going on, because then I could hope that it would 'work itself out' or go away. Of course it didn't. By the time I finally acknowledged what it was I was experiencing and then naming it, I was in quite a state.*

*"What really helped me was when I could finally 'name' this thing I was experiencing and then take the risk of asking for help and support from those around me. I was lucky that my supports challenged my feelings of failure and inadequacy to the extent that I realised they were right. Then I could move on and actually do something about it, take action and discover the things that helped me recover".*  
Anonymous

In terms of mental illness, we need to be mindful of what it is we are asking people to accept. For some, accepting a diagnosis of mental illness is unacceptable as it means accepting all the fears, myths and stigma associated with it. This offers some explanation for why so many avoid mental health services. They are not willing to accept mental health services' view on what their experience means.

This is where clarifying a person's belief, world view and frameworks is important in helping a person find meaning. The importance here is to work with the person's framework, be that spiritual, social or medical, and not impose your views onto them.

Acceptance is the first step in

taking personal responsibility for one's Well-being and by asking someone to accept something they have no control over runs the risk of obliterating hope and creating passivity and dependency.

One common myth in mental illness is that it is like a physical condition and as such needs expert or specialist diagnosis and handling and that complying with prescribed treatment options is expected. However, what role does the individual play and what kind of control do they have over a process that is physically determined?

Acceptance that this experience is something we have no control over is a potentially scary thing and we should be mindful of the devastating effects of this. But accepting an experience within our own systems of meaning gives us our control back and a sense that there is something we can do about it.

*"As my suffering mounted, I soon realised that there were two ways in which I could respond to my situation; either react with bitterness, or transform the suffering into a creative force. I choose the latter".*

Martin Luther King, *Art of Recovery: A Pocket Guide*, by S. Heyes & S. Tate

We all experience decisions in our lives, we all experience the realities of acting or not acting. We know that some opportunities present themselves only once and what we make of them becomes the story of our lives and our ability to live with ourselves as a result.

We don't have to be happy about change, but we can accept that it is an inevitable part of our lives. Once we've figured this one out on a deep level it gives us freedom.

### Personal responsibility

Once we have accepted what we have here and now and begin to believe we have control over our future, we can take personal responsibility for our lives, Well-being and Recovery.

Recovery is an active process and the action is generated from the individual who leads the process. Knowing that you are responsible for your life, happiness and fulfilment is an essential part of growing up and growing into our skins as humans.

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### Self management is a vital part in personal responsibility as you learn to realise the control and influence you have over your health, Well-being and Recovery

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If we allow others to define what is important to us, then we are no longer leading our own lives. However, this is so common in those who have had long-term contact with mental health services and systems. Believing you can and do have control over your health and the ability to reclaim control over your life powers this process.

Recovery does not involve passively accepting what is offered, but taking an active part in deciding what it is you want, how you are going to achieve this and going out and doing it.

Self management is a vital part in personal responsibility as you learn to realise the control and influence you have over your health, Well-being and Recovery.

### Education

Education and information are important elements that affect a person's decision to choose the road of Recovery.

The information available to us internally, as well as what is offered by others, gives us the vital evidence needed to support our decisions.

If the information offered is timely, clear and offers us different perspectives and is delivered with authority, it can be of tremendous benefit to our sense of control.

Knowing what it is we are dealing with, gives us a process of finding out what this means and what we can do to influence the outcome or experience. Fear of the unknown is a huge disabler and information helps us become clearer about what it is we are dealing with as demonstrated in the following quote:

*"I didn't realise there was so much to this. When I started looking, I found so many different perspectives on this, some were really interesting and provided me with a new way of looking at things".*

With the development of the internet, there has been a proliferation of useful websites

that offer a wider range of perspectives and information.

### Recovery starts here

Recovery starts somewhere but fundamentally it starts with believing it is possible for you or your client/loved ones.

Recovery involves a journey of discovery and a deepening understanding of who we are, what we are capable of and the freewill to make this a reality.

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# Strategies for Living

by Vicky Nicholls

Recognising and nurturing people's strengths – others' and our own – can be a significant challenge in a culture dominated by a disaster and fear-obsessed media, yet equally focused on success and achievement. Living and supporting what might be seen as a whole life is, in this context, counter-cultural, entailing as it does an awareness of the individual with all of his or her emotional, mental, physical and spiritual complexity embedded within family and community; settings which exert powerful historical and current influences on the person (see Gilbert, in the Recovery and Spirituality section).

In considering how best to nurture Well-being, choice and control in people experiencing mental health problems, there are further barriers to transcend for those working within mental health services, such as bureaucracy, targets and power inequalities which can interfere with the common humanity that is potentially experienced in any 1:1 interaction.

### Values in healthcare

Moves towards working from a clear values base, on the other hand, such as that espoused by New Ways of Working, provide a supportive framework within which practice and relationships can be held and understood at a personal level. Developments such as the Centre for Philosophy and Ethics in Mental Health at the School of Ethnicity and Health, University of Central Lancashire, offer a stringent approach to debating and shaping the underlying basis on which mental health services are provided, which is to be welcomed.

The Janki Foundation for Global Health Care in London runs a Values in Healthcare training course which aims to give participants the opportunity of exploring in depth some values which are of particular importance in healthcare practice.

These are briefly described below.

**Peace** is introduced as our natural state, i.e. that within all of us there is an innate core of calm and tranquility. The programme uses simple yet powerful ways to rediscover this inner peace. By practicing peacefulness, participants can access their positive qualities which help to build self-respect and contentment. Peacefulness is the medicine for 'burnout'.

**Positivity** is about having the choice and power to change the way we think. Health care professionals can often think critically or even negatively out of habit, whereas positive thoughts make people feel good. The programme helps participants to recognise unhelpful patterns of thinking and change them to more positive ones by learning to observe their thoughts. Their resulting positivity and optimism bring benefits not only to themselves, but to colleagues and patients.

**Compassion** brings humanity to health care. It is the expression of our innate qualities of patience, generosity and kindness, yet there are often personal barriers to its expression - anger, anxiety, guilt and attachments. The programme helps participants to acknowledge and tackle these barriers and to view compassion as a value they can consciously express throughout their practice.

**Co-operation** is about working together successfully as individuals and teams. The programme helps participants to gain an understanding of the thoughts, attitudes, feelings and behaviour that enable successful co-operation. It enables them to build team spirit in non-competitive ways, so that tasks become enjoyable and creative.

Valuing the self requires that we

recognise our own worth, and in doing so, can better acknowledge the intrinsic worth of others. Participants explore the question of 'who am I?' in the context of how they look after themselves. This can help them to bring mutual respect and harmony into their relationships, to the benefit of themselves, their patients and colleagues.

Spirituality in health care is a vital concept in furthering the ideals of holistic health and spiritual care. The programme involves participants in clarifying concepts of healing, spirit and spirituality, in order to further develop their values-based practice.

### Service user perspectives and values

Service user and survivor perspectives have been given greater attention in recent years and their systematic collection, analysis and recording through research initiatives offer a rich resource for anyone seeking to open up their awareness of what really matters to people experiencing distress or mental health difficulties.

Some user-led projects have set out a clear conceptual framework within which they have worked. Strategies for Living at the Mental Health Foundation, for example, worked from an understanding that knowledge is not neutral - there are hidden agendas contained within it – a viewpoint which stems from a backdrop of feminist, Black and other anti-oppressive standpoint research which has an aim beyond the discovery of knowledge to changing the world. This is sometimes known as emancipatory research, and recognises that all players in a scenario have a perspective, none of which is neutral. One of the intentions of standpoint research is that by making explicit the identities (and

potential bias) of researchers, the power imbalance with the people participating in the research is reduced (Nicholls, *MHF*, 1999).

Paulo Freire, the famous Brazilian educational psychologist, argued that oppressed people experience life as objects - they are acted upon, as opposed to acting for themselves. They therefore lack critical skills essential to influence the institutions that have control over their lives, and to teach people about the power relations in which they are caught up, covers essential prerequisites to any genuine moving on and liberation. In a mental health context this means recognising the power of psychiatry and hospitals amongst others, and working towards self- and collective fulfilment. As Martin-Baro put it:

*"If our aim is to serve the liberation needs of the people, we need to ally ourselves with poor and oppressed groups in their struggle for justice and dignity."*

This implies working with values which include transparency and equity and a belief in the sometimes hidden potential of every human being.

### Strategies for Living

Several innovative user-led research projects have highlighted what people with experience of emotional or mental distress report as finding helpful in coping with distress or living with ongoing difficulties. These findings can be, but do not have to be, seen as part of a Recovery journey - a qualification that seems essential to make in the light of the current hegemony of Recovery that is not always owned by those it is supposed to be there to serve.

Below I look at some of the 'flowers' (see 'feeding the flowers' website, details can be found in bibliography) or strengths that have been identified by service users in such user-led research.

The Strategies for Living Project ran at the Mental Health Foundation for six years and was a truly innovative user-run research and research support project. It derived its name from work with people who were HIV positive and learning to 'live with' an experience which is accepted as being ongoing. In this Project, UK-wide qualitative research with over 70 people with experience of mental health problems identified a number of key themes and approaches that people described

as being helpful to them.

People who were interviewed talked about various aspects of their lives that had helped them to cope, given them strength, enabled them at times to stay alive or brought them enjoyment. Many of these themes have since been mirrored by other user-led research, notably the Rethink Self-management project, and resound in many other sources.

### Strategies for Living themes Acceptance

People interviewed in the Strategies for Living research reported that the stigma and discrimination experienced in relation to mental illness made the acceptance of others a vital element of their survival, and frequently a means of achieving self-acceptance. Many people found coming to terms with distress and diagnosis a long and difficult process. The value and support, the affirmation and acceptance of others, served for many as a valuable and vital route through that process, a lifeline to survival. The interviews suggest that many people experiencing mental distress seek out and create their own 'accepting communities' (see Mind, 'Creating Accepting Communities', 2001), whether among friends or family, or among other people with similar experiences or a shared identity. Where they cannot do so, or are prevented from doing so, isolation and social exclusion result:

*"[Drop-in] is like a safe haven really, from out there... they are just accepted for the person that they are, underneath the illness. That really is the key to it all here"*

### Shared experience... shared identity

Acceptance was very often found in the company of others who shared similar experiences, or who shared a key aspect of an individual's identity. Some people had discovered the value of shared experience through self-help groups addressing a particular aspect of mental distress, such as sexual abuse or depression, whilst others had discovered it through voluntary sector projects, drop-ins or day centres, where they had met 'like-minded' people.

As much as the frequency with which this theme recurred, it was the strength and passion with which it was expressed that caused it to stand out. For some people, finding others who had experienced something similar to

themselves was in itself important, because they had previously felt alone with their experiences, and now were able to find reassurance and affirmation of their experiences in the company of others.

There were additional issues of racial, cultural or sexual identity for some of the interviewees, which it was important to share with the people from whom they sought help. This support was most frequently found through culturally specific voluntary sector projects, such as Asian or African-Caribbean day centres or projects. It is significant that many of the Asian and African-Caribbean people interviewed had experienced very little, if any, help outside of these projects; as one Asian woman put it:

*"Only [this project] has helped me. No-one else has ever helped me"*

### Emotional support... 'Being there'

It was mainly named individuals who were identified as providing that most underestimated of functions: just 'being there'. This included mental health professionals who were available and accessible, people who listened and believed, and close members of the family or friends who had stayed with the person throughout a period or periods of distress. 'Being there' was more than just a physical presence, of course; it also meant a sense of safety or security for the person in distress, and a sense of being accepted 'warts and all':

*"It's just that he's always, he's been there, and I know he's there for me, and it's just knowing he's there can help sometimes. I do know there is somebody at the end of that telephone"*

### A reason for living

A few interviewees identified individual people in their lives, usually family and often children, as an important source of motivation to carry on with the struggle, perhaps because they felt needed as a carer or felt that they needed to be strong for the other person. This often arose in relation to children, but also in relation to a friend or relative who relied on the person being interviewed for care or support. One or two people identified their children as a reason for living, because of the hope they provided for the future or because they could lift them out of depression.

There were a number of other

strategies and supports given as a reason for living. Religious and spiritual beliefs were often given as a fundamental belief system that provided meaning in people's lives and a reason to carry on through deep, and potentially suicidal, distress. One woman described her creative artistic activities as a vital lifeline, that had 'actually kept me alive' on more than one occasion.

### Finding meaning... and purpose

A few people gave their religious faith as one of the most helpful factors in their lives. As one person expressed it, religion could represent a complex mix of support elements; it could be faith and spirituality, as well as the support of like-minded people. But one of the key underlying themes to having a religious faith was that it sustained people through giving meaning or purpose to their life.

People could also find meaning in their life through the care or support of others; often having been supported through their own illness or distress, they felt the need to provide help and support to others in return, to pass on their experience and knowledge, and this gave them a sense of purpose and value.

Other people found purpose in their life through employment or through other meaningful daytime activities, having something to get up for on a day-to-day basis being a sustaining element of a 'sense of purpose'.

### Peace of mind... and relaxation

Several people spoke of the value of achieving peace of mind, whether simply through long experience or through other routes, such as religious or spiritual beliefs, or creative expression. These people had sought out an island of peace or quiet, or patience, within themselves that enabled them to live with their difficulties or to prevent further pressure or stress from affecting them. For example, one man described his search for peace as a strategy for reducing stress, and related it to his religious belief.

Relaxation was achieved through physical or creative activities, music or complementary therapies (such as massage and aromatherapy) or through finding peace at home alone. Relaxation emerged as a strong theme in the Knowing our own Minds survey, where a range of alternative and

complementary therapies were explored.

### Taking control... having choices

People found different ways of taking control of their distress or taking control of their lives. For some people, it had been vital to develop a positive attitude through self-help strategies. Their personal strategy for self-help had a proactive connotation, involving the encouragement or development of a mental or emotional state within themselves, a positive frame of mind or self-assertion to overcome negative thoughts or feelings.

Some people had achieved greater control over their lives through taking a more proactive approach towards the treatments or therapies they used for their distress: for example, learning to self-medicate or using complementary therapies or alternative strategies within a self-help approach. Physical exercise had proved important to a number of people, through enabling them to take control over their physical and mental health and Well-being.

An important aspect of taking control is being able to make choices. Some people talked about the importance of having access to appropriate information (for example, finding out information about their medication or diagnoses, or about alternatives to medication), and some talked of the importance of money in providing them with access to more choices in the strategies or activities they could adopt:

*"Because [money] allows me to access everything else, without the money I would be... alone... would have to find a job, I can even stay in the flat I'm living in. So, I would say the money is the most important thing".*

### Security... and safety

Security could be emotional, physical and/or financial. For some people, finding a secure home had played an essential role in the development of their survival. Financial security was given as the most helpful factor in a couple of people's lives, because it enabled them to feel secure about their home and standard of living (and because it gave them access to other things - see above). The people who valued their home or money as a foundation for their strategy for living with distress had either experienced homelessness or

financial difficulty, learning by experience how essential these basic factors are:

*"Because you know they're there, you often don't actually need to make that phone call, because you think... 'I feel safe'".*

Security could also be about feeling safe in the company of others, an emotional safety that enables trust to develop and distress to ease. Safety in this sense was most strongly highlighted by people who valued and sought the shared experience or shared identity of others; for example, lesbians and gay men, women who had been sexually abused, or people of African-Caribbean or Asian origin.

### Pleasure

Finally, we turn to the element of pleasure in people's lives. The concept of living with mental distress is inevitably presented as difficult and serious, as earnest and bleak.

And of course, this is very often the case; as described above, the stigma and discrimination associated with mental illness brings with it an extra layer of distress that makes life more difficult than ever to deal with.

But the fact that people can and do find pleasure in many things, and sometimes in the distress itself, is not to be underestimated. A couple of the Strategies for Living interviewees had become proud of their distress and their survival. There were also many people who described the pleasure they found in a range of different activities and interests, from creative and physical activities, through to gardening, reading and betting on the horses:

*"Well it's, maybe, first on the list that helps me, having a bet on the horses, just watch them on television and that. I don't need to have a bet to enjoy them, like, you know. Watch them on the television and that, I enjoy that a terrible lot".*

### Rethink research

What people had to say about their self-management fell under five broad headings:

- Maintaining morale and finding meaning
- Relationships with other people
- An ordinary life: coping
- An (extra)ordinary life: thriving
- Managing 'having schizophrenia'

The 'top ten' themes referred to by

participants were:

1. Occupation, including education, voluntary work, work within the user movement, art and creative occupations, and paid employment
2. Relationships with other people, including family and friends and other 'users'
3. Personal qualities, attitudes and beliefs involved in maintaining morale
4. Coping strategies for the experiences of schizophrenia
5. Managing medication, including managing relationships with prescribers.
6. Exploring and understanding the experience labelled schizophrenia, including getting information
7. Religion and spirituality
8. Counselling and psychotherapy
9. Complementary therapies
10. Healthy living, such as diet and exercise.

Clearly there is much overlap between the themes identified by service users in both the Strategies for Living and Rethink self-management projects. In the context of the Our Health, Our Care, Our Say, White Paper which emphasises choice and independence, a lot could be learned by listening to what people with experience of mental health problems have said, and continue to say, about what helps.

This includes crucially the centrality of relationships with other people, and this is likely to include trusting relationships with mental health and social care professionals, whose role in continuing to boost people's morale and self-confidence will continue long after the current raft of Recovery-oriented initiatives has been left behind.

# Recovering Healing Communities

by Rufus May

Recovery is a word that has been used recently in mental health contexts. I like the flexibility of the Recovery concept. We can talk about Recovery from many things, we do not need to assume that to talk of Recovery we have to imply that we are recovering from a 'mental disorder'. For example: We can consider how we recover from spiritual crisis, from alienation, from a toxic society, from emotional trauma, from a psychiatric system, from mental distress or from demoralisation. In my experience, it is important for people to be able to define for themselves what they are recovering from. In this paper I will look at how we recover groups of people and relationships that support the healing process.

## Recovering Healing Communities

For me Recovery is a concept with strengths and limitations like any other. I am interested in thinking about applying Recovery to communities. How can we recover healing communities? Communities that listen, that enable, that offer space for growth and change in a flexible way. Communities that allow people to speak their truths, that create atmospheres of trust and allow people to choose ways forward in their lives, that enable conflicts to be peacefully resolved. If we are to recover healing communities, the implications for how we do things in mental health are radical. It will not come from top-down policy directives but from grass roots pressure that the media will no longer be able to ignore. We have to say loudly that our experiences of distress and confusion are meaningful, that they relate to social injustices and cultural contexts, that our so-called symptoms are messages that should not be shot down with mind numbing medication,



but listened to and made sense of. Healing communities are about people coming together as equals, spaces where people can be listened to and a range of approaches tried out. We have to be open-minded. To use technical language we have to take a social constructionist view to look at how language and the way we describe ourselves can limit our freedom. The solution is thus to create spaces that embrace different ways of seeing the world. If we have had much contact with mental health services our worlds may have been colonised by psychiatric concepts. The concept of Recovery can be usefully juxtaposed against pessimistic stories. People are so often told that they have a lifelong, biologically caused condition and there is nothing they can do about it apart from taking their pills.

As well as this I have found it useful to enable people to deconstruct established terms like diagnostic language, and the clinical language that is so often about what is lacking and does not look at the different possible meanings of people's experiences. Once we have deconstructed the medical model of distress, then we can reconstruct our stories using language that pays attention to our lived experience and links us to being able to take positive actions (for ourselves and others).

Healing communities are where

we can listen to our deeper values and wisdom and find ways to care, and to support each other. They may be spaces where lots of talking or creative expression takes place, they may be spaces of meditative and peaceful silence. Through these spaces we can find new ways to live harmoniously, balancing our own needs to be creative with the wider needs of the communities we live in.

## What are the obstacles to the creation of healing communities?

Broadly speaking there are the values of capitalism, such as consumerism and individualism that appear to challenge our sense of community and Well-being. The media psychologist Oliver James has outlined this well in his recent book *Affluenza*. James shows how Britain has twice the levels of psychiatric distress compared to many European countries and links this to our levels of economic inequality and competitiveness.

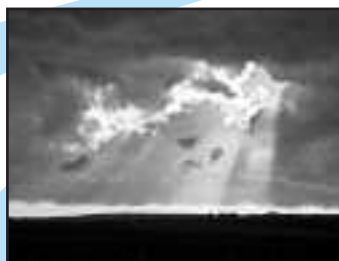
Then there are particular forces that relate to mental health service provision that may, in fact, undermine the development of healing communities. Firstly, the pharmaceutical industry's promotion of disease models and the assumption that drug treatment is both necessary and desirable for almost all forms of distress. The promotional material of the pharmaceutical industry is rife in mental health services and governmental organisations. Secondly, the pressure on mental health professionals to create a sense of safety by treating people in crisis coercively with a 'we know what's best for you' attitude.

Thirdly, the self-interest of professionals means there is a tendency to colonise expertise rather than share it with the

wider communities surrounding someone in distress. And finally, the tendency of the media to pander to the aforementioned values via pundits like the regular use of 'mental health' spokeswomen who have not been given the right to speak for 'service users', and mental health stories that focus on dangerousness. All these processes act to isolate the individual in distress from supportive others and pacify their ability to become an active agent in their life. So how do we counter all that?

### How do we create healing communities?

We need to work both underground and overground to build healing communities, to create places that are understanding, optimistic and supportive. These communities will need to be strong enough to resist the wider values of society that appear to be quite toxic to emotional Well-being. I see it as important to work both inside and outside of mental health organisations. Initially, people need places of safety to express their experiences and to hear from others about how they have dealt with and navigated similar experiences. At times these will need to be safely away from the prying eyes of risk assessments and therefore have an 'underground' quality. Self help groups seem an excellent resource that complement one to one supportive relationships. I am involved in setting up groups within hospital and community settings. I also divide my time between paid work initiatives, which provides me with some economic stability, and voluntary initiatives where I have more freedom to be creative. If, once we are on safe ground, we speak up about our Recovery stories and different ways of living with difficult emotions and experiences, we can establish our journeys through pain and confusion as legitimate, worthy of being respectfully listened to and learned from. We have to find ways of doing this both in independent media such as independent films, publications and web sites and, as we get stronger, the forums of newspapers, radio and television are worth tackling. Homosexuality was de-medicalised in the 1970s, not because of an evidence base but because of a popular movement which started underground and gradually became more and more visible in wider society.



Nevertheless, academic workers will be a valuable part of this consciousness raising process, which will involve challenging received wisdom about 'mental illness' and treatment.

There is great wisdom in the origins of the Hearing Voices Movement, which initially studied both voice hearers who had never used psychiatric services as well as voice hearers who had used psychiatric services. Following on from the broad range of knowledge gained from this approach, we have sought to make links with and gain a dialogue with people who have opted out of conventional mental health services and found their own ways to live with and transcend distressing experiences. It can be very empowering to hear about how someone has managed their distress outside of the usual systems of mental health care.

In West Yorkshire we have attempted to plant the seeds for supporting the growth of healing communities by running regular Evolving Minds public meetings which are open to everybody ([www.evolving-minds.co.uk](http://www.evolving-minds.co.uk)). Evolving Minds meetings happen in the evening and look at different ways to approach mental health problems. We highlight the value of personal experience and diversity of approaches. We also always warm up our meetings with some storytelling, poetry or music. Examples of subjects recently covered at the meetings are sacred chanting, conflict resolution, ways to develop a positive attitude, five rhythms dancing, shamanic healing practices, using narrative therapy techniques, grounding techniques, mindfulness and how to live in a sick society. Running these meetings we have found it useful to link with different faith communities such as Buddhists, Pagans, Quakers, Christian and Islamic groups. We also now have good links with Green and peace promoting organisations.

These are not therapy meetings; up to 30 people can attend - they are more public education spaces

where we learn from each other in various formats.

The increased knowledge about holistic approaches to dealing with emotional health problems means that we can introduce people using mental health services to a broader range of strategies and ideas. For example, the current members of our hearing voices group in Bradford use coping strategies that include the following: Yoga, shadow boxing, diary writing, drama work, prayer, relaxation strategies, physical exercise, generating compassion for aggressive voices, talking with voices, using non violent communication techniques, visualisation techniques, walking in nature and art work.

Quite a few group members have chosen to use such strategies as a way to successfully reduce their use of psychiatric medication. We have been able to introduce some alternative approaches into the local psychiatric hospital such as Recovery self-help groups, tai chi, 5 rhythms dance and drama classes. I see these initiatives as ways of *bringing the community into the hospital*.

The Evolving Minds meetings have had a number of side effects. They have generated a campaigning group who have initiated three Great Escape Bed Pushes to highlight the need for more alternatives to coercive psychiatric practice (see [www.bedpush.com](http://www.bedpush.com)). One of the latest spin-off projects from Evolving Minds is a Coming off Psychiatric Medication Support Group that has met weekly since June 2007.

We have also established a web site: [www.comingoff.com](http://www.comingoff.com). This aims to provide information about how to reduce medication and alternative ways to deal with difficult emotions and thoughts that may re-emerge or emerge as part of the withdrawal process. This project has a number of volunteers whose skills include reflexology, tai chi and qi gung, counselling, community theatre and pharmacy knowledge.

### Conclusion

The process of recovering healing communities is about creating communities of hope, of acceptance, of opportunity, of open-mindedness, of creativity, of understanding, of restorative justice and of love.

# Commissioning for Recovery, Well-being and a Whole Life

by Perry Marshall

Commissioners of mental health services now have an emerging range of policy and commissioning guidance not previously available to them. Strengthening Recovery and social inclusion approaches in mental health offer an opportunity for commissioners to shape effective, person-centred services for the future. It is incumbent on them to deliver, wherever possible, services that people need, where and when they want, that facilitate individual Recovery and provide a Whole Life mental health system.

## What is commissioning in mental health?

*“Commissioning is the process of translating aspirations and need into timely and quality services for users which meet their needs, promote their independence, provide choice, are cost-effective and support the whole community.”*

Relentless Optimism

Commissioning is distinct from contracting and procurement, which are more concerned with the formal arrangements for purchasing and monitoring of services. It consists of a cycle of strategic activity that is constantly responding to the needs of a local population. This cycle normally includes four stages: analyse, plan, do and review.

*“Managing the market to ensure the right mix and pattern of services to meet statutory guidelines and local objectives within the resources available is the holy grail of commissioners.”*

Commissioning E-book

If this market is to be effective then it needs to provide a range of ‘products’ based on personally expressed needs related to an individual’s Whole Life, not on a historical legacy of what others think they need.



Commissioning has historically tended to focus on specifying inputs (the activities and functions that are expected from a service) and outputs (number of service users, number of particular activities, number of referrals etc). The challenge for commissioning in the future will be to shift the focus towards the positive changes there have been for people using services.

Commissioners will need to specify how we achieve these aims and outcomes and be able to measure the difference it has made to individual service users in reducing stigma and social exclusion.

## What does Whole Life and Recovery mean for commissioners?

We live with a historical legacy of mental health services dominated by clinical outcomes and an understanding of mental distress firmly embedded in a psychiatric/medical discourse. For many, an option to use medication and/or hospital has been much needed and effective, but, for those who choose not to use hospital or medication, there have been limited alternatives.

The last few years have seen a wide-ranging and heated debate as to what counts as evidence of effectiveness in mental health. Mental health services are moving from a paradigm of clinical Recovery from mental health problems to one of facilitating and empowering services users to direct their own Recovery journey.

This may mean support to reduce the symptoms of mental health problems but, just as importantly, it means providing the mechanisms to ensure citizenship and full participation in society.

Commissioners therefore face a real challenge in addressing the tension between ‘clinically effective’ treatments based on medical and psychological models and an increasing need to provide effective services based on a socially inclusive Whole Life agenda.

How do we reconcile these competing needs given there are finite resources? Commissioners need to develop a clear understanding of a wide spectrum of mental health needs of their local population. This will need to be used in conjunction with national service user evidence as well as clinical evidence.

## Whole Life outcomes in mental health services

Historically, commissioners and contracts departments have been more interested in outputs and budgets. That is, that the specified numbers of service users or hours of activities are taking place and that organisations are managing to balance the books. These are no doubt important considerations but a much greater emphasis is needed on outcomes for people using services. By this we mean ‘what changes has this service made to an individual’s Recovery and quality of life?’.

There are a number of personal outcomes provided in ‘Our Health, Our Care, Our Say’ which have a close affinity with a Whole Life approach in mental health. These include: economic wellbeing, choice and control, personal dignity, etc.

Evaluation of services will need to incorporate measurements that

can capture the differences made to people's lives from a range of outcomes similar to those above. Tools are currently being developed which should help commissioners and services to measure effectiveness in providing a Whole Life, socially inclusive approach to mental health problems (e.g. National Social Inclusion Programme, National Development Team).

### Workforce planning

Evidence has shown that it is simply not enough to brand teams as 'Recovery' teams or to introduce Whole Life principles without real opportunity to embed this approach in organisations and with staff through a cycle of training, practice development and reflection. This is probably true for all organisations across the spectrum of statutory, voluntary and independent provision.

Recovery has been defined as: *"a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and roles."* SCIE (2007)

This is as relevant to staff and organisations as it is for clients of our services. Without a change in attitude, in thinking and in the relationships we have with our clients, we will not be able to effectively achieve the Whole Life

changes that people have said they need.

By specifying functions and outcomes related to a Whole Life, whole systems approach, commissioners can support organisations to develop the relevant competencies and skills needed to work from a client-centred, Recovery approach.

### Partnership working

There is a pressing need to work across the primary care/secondary care divide and also between health and social care organisations. Primary Care Trusts have been tasked with improving the health and wellbeing of their local populations and this includes mental wellbeing.

*"Too often services fail to recognise the interconnected nature of people's needs...many services tend to focus on problems in isolation from the rest of their life. Rather than experiencing a single targeted intervention to meet their whole needs, they receive multiple interventions that lead them on an unpredictable journey around different agencies."*

Haselgrove, S. & Tibbles, I (2005)

Service users, as a rule, are not interested in funding sources, interfaces or demarcations

between different types of services. They are, however, concerned in being handed off from one person to another and in delays in receiving the treatments or interventions that they need.

Pathways through services will need to be carefully analysed to ensure that more choice does not correspond to more complexity for clients. This can only be achieved by building strong links between health and social care commissioners and, in turn, with service providers and the community at large.

### Resourcing Whole Life mental health services

Choice is central to the development of more modern services. Offering more choice can help to improve outcomes, support social inclusion and support system reform. It gives power to shape a tailored pathway and create personalised services organised around people's whole lives.

Current policy and legislation is creating an opportunity to move away from a one-size-fits-all approach to services. Our Health, Our Care, Our Say sets out clear guidelines for a move to effectively integrating services and giving individuals more personalised care.

The introduction of direct payments and individual budgets create opportunities for service users to genuinely direct, choose and purchase their own services.

The purpose of these mechanisms is to give recipients control over their own life by providing an alternative to social care services provided by a local council (and in the case of individual budgets to incorporate funding for housing support and employment services).

The implications of this approach are far reaching and for commissioners the challenge will be to continue to advocate for the choice and control this approach to resourcing brings, but also to be sensitive to the effects on current provision and the local mental health system.

### Hope for the future

This paper has touched on some of the challenges facing commissioners if there is to be genuine movement towards a Whole Life approach in mental health services. Without imagination and risk-taking we will continue to tinker around the edges and will not achieve the paradigmatic change that is necessary to support a Whole Life approach.

Commissioners have an opportunity and a responsibility to listen, plan and change services to reflect principles of hope and personal Recovery.

A recent Commission for Social Care Inspection paper noted in a seminar they held that:

*'... the group that included people who use services came up with the most radical solutions, proposing that services be redesigned from scratch'. Another service user spoke of 'giving people the right to dream.'*

The introduction of 'Recovery' and Whole Life in mental health services in England is akin to the process of Recovery for an individual. Change will bring anxiety and even pain and distress. Mistakes will be made and, hopefully, lessons learnt. Clear communication and effective relationships will be crucial. Let us hope then, that we can learn and gain from our experiences to transform and provide services that will inspire hope for the future of all involved.



# Turning The Circle and Seeing Again

by Christopher Newell

**A short poetic reflection on a Life Story  
(Unfinished) July 2007**

To live a hidden life where voices come and go and some stay unwanted;  
To not know why you feel the way you do and wonder whether you are the only one;  
To linger on lonely hills, wet and cold, shivering with the temptations inside your head;  
To say cheerily, hello to your congregation and preaching love and grace whilst knowing, knowing how dark and deep your darkness is.  
To live a life of secret lies, of terrors in the night when in the day your  
Christian priesthood speaks of eternal, loving truth.  
To finally see your world collapsing all around and a gloomy forest night embrace you in its grasp.  
To be rescued, to be saved but not in a Christian way and yet, yes, in a Christian way.  
To find myself at last in hospital, sectioned, stripped seemingly of who I am and who I was and who I will be.  
To feel a loss of self, a loss of being, being a priest, being a father, being a partner, being strong.  
To see my nightmares, real and vivid, overwhelm my dreams, distant and fading.  
To be alone, alone, alone.

*THAT IS HARD, SO VERY HARD*

To slowly, gradually, beautifully discover friends, discover I am not alone and no longer hidden.  
To find in others, all manner of others, some who call themselves professionals,  
Some who are called patients, service users, survivors, carers,  
All who call themselves human,  
Wisdom and compassion, solidarity and abiding faith and heart and gracefulness.  
To discover in my naked weakness, a strength I never knew, in my broken mind, a healing I hardly dreamt of  
at all.  
To reveal in my dis-ability an ability, in my illness a truth, in my fear, a hope, in my life, a new life, in my  
voices, a conversation, amongst my friends, support and space for me to be revealed.  
To know that with others I journey, uncertainly, sometimes scarily, often fearfully, always lovingly to  
destinations unknown but in the most exciting way.  
To understand my Recovery as a lifelong process in which my past and my present and my future will be  
partners and not enemies, will ensure my times  
Of light, my times of dark, my grey times and my times of colour will be shared  
With others who will support me as I may support them.  
To find my lost things, my self as partner, father, priest and friend.  
To return to my hospital, sometimes still as patient, service survivor, whatever you may call.  
More often, as a priest once more, a professional, a human being, above all a human being.  
To share the task of breaking down distinctions, of challenging the stigma of being ourselves.  
To be together, to be together, to be together.  
To turn the circle and see again.

*THAT IS GOOD, SO VERY GOOD*

# A Personal Account of Recovery

by Lisa Solheim

## Recovery

I sit here and try to write, try to think and make sense of my life, of what I've been through, and know if I told all that no-one would believe me. After all, it seems that my life in some ways parallels the dramas that we see in the soaps on TV.

Hope and Recovery to me are ambivalent words, words that mean to me something different tomorrow than they did today. I would love to say that I believe in these words and sentiments, yet life has taught me that you have to be careful what you believe. How cruel is it to have hope about a future less painful and difficult, about Recovery and maintaining wellness, but also to know that tomorrow all hope may be extinguished, and hope itself becomes painful.

I guess I don't want to really discuss my distant past in detail here, but suffice to say that my upbringing was troubled, and those troubles leave me scarred to this day. I was brought up not knowing about emotions, the only 'feelings' I could identify with were feeling hungry, or tired or suchlike, which I now know are not feelings at all!

I first remember experiencing what I now know is depression in my teens. It was never recognised, and left me on my own with emotions I could not understand or explain. Being emotionally illiterate, and unable to express these feelings in a safe way my emotion became physical, I began to self-harm by punching a granite wall in my room. You can guess that I didn't damage the granite! It was the only way I knew that I could channel the emotion I was experiencing in a safe way.

I left home when my parents split up, at first living in a grotty bedsit, unemployed after doing disastrously badly at my A Levels.

The housing I was in, and living on benefits brought about the return of the depression. It was hard, but I somehow got through it. I managed to get myself a part time job working in a hospital which I really enjoyed, and from there was accepted to train as a mental health nurse.

Being still pretty much emotionally illiterate this was a steep learning curve. I found it demanding but probably amongst the most rewarding things I've done. Unfortunately the depression was triggered again, and this time things went completely haywire.

I had some time off sick before trying to return to work, which went disastrously wrong. No one was at fault, but within a few days I had overdosed and was in hospital. This led to a lengthy psychiatric stay of three months, mainly out of the county because I was staff.

It was really difficult being on the other side of the office door; I knew what was likely to be happening within. I knew that the staff now saw me as being different. I knew that the view would be shared by the other service users and that I would be treated with suspicion. Nobody, let alone me, knew where I fitted into the 'them and us', of staff and patient. That was eight years ago, and life is still a struggle. I have had several admissions, but none for a while as it has now been judged that hospitalisation doesn't help me.

My time as a service user began in hospital, in the community it has brought me into contact with lots of staff. Some have been stars, and others sometimes much less than helpful. I'd like to thank those who have accompanied me along the journey, people who may not have realised that they have helped.

My diagnosis has changed from depression to borderline personality disorder. I really struggled with this due to the stigma that this diagnosis carries, and I still get horribly depressed. One of the best things that came of the new diagnosis was that I had a chance to work with a nurse specialist, and I know that without their support I would not be here today to write this.

I wish I could say, "I'm cured!!" But I realise that a cure is not quite possible! I have changed since I first became unwell, some things for the better, some things I still struggle fiercely with, including life itself. But I have also managed to achieve things with the support of people round me.

I have just gained a qualification in mental health service improvement leadership, and have set up a peer support group for people with personality disorder. At some point, in a safe and supported way, I would like to return to work in the field of mental health.

I guess that brings me back to where we began, and that word 'hope'. I do not know what the rest of life holds for me, or how long my life will be. My grasp on it becomes fragile at times. I know myself well enough to realise that life is good at throwing the unexpected at me and sometimes I cope better than others.

Maintaining any kind of wellness is very difficult, and I owe much to the people who have been there for me, members of the family, my friends, staff, people who have shared some part of my journey with me. Without their love, help, support and validation things could have been vastly different. And last but not least do I owe thanks to the cats, dogs and horses that have provided relief and unconditional love therapy along the way.

# Life's a Botch

by Kevin Parish

So I've got a bad back. One in four of us have similar problems (now where have I heard that before?). The problem is it didn't grow straight, giving me as a teenager a peculiar bent, some pain, susceptibility to injury and a slight level of disability. Well you know how it is; we get on with life, ignore the problem and do the best we can.

But that's a physical (organic) problem – it's obvious, visible. Doctors and therapists can prod, tease, and recite phrases in an incomprehensible language with bits of Latin. X-rays become the norm, diagnoses can be clear, proven and substantiated.

Not so obvious was the real pain in my life, also stemming from teenage years. Periods of intense anxiety that crippled me for days, weeks of lethargy and

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**At age 50, I really lost the plot. I thought I knew everything**

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hopelessness, then wonderful times when I could do anything but would inevitably burn out under the self-induced pressure. No surprise that at the age of 35, after three suicide attempts, a psychiatrist floated the words 'manic depression' across the ether of my confusions.

My reaction? Well, the words meant nothing to me, the medication made me feel like a zombie. I just plain didn't understand how what for me was normality suddenly became quite a serious mental illness. So I went sky-diving. In those days it didn't involve 'buddies' – you just left the aircraft and sorted out the mess yourself.

At age 50, I really lost the plot. I thought I knew everything I needed to know about self-



managing my back pain. Compliant with medication, respectful of the limitations and very well 'read', it came as a shock to find that pain and

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**In the middle of my nightmare it became obvious that this was my illness, my life my problems, and my shoelaces**

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disability levels increased exponentially in a year. My consumption of prescribed opiate pain relievers increased to frightening levels, and depression became a fact of life. Two more

coma-inducing suicide attempts later I was sectioned, and my psychiatric career had begun.

One year on. I was left with just the clothes on my back and a long list of questions that went a bit like this:

- How can I get a life back?
- How can I recover?
- How can I cope with these mind-numbing drugs?
- How can I be safe?
- How can I pick myself up by the shoelaces?

The reader will note the 'I' appears in every question. Unknowingly the prerogative just

appeared. In the middle of my nightmare it became obvious that:

- This is my illness
- This is my life
- These are my problems
- These are my shoelaces

The ownership carries with it a level of power over outcomes

### Recovery

I'm not buying into 'Recovery'. Contentious? With good reason. It's become a buzz word in recent years, got a real political context and is much too useful for the Government and Department of Health to bandy around. Over the last few years I have spoken extensively with a couple of the top psychiatrists from Trieste on the subject. Guess what? They don't buy it either!

What we do agree on is that symptoms can be managed, can be integrated into the 'Whole Life' experience. At worst, symptoms may persist but with the right help be rationalised by the person themselves. At best there may be a remission. What we really mean could be described as 'thinking with a limp'.

### Illness?

Sorry, but I'm not buying into that either. We know that the symptoms are episodic; there will be some really bad, tough times. But in between the tough times, any disorders will be behavioural, and I can slap my own wrist if I'm naughty. So I will call it a 'disorder'; I'm not going to elevate it to the status of 'illness'.

The same with medication: over a period of years I got the dose down to an acceptable

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**Dreams are meant for dreaming, they cannot be bought in shops. The focus instead is on life's small things. There is more value in the satisfaction of cooking a good meal oneself, than ordering a take-away**

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minimum. When the going gets tough the dosage goes up. Self-monitoring is essential here, and if I need help then I get it before things get out of hand.

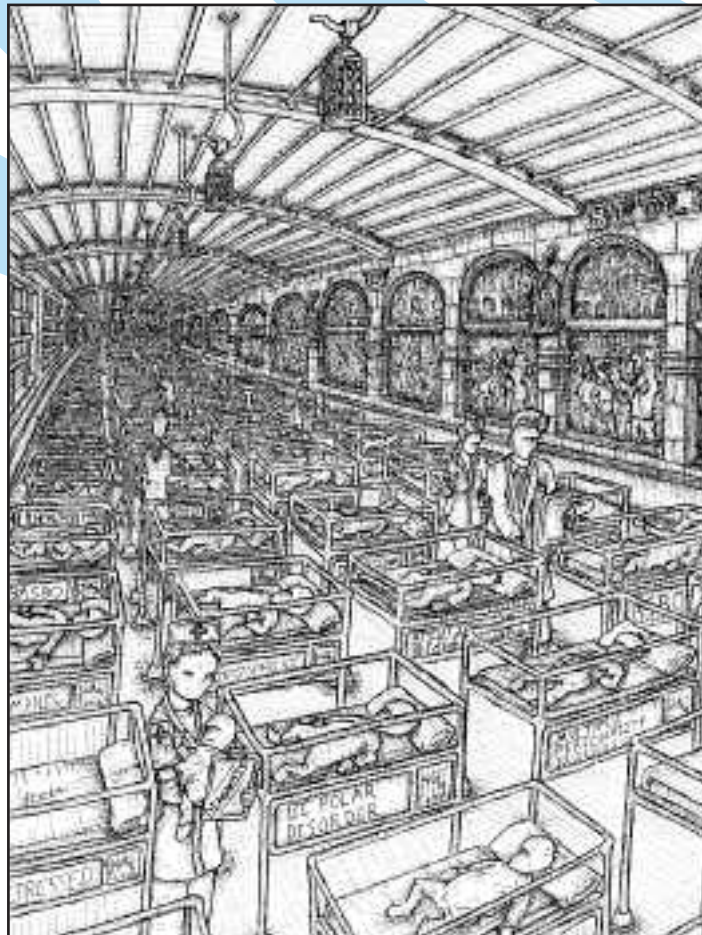
Most doctors and psychiatrists will not approve of this. It's good for me, but only after I worked things out for myself. I am lucky to have a brilliant GP who trusts me with myself.

I always take the minimum

necessary level of medication. This is not the only tool in the box, but it keeps me safe when all else fails.

### Life

The true beauty of being homeless, broke or alone is that it re-defines one's view of life. Gone forever is the life you knew, but gone forever are the millstones you carried. At this level simplicity can be therapeutic. It doesn't overwhelm you.



Expectations too change in line with circumstances, (I am not going to save up for that plush car - I could never afford the petrol). Dreams are meant for dreaming, they cannot be

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**If you can sit alone with your troubles, and resolve even one of them, you've made a start on a different life**

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bought in shops. The focus instead is on life's small things. There is more value in the satisfaction of cooking a good meal oneself than ordering a take-away.

### Problems

Getting control of the disorder, giving yourself space to deal with it without it controlling you and being less than perfect has got to be top of the list. For this you

have to learn about it, know it inside out. It is after all an essential part of your being; doesn't it make sense to know your best friend, yourself?

I felt a victim of the 'professional divide', which is composed of only one thing – knowledge, and that you have this is paramount. Mental health services are not good at giving you this. They often take the view that if you are

informed of the details of your disorder, then you might 'acquire'

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**I've still got a wonky back, and suffer from 'thinking with a limp'. But I found happiness. I found it within myself on the journey to find out who I really was**

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those symptoms. In addition, they may feel that you are in no condition to absorb the information.

But you cannot drive a car if you don't know how to point it in the right direction, make it go and make it stop. These are the painful basics in the management of any disorder: having some kind of instruction book. Knowledge is power, but supplicants are powerless.

Eventually, if you can sit alone

with your troubles, and resolve even one of them, you've made a start on a different life.

### Mental Health Services

Will want to protect you, and are allergic to risk. It is extremely difficult to discharge yourself from care. Accept all the help you can get, but don't make it the meaning of your life.

The best services walk beside you on this journey. Help you when you need it and yet maintain a light touch when you're OK.

Forgive a digression, but I remember the last time I spoke (as a patient) with a psychiatrist. Ten minutes with an SHO. He decided to change my medication and had some difficulty with my assertion that 'I'm doing OK as I am'. We got there in the end.

When I got home the cat climbed up on my lap and purred. After 10 minutes I felt a new man. Moral? My cat knows me better than my psychiatrist!

### Lifting by shoelaces

Take back the power by owning the problem.

Keep life simple; if it gets complicated, something went wrong.

Dream your dreams but be real with reality.

Turn off the TV. What are you going to learn from soaps? Go get a book from the library, meet some 'normal' people.

Buy some cheap basic foods, cook them, burn them, bin them. Now you're learning how to make a meal!

Be proud of yourself, you've been to hell but now you're back.

### And finally...

I've still got a wonky back, and suffer from 'thinking with a limp'. But I found happiness. I found it within myself on the journey to find out who I really was. It never occurred to me that happiness was there all the time, I guess we are educated to believe that it's a response to an external stimulus.

And I'm 60 now. When the Practice Nurse gives me a telling off about blood pressure she seems surprised when I point out that we might expect things to go wrong as we age. From age there is no 'Recovery', but I'm lucky nothing's dropped off yet!

# Introduction to Spirituality

by Peter Gilbert

Spirituality is an essential part in the Whole Life approach, as it is a vital element in each one of us. Because of modern life's emphasis on material possessions, wealth, power and status, many people feel a strong undercurrent of anxiety in their lives – what some commentators have called 'affluenza'! (See Coyte, Gilbert and Nicholls 2007, forthcoming.)

Because our 'human services' have been placed in a straightjacket of bureaucracy, statistics, targets, paperwork, computerisation and management-speak, many people in Health and Social Care feel that the essential values – the spirit of the service – has been squeezed out. As some Health and Social Care professionals have put it, the service seems to have 'lost its soul'. Interestingly, Professor Lewis Wolpert (Wolpert 2006) talks of depression as being an experience of 'soul loss'. This is particularly interesting as Wolpert describes himself as a 'hard-line materialist'!

All the surveys of Health and Social Care demonstrate that users of services want not only professional expertise, but also recognition of mutual humanity and respect for their innate dignity and their culture – including spirituality and religion.

When the NIMHE/CSIP Spirituality and Mental Health Project was set up in September 2001, and a kind of 'strategic permission' was given to speak about spirituality, users and carers, and staff, came forward in droves to say that they wished to discuss their spirituality (which may or may not contain religious beliefs), but had been constrained – even frightened – to do so! As one service user put it: 'talk about God and they up your medication.'

*'I have to behave myself today,*

*no talking of God  
and of his plans for me...*

*All too soon the fun had to  
stop;  
I had to return to the ward on  
the hill  
With others of my kind.'*  
Extract from 'Year 2000 on a  
Section 3', Sue Holt, *Poems of  
Survival* (2003)

Not everybody likes the word 'spirituality'. For some people, it is a bit too loose as a phrase, even woolly, but it is a useful 'gateway' word, which can open a door to many beliefs and experiences.

All the major philosophies and religions talk about women and men having an essential spirit, which is the spark that energises and drives us.

The Jewish faith talks about ru'ach being not only life, but invigorated life – and we all want some of that! Muslims speak of ruh. The Greeks spoke of pneuma, and all of these words mean both 'the breath of a human being' and 'wind', which invigorates nature.

Plato, the Greek philosopher, wrote that:  
*"As you ought not to attempt  
to cure the eyes without the  
head, or the head without the  
body, so neither ought you to  
attempt to cure the body  
without the soul ... for the  
part can never be well unless  
the whole is well."*  
Quote in Linda Ross, *Nurses'  
Perceptions of Spiritual Care*,  
(1997)

Spirituality is therefore about:

- What makes us tick.
- What keeps us going when times are tough.
- Hope.
- Connections and connectedness.
- What makes me, me; and you, you?

- How we channel our desires.
- Our life pilgrimage, or quest.
- Family and friends.
- Nature; connecting to animals and plant life.
- Music and poetry.
- A sense of something beyond ourselves; God, the spirit, and the cosmos.

## Religion

Religion, in a formal sense, is about:

- All of the aspects described above, usually in the context of belief in a transcendent being or beings, and with a meta-narrative which seeks to explain the origins of the world and those living in it, and the questions which face human beings around life, suffering, death, and re-awakening in this world or another.
- Religion can provide a 'world view', which is acted out in narrative, doctrine, symbols, rites, rituals, sacraments and gatherings, and the promotion of ties of mutual obligation. It creates a framework within which people seek to understand and interpret and make sense of themselves, their lives and daily experiences.
- Faith communities can be welcoming, integrative and supportive; while some others can be exclusive and stigmatising of people experiencing mental ill-health.

## Speaking personally

If you were to ask me for one word which expressed my spirituality it would be connection. The most terrifying aspect of my depression, seven years ago, was the sense of disconnection: to other people, to my inner spirit, with God, and with the world around me.

As a natural extrovert, I enjoy making connections with people, yet this is despite (or perhaps because?) of a rather solitary childhood, having been born and brought up on an island. I find people's stories fascinating, and, as someone who goes for long runs with a group on Sunday morning, there is plenty of time to listen to people's unfolding narrative.

Running has been a major feature of my life. Not only does it help the stress levels brought on by my incipient workaholism, but it wipes away many of the niggles and doubts that clog my brain. It's perhaps my workaholic version of meditation? Runners often say: "Running clears my

head”, and, in a busy, over-full modern life, this graphically describes how running brings about a sense of ‘flow’, which bathes us and sluices away the detritus in our muddled and muddled minds.

Perhaps our hardest relationship is with our self? I find other people fascinating, but I’m often bored with myself. So even on my own I need to connect with something other than myself. As an islander, that something is often the sea, with its surge, spray; its still and stormy voice; and its insistent movement to and from the shore.

In the depths of depression I was also fortunate to have a place of spiritual asylum, Worth Abbey, where I went, and, though feeling disconnected from God, was borne up by the chanting of the monks – in community without communing; swept along as though running by the river or floating on a sea breeze. The Greeks have a saying: ‘*The Sea, Me and God*’ (See Nicholls and Gilbert, 2007) and it’s to that sense of oneness that I return.

### Why are Spirituality and Religion of increasing importance?

It is because:

- Service users and survivors tell us it is, as we have seen above?
- Of international and national legislation e.g. The Human Rights Act 1998, Article 9, and the Equality Act, 2006, enshrine freedom of thought, conscience and religion?
- In a consumerist society (see Bauman, 2007), people wish to assert that there is more to life than material goods and being given value through how much we consume?! By basing our value, as human beings, on consumption eaves out so many people, such as those with severe and enduring mental illness, people with learning disabilities, those who are elderly and mentally infirm, asylum seekers, and those who are deprived for financial and other reasons.

Whether or not we like the concept of ‘multi-culturalism’, Britain is a society with a complex make-up with a variety of belief systems. Every person has a variety of aspects to their identity. National policy guidance on health and social care, and social cohesion,

promote an accent on the personalisation of care and interdependence as well as independence.

Research shows both a very high national interest in spirituality issues, and many people’s affiliation, even if somewhat loosely, to a religious belief. International research demonstrates the importance of belief in physical and mental health and Well-being, and longevity.

It could be argued that after the traumatic events of 9/11, many people of Asian ethnicity are choosing to define themselves by their religious faith, rather than their race. Building a positive connection between statutory and faith-based services is an essential element of social cohesion (see Commission on Integration and Cohesion, 2007).

Furthermore, The connection between mental Well-being, economic productivity in a knowledge economy and social cohesion, is increasingly recognised (see Layard, 2005).

### The spirituality dimension

Michael Marmot, one of the UK’s most distinguished epidemiologists, trained as a doctor, and expanded his views on personal and public health, through working as a junior psychiatrist in a deprived area of London (Marmot, 2005). He saw that each individual was made up of different connected dimensions; physical, mental, emotional, spiritual, social, psychological, and that people lived in a complex network of family, community and societal relationships. In effect, we all live as whole (although sometimes impaired) persons in whole (although sometimes fragmented) systems.

### Blocks to recognising the spiritual dimension

The main block to recognising the spiritual dimension in those experiencing mental distress is our failure to empathise and recognise our own pain. So why do we find it so difficult to be human?

- We have to acknowledge our own vulnerability.
- Empathising with ‘difference’ may pose challenges for us.
- Looking inwards into what makes us tick can be threatening and frightening.
- It is easier to do the ‘us’ and ‘them’ bit: ‘I’m sane and

you’re mad’; and/or ‘I’m a professional, you’re a user’; or ‘you’re a professional and you can’t possibly understand me as a user’.

- We have to give up some of our power!

### What is the NIMHE Spirituality and Mental Health Project about?

The Project focuses on two main issues:

1. Spirituality as an expression of an individual’s essential humanity, and the wellsprings and motivation of how they live their lives and deal with crises.
2. The establishment of positive relations with the major faith communities, at a time when a harmonious construct between statutory agencies and faith communities is essential.

The work of the Project, set out in Inspiring Hope (November 2003), has been undertaken in a number of ways:

1. The setting up of Pilot Sites or collaboratives in all eight regions of NIMHE/CSIP. There are about 30 Sites in all (though mergers and changes affect this) and in 2007/8, regional events will take place to assist in developing and celebrating good practice.
2. Positive relationships have been built with faith-based groups and networks. A multi-faith symposium was held on 1st November 2006, as a partnership event between Staffordshire University, the National Spirituality and Mental Health Forum and NIMHE/CSIP. All nine faiths liaised with by the Government, the Humanists and a strong user voice, came together to focus on a range of issues and the synergies between belief systems (see Gilbert and Kalaga, forthcoming).
3. A Resource Pack was produced between NIMHE/The Church of England/Mentality in 2004, and can be used as a model for working with other faith groups (Tidyman and Seymour, 2004).
4. The National Spirituality and Mental Health Forum has now been registered as a charity, and acts as a partner with the NIMHE Spirituality and Mental Health Project, although in an independent mode.
5. Work with different professional groups has taken place. It is worth noting that the Special Interest Group on

Spirituality and Psychiatry at the Royal College of Psychiatrists is now the fastest-growing special interest group at the Royal College.

6. Links with Government departments and the Prime Minister’s Inter-Faith Advisor, the Scottish Executive, the Welsh Assembly Government and the Channel Islands, are maintained and nurtured.
7. Links have been developed with a growing number of university centres. A UK-wide research forum is being set up currently, which will have international links.
8. Work has taken place across the NIMHE Programmes – Whole Life, Values, Choice - Social Inclusion, Race Equality, Workforce Development, Recovery, etc – and input has been made to the International Diagnostics Group, looking to reinforce whole persons and whole systems approaches.
9. Partnership work has taken place with national charities and development centres.

### Conclusion

The latest consumer research into what service users/patients want from services brings us back sharply to issues around our basic and shared humanity.

Across health and social care people tell us that what they really desire is to be respected, listened to and treated as a fellow human being, not an object or a body part/machine, and for their own perception of what makes them tick to be taken seriously.

We talk about one-in-four people suffering from mental ill-health, but in my conversations with a wide range of people, I’ve found very few people who haven’t gone through the valley of shadows at some stage in their lives!

If we can, in all our lives, both forge anew the common bonds of humanness and link this to the unique spirit in each of us, then we can take humanity to new heights!

Peter Gilbert is NIMHE National Lead on Spirituality and Mental Health, and Professor of Social Work and Spirituality at Staffordshire University

# Me, My BPD, and God

by Christine McDonald

Until a few years ago the words spiritual and mental were in the same place in my mind as the occult – a scary place that I had no plans to explore. In some ways, they had bed mates – other hang ups that I had – long haired men, people in wheelchairs, and those with different coloured skin, for example.

I had lived a sheltered life in many ways and these people were different from me. In my eyes, I was normal, and they were not. Then life got in the way. Basically I grew up, married, and had a successful career in local government; first as a buyer, followed by marketing and sales. Then, my husband and I decided to start a family.

Whilst on maternity leave, I received notification that my applications for professional membership of two Chartered Institutes had been accepted, that of Purchase and Supply and of Marketing. I checked out the membership lists, and found I was the only person worldwide with both qualifications, giving me evidence of great achievement in two opposing disciplines – buying and selling. I was unique. At this point, it was as if an electrical circuit had been completed in my head. I remember feeling a physical difference as if pathways were opening up in my mind.

## Then I met God

He was sitting on a cloud, and I asked him how he knew He was God, and I wasn't? He replied, "Because I am up here and you are down there. I asked if I could join Him, but His answer was "No! not yet".

I argued that I had reached my peak, cited my motherhood and newly received membership cards as proof, but He continued, "Get back down to earth - you haven't played all your cards yet. I have selected you to spread the word that I am available to anyone who needs me. You can use your own experiences to explain".

I wish now that He had said, "...spread the word... at appropriate times", because learning this forewarning would have saved me a whole lot of trouble, anxiety, and maybe even the diagnosis and stigma when I mentioned the conversation to others.

After a time, I forgot about my dialogue with God on the cloud. Somehow though my mood had lifted and I picked up a newspaper to read. An article jumped off the page as if written just for me, and I was soon on a tidal wave, driven to research everything about the subject, and to produce a dissertation. I had 100 copies of my report printed, and sent them to everyone on my Christmas card list, then posted them in all the letter boxes in the village, and started thinking about extended distribution.

Just then my baby cried, and I switched immediately from work mode to baby mode. After dealing with the immediate needs of nature, I looked around and saw the pile of presents we had received at my child's Christening. They included a photograph album - one of those with spaces for the first lock of hair, and for pictures of family members.

It made me think about my father, who had died when I was six years of age. I had an urge to find out more about him, which became more and more intense. I wanted to get closer to him and tell him he was a grandfather. I reached this closeness by discovering his spirit in a packet of scented talcum powder and sprinkled it everywhere, rather like incense in high church.

The following day, I was diagnosed with Manic Depression - Bi Polar Disorder - BPD - as it is now called. The text book cites various typical clinical signs of mania. For example, a belief at being the chosen one, delusions of grandeur and hallucinations. Were these the experiences I had when I met God on

His cloud? So I was mad, after all, and my pact with God must stay a secret, for to tell anyone was proof of mania .....mental illness. When I first received the diagnosis I was terrified – to me manic depressives went around with axes murdering people. People told me I was silly to think that, but it didn't help – the thought was in my head, and no-one listened to the message I was putting out - that I needed someone to listen to how I felt, and not judge what I was saying.

To me, their judgment was that I was trivial and puerile ...and it hurt. For the last 14 years I have had a fair share of 'character building experiences'. There were many times when I have forgotten about God. But when I remember, we have a little chat.

We have special ways of communicating. We have a laugh together in private, but at times He tells me off and advises me not to be too flippant. "Be careful not to upset the beliefs of others", He warns. So, I am careful whom I tell about God. I have learned my own caveat, my own self-management skills as to when to share thoughts and feelings ..... and when not to. (Until now, that is!)

Along my journey I have met a cornucopia of personalities who have touched upon my life - many of whom I would not have met had I not seen the world from the 'other side'.

I feel privileged I have met God and been able to share my conversations with Him. I feel I have played many cards in my deck, and just when I have won a hand, someone comes along, collects up the cards, shuffles them and re deals. One time when I was an inpatient, I had the experience of a few days of long, sincere and searching conversations with two special new found friends, who were co-patients. We talked as a threesome exploring life, death and all things in between.

One was an Angel, the other relied on The Bible to attempt to quell my almost insatiable appetite for knowledge about such things that were a mystery to me.

It was an experience I shall treasure for the rest of my life.

NB This experience was over three years ago. It was the last time I needed acute care, after well over a decade as a revolving door patient.

# BPD or Spiritual Crisis?

by Larry Culliford

Dr Larry Culliford was present in Chelmsford at the Essex 'Mind and Spirit' conference on 5th February 2007 when Christine McDonald gave her fascinating talk on, "Me, My BPD and God". Her courageous performance was both lively and captivating; however, I soon began to wonder about an alternative or additional diagnosis based on the paper Christine delivered.

When I spoke to Christine afterwards about the possibility of her having gone through a spiritual crisis, she wanted to know more.

To put it briefly, spirituality is where the deeply personal meets the universal.

The Spirituality and Psychiatry special interest group (SIG) of The Royal College of Psychiatrists, founded in 1999, now has almost 1,500 members. It is increasingly expected of psychiatrists that they will routinely take spiritual histories. In mental health care, spirituality is identified with experiencing a deep-seated sense of meaning and purpose in life, together with a sense of belonging.

In a leaflet published by The Royal College (2006), prepared by members of the SIG, it says, "Making a spiritual assessment is as important as all other aspects of medical history taking and examination. When making a diagnosis, a psychiatrist should be competent in distinguishing between a spiritual crisis and mental illness, and be able to explore areas of overlap and difference between the two".

According to the website of the Spiritual Crisis Network, "A spiritual crisis can be described as a turbulent period of spiritual opening and transformation. Spiritual crisis is also referred to as

spiritual emergency, where a process of spiritual emergence or awakening becomes unmanageable for the individual. A person may experience psychological or mental health difficulties. Hence the term psycho-spiritual crisis is also used sometimes".

It is no surprise then that Christine wants to give something back to the sacred universe: by speaking at conferences, by her involvement in the Mind and Spirit Forum, by writing about her story, and in other ways. It is obvious that she also wants to alert people to the powerful inner resources that come with spiritual awareness and depend on a personal sense of universal connection. This is normal when you have experienced what she has. Her self-evident courage is undoubtedly based on faith, and she deserves our trust and support. That way, new-found inner strengths and virtues get backed up by the external support of like-minded people.

Our materialist culture can easily isolate and alienate us from each other, but here is an excellent antidote. A group forms and becomes a genuine community in

which people share highs and lows, good times and bad. At the heart of it is a sharing of both spiritual values and practical ideas. The key ingredient for success is selfless love. It is not so much about meeting God sitting on a cloud, as about discovering divine inspiration within yourself and others too.

I send Christine, and those who join her, the very best of my wishes.



# Taking a Spiritual History

by Larry Culliford

Spirituality links the deeply personal with the universal (Culliford, 2002b). It has a lot to do with individual subjective experience and, according to the researcher David Hay, it is rooted in human awareness (Hay & Nye, 2006). On the basis of extensive studies involving both adults and children, Hay reports persuasively that, rather than being a social or cultural construction, 'It is really there' (p. 18). 'It' can be thought of as a spontaneous and consistently operating communicating principle, connecting individuals to one another via a seamless and indivisible whole. This entirety exists as a kind of sacred unity, and is referred to by some as 'creation'. The faculty of spiritual awareness appears better developed (or, according to David Hay, less completely atrophied) in some than in others.

Unlike religion, which tends to be associated with particular buildings, artefacts and scriptures, with rules and commandments, with trained officials, repetitive ceremonies and dogma, spirituality might be experienced as warmer and more spontaneous, associated rather with love, inspiration, wholeness, depth and mystery; with personal devotion and meditation, rather than with collective prayer and worship. A person's sense of spiritual connection is with humanity at large, rather than with exclusive or partisan groups.

Spirituality and religion are obviously vitally linked, and Hay uses metaphors to describe the dynamic interaction between them: spirituality as a journey with the religions as different modes of transport; spirituality as the fuel enabling the machinery of religion to operate; spirituality as the roots and trunk of a tree, of which the different religions are the branches and leaves. A

spiritual history should include details of a person's religious antecedents (or lack of them), but this is only one component.

## Why take a spiritual history?

A few years ago in the pages of APT I discussed the relevance of spirituality to mental healthcare (Culliford, 2002a). The reasons for taking a spiritual history in psychiatry are complex. The more obvious include:

- the very nature of spirituality as a source of vitality, motivation and a healthy sense of belonging and being valued.
- the long historical relationship between religion, medicine and mental healthcare.
- the patient's needs and wishes.
- the epidemiology of spirituality/religion and mental health.
- the influence of spirituality/religion on the attitudes and decisions of psychiatric staff.

*purpose in life. It is the spirit which synthesises the total personality and provides some sense of energising direction and order. The spiritual dimension does not exist in isolation from the psyche and the soma. It affects and is affected by our physical state, feelings, thoughts and relationships."*  
Ellison, (1983)

Spirituality is thus supraordinate to, and an integrating force for, the other hierarchically arranged dimensions of human life: physical, biological, psychological and psychosocial (Culliford, 2002a, 2007). Nevertheless, it is a dimension that has, until recently, been neglected in both physical and mental healthcare (Swinton, 2001). This neglect can largely be ascribed to the secularisation of the culture in which the mainly science-based discipline of psychiatry has developed.



Lisa Solheim

Spirituality is universal, unique to every person. It is essentially unifying and involves everyone, including those who do not believe in God or a 'higher being'. Ellison has suggested that spirituality:

*"...enables and motivates us to search for meaning and*

Secularisation is a complex word that in Western culture initially referred to the divorce of personal spirituality from organised religion. This initial position then led to secularisation of the intellect, and in turn gave reason primacy over other major mental faculties: actions, sense perceptions, emotions and,

### Box 1 Key elements of spiritual care from the patient's perspective

- An environment fostering hope, joy and creativity.
- Being valued and trusted, treated with respect and dignity.
- Sympathetic and confidential listening.
- Help to make sense of, and derive meaning from, illness experiences.
- Receiving permission, encouragement (and sometimes guidance) to develop spiritually.

(Adapted from Nathan, 1997)

### Box 2 Benefits of spiritual care

- Healthy grieving of losses (letting go).
- Improved self-esteem and confidence.
- Maximisation of personal potential.
- Improved relationships (with self, others and with the Absolute/God).
- Renewed sense of meaning and purpose.
- Enhanced feeling of belonging.
- Improved capacity for solving problems.
- Insoluble problems, continuing distress and disability are more easily endured.
- Hope renewed.

(Adapted from Nathan, 1997)

particularly, intuition.

This division, and the resulting imbalance among these seamlessly and dynamically interrelated faculties, became more extreme and entrenched, partly in response to the perceived conflict between religion and science, for example in regard to evolutionary theory. In medicine and psychiatry, dualistic 'either/or' thinking continues to prevail over the more holistic 'both/and' style (Culliford, 2007). Renewed balance is called for.

Although opinion polls indicate that religious beliefs and practices are in decline, spirituality remains strong (Hay & Hunt, 2000). The relevance of this for healthcare professionals and especially for psychiatric staff is that at times of emotional stress, illness, loss, bereavement and death people confront what Buckley (1987: p. 360) has called 'the great issues of life', that lie 'far beneath the formal separation of the sciences, and of the sciences from the humanities'. In dealing with these weighty matters, mental health professionals can best help themselves, their colleagues in other disciplines and their patients by using ordinary language rather than religious terminology. In this way they will hit spontaneously on what Nolan & Crawford (1997) call a 'rhetoric of spirituality'. Taking a spiritual history involves engaging people as equals in enquiry and discussion, using their own words, about what – at the

deepest level – makes sense to them and what puzzles them, what motivates them and what holds them back. This is the most direct way to get quickly to the heart of whatever is troubling the patient. It coincides with the essence of good medical practice: two people, doctor and patient, engaged in genuine and meaningful communication about what matters most. It seems worth adding that both may gain from the encounter.

It is not surprising that, where spirituality is concerned, patients' needs and wishes coincide (Faulkner, 1997). As Greasley et al (2001) note, spirituality is a vital concern for most service users.

In a study of spiritual care in mental health practice, Nathan (1997) asked psychiatric patients to describe the most important elements of 'spiritual care' and the potential benefits such care may bring. Their responses are summarised in Boxes 1 and 2. A spiritual history is most clearly necessary when spiritual or religious issues are part of the presenting problem, for example in religious delusions, feelings of rejection (by God or a faith group) and excessive guilt or shame. Although it is acknowledged that religion can have negative effects, confidence is growing in the benefits to both physical and mental health of spiritual beliefs and practices. This confidence is based on substantial epidemiological research of improving quality (Koenig et al,

2001; Levin, 2001). These authors suggest that, whereas 20% of studies report negative effects, 80% identify spiritual/religious beliefs and practices as beneficial, not so much part of the problem as part of the remedy (Box 3).

The influence of spirituality/religion on the attitudes and decisions of psychiatric staff is also complex. Although curricula exist (Puchalski & Larson, 1998), in the UK, the topic has seldom been taught as part of professional training as it needs to be: in terms of knowledge, skills and attitudes. When individual views on the subject have been canvassed, it is not surprising that mental healthcare professionals' attitudes towards spirituality have tended to be negative (Neelman & King, 1993).

At one extreme, any expression of religiosity or spiritual awareness might automatically be deemed psychopathological. Routinely taking patients' spiritual histories, and becoming more skilful at doing so, will provide staff with both information and material for reflection. The experience and knowledge thus gained will help correct any previously held attitudinal bias. At the other extreme, caring efficiently and compassionately for disadvantaged others can legitimately be experienced

vocationally, as part of a sacred and undeniable calling. Many mental health workers consider themselves to some degree spiritually guided. For these, the taking of spiritual histories will be an expression of spiritual caregiving, and therefore fulfilling in itself, as well as being a necessary preparation for dealing appropriately with patients' spiritual needs. The benefits of assessing spirituality are therefore many and widespread.

### How to take a spiritual history

Taking a spiritual history is best thought of as a clinical skill to acquire and hone, rather than as an activity to be performed by recipe or rote. It is a skill that requires empathic engagement with the patient, which therefore sanctions the judicious use of both intuition and initiative on the part of the assessor. This may lead, for example, to sensitive exploration of what the patient only hints at or seems to be avoiding. Such exploration is to honour and uphold the spiritual values of truth and truthfulness, the enemy of which is concealment, whether conscious or otherwise. It is important to seek to avoid witting or unwitting collusion with the patient. It is therefore wise always to be reasonably systematic and, thereby, thorough.

The interview works best in a

### Box 3 Positive effects of spirituality and religion on mental health

- In addictions (e.g. Alcoholics Anonymous and similar groups using the 12-step method)
- Enabling of inner resources (e.g. sources of hope and calm)
- Connecting or reconnecting with external resources (e.g. within the person's faith community)

### Box 4 Suggested definitions for spiritual identities

*Atheist:* To be atheist is emphatically to deny the existence (even the possibility) of a sacred being, supreme reality, god or other deity.

*Agnostic:* To be agnostic is to assert that we cannot truly know about the existence or otherwise of a sacred being, supreme reality, god or other deity.

*Unsure:* To be unsure is not to know what one believes about a sacred being, supreme reality, god or other deity.

*Religious:* To be religious is to believe and have faith in a sacred being, supreme reality, god or other deity, and/or to belong to and practice within an organised religion (people might see themselves as both religious and spiritual).

*Spiritual:* To be spiritual (but not religious) is to believe and have faith in a sacred being, supreme reality, god or other deity, but to be independent and not belong to or practise within an organised religion.

comfortable, quiet and confidential setting, and a gentle, unhurried approach is recommended. More than one conversation may be necessary. Notwithstanding the ideal of thoroughness, it is sometimes necessary to make rapid assessments of psychiatric patients. At such times, two main types of question are useful:

- 'Are you particularly religious or spiritual?'
- 'What helps you most when things are difficult, when times are hard?' (for example when facing big problems, major losses or important challenges).

The first question might lead the psychiatrist to ask the patient more directly whether they are atheist, agnostic, unsure, religious or 'spiritual but not religious' (Box 4).

The patient's reply to the second question usually points to the principal values they hold and to what is most meaningful in their life, and is indicative of their major spiritual concerns and practices (Box 5). Supplementary non-directive questions may be necessary, for example 'Would you like to say more about that?'

An appropriate next step, even in a brief screening, would be to ask in more detail about spiritual practices. Regularly engaging in such activities identifies a person as spiritually engaged as much as does holding and expressing spiritual or religious beliefs. Listing one or more 'mainly secular' spiritual practices may give cause to people who describe themselves as atheist, agnostic or unsure to reconsider their selfassessment, and – whatever beliefs they have – to begin to accept themselves as in some way 'spiritual' and therefore spiritually influenced.

### Taking a more detailed spiritual history: five approaches

A brief screening will often indicate that a more detailed history is required to establish relevant aspects of the patient's background, specific problems related to spirituality or religion, available spiritual supports and additional spiritual needs.

Various authorities have separately designed guidance on assessing the religious and spiritual aspects of people's lives. However, they are fairly uniform regarding the topics covered. This allows practitioners to pick the style with which they feel most

### Box 5 Common spiritual practices

#### Mainly religious

- Belonging to a faith tradition, participating in associated community-based activities.
- Ritual and symbolic practices and other forms of worship.
- Pilgrimage and retreat.
- Meditation and prayer.
- Reading scripture.
- Sacred music (listening to, singing and playing), including songs, hymns, psalms and devotional chants.

#### Mainly secular

- Acts of compassion, in everyday life and as part of one's work, especially teamwork.
- Deep reflection (contemplation).
- Yoga, tai chi and similar disciplines.
- Engaging with and enjoying nature.
- Contemplative reading (of literature, poetry, philosophy, etc.)
- Appreciation of the arts and engaging in creative activities, including artistic pursuits, cookery, gardening, etc.
- Maintaining stable family relationships and friendships (especially those involving high levels of trust and intimacy).

### Box 6 Some types of spiritual experience

- Mystical experiences (broadly defined).
- Near-death experiences.
- Twelve-step spirituality (as in Alcoholics).
- Anonymous and similar programmes.
- Dreams.
- Psychedelic (drug-induced) states.

comfortable. Guides tend to take the form of an aide-memoire rather than exact prescriptions. Here I will mention only five of these.

In the first, published by the Spiritual Competency and Resource Centre ([http://www.spiritualcompetency.com/assess\\_spirit/ASrshx.asp](http://www.spiritualcompetency.com/assess_spirit/ASrshx.asp)), questions focus on: religious background and beliefs; spiritual meaning and values (e.g. spiritual practices (Box 5) and spiritual experiences (Box 6)); and prayer experiences.

Second, in her guide to the assessment of spiritual concerns in mental healthcare, Egger (2005) lists some simple, non-intrusive questions that can inform the care team's approach. These look, for example, at the place of spirituality or religion in the patient's past and present, the nature of its influence (positive or negative, supportive or excluding) and whether they affect the patient's acceptance of and engagement in treatment.

Third, the leaflet Spirituality and Mental Health (Royal College of Psychiatrists, 2006) suggests five broad areas of questioning: setting the scene; the past; the present; the future; and remedies. These gather a picture of how patients see themselves, their place and purpose in life and their

future, and ask whether spirituality or religion are part of the problem and could be part of the solution.

Fourth, in an article aimed at healthcare professionals in general, Puchalski & Romer's (2000) guide to taking a spiritual history uses the mnemonic FICA:

- Faith and belief (what gives the patient's life meaning).
- Importance (how important this is to their situation).
- Community (their place in any social or religious group).
- Address in care (how they would like their beliefs to be addressed in their healthcare).

Finally, another tool for spiritual assessment is the HOPE questions (Anandarajah & Hight, 2001). The mnemonic HOPE directs the assessor's attention to four areas of the patient's life:

- sources of Hope, meaning, comfort, strength, peace, love and connection
- Organised religion
- Personal spirituality and Practices
- Effects on medical (psychiatric) care, and end-of-life issues.

### After taking a spiritual history, What next?

#### Formulation

Formulation is the term used in psychiatry for summarising and making sense of information

gathered and observations made while taking a history, examining the physical and mental state of the patient and conducting specific biophysical and psychological tests. Formulation is not a goal or endpoint. Its primary purpose is to assist the patient.

Formulation is a skilled process that helps clarify where an assessment is incomplete and therefore what useful information remains to be gathered. Most formulations are therefore provisional, and should be revised regularly as observations continue and information develops.

The simplest type is the diagnostic formulation. Once the diagnosis is reasonably established, short-term treatment plans can be devised and implemented. Depending on their outcome and other developments, medium- and long-term treatment plans will follow. Some refer to this diagnosis-treatment approach as invoking the medical model of mental healthcare.

A more comprehensive, and therefore preferable, approach involves the bio-psycho-social type of formulation, in which problems and their solutions are sought under headings involving three dimensions of human experience. This is a big step towards holism, towards considering the symptoms and problems in the context of the whole person, and the person in the context of family, community and culture. Including a spiritual history allows this process to be completed, through what may be referred to as a bio-psycho-socio-spiritual (BPSS) formulation (the terms psychospiritual, person-centred and holistic are also used).

The BPSS formulation still has as its primary purpose the Well-being of the patient, acting as a guide to clinicians' planning and execution of helpful interventions.

### How may a spiritual approach contribute to patient welfare? Better rapport

Clinicians regularly discover that taking a spiritual history – enquiring attentively about

patients' primary concerns and motivating factors – deepens rapport and improves its quality. Feeling valued as individuals, patients often relax and invest further trust in the doctor, thus improving the therapeutic alliance.

### Clarifying psychotic symptoms

There are two main ways in which taking a spiritual history can help clarify psychotic symptoms.

First, it helps distinguish 'spiritual emergence' from psychosis. Originally called 'spiritual emergency', this refers to a destabilising period of rapid spiritual growth (Vega, 1989; Grof, 2000; Slade, 2004).

Second, existential questions such as 'What is the purpose of my life?' are conundrums that become problematic for many. Religious grandiosity of delusional strength may be a powerful but immature defence against meaningless insignificance. As part of a psychotic reaction, such symptoms may be common to those feeling particularly unworthy or unloved, and their religious content hints at a spiritual solution.

To be psychotic and consider oneself divine is satisfying only narcissistically, through a false inner sense of supremacy. It does get people's attention, however, in a way that, often accompanied by corresponding feelings of persecution, may foster the individual's sense of grandiosity. It is better that such a person, when well enough, is encouraged to understand the true origins of their distress and work towards more modest, mature and acceptable ways of gaining meaning, recognition and satisfaction in daily life. This mirrors the cognitive-behavioural therapy approach but with an extra dimension. Only what may be called 'spiritual sustenance' will be effective against the degree of insignificance and all-consuming meaninglessness that can be at the heart of psychotic and other disorders. Pastoral or spiritual support and spiritual practices may both appropriately be recommended in such cases.

### 'Psychoneuroses'

Anxiety and depression are key elements in a range of non-psychotic psychiatric disorders, particularly the psychoneuroses'. Another universally experienced existential problem derives from

### Box 7 Useful websites and webpages

- Spiritual Competency Resource Center <http://www.spiritualcompetency.com/index.asp>
- Royal College of Psychiatrists' Spirituality and Psychiatry Special Interest Group <http://www.rcpsych.ac.uk/spirit>
- George Washington Institute for Spirituality and Health <http://www.gwish.org/index.htm>
- American Academy of Family Physicians: Anandarajah & Hight's (2001) paper on using the HOPE Questions <http://www.aafp.org/afp/20010101/81.html>
- Alcoholics Anonymous <http://www.alcoholics-anonymous.org.uk>
- Narcotics Anonymous <http://www.ukna.org>
- Gamblers Anonymous <http://www.gamblersanonymous.org.uk>
- University of Minnesota's Center for Spirituality in Healthcare and Healing (online learning about spirituality in healthcare and free module on taking a spiritual history) <http://www.csh.umn.edu/modules/index.html>

emotional attachments. As soon as these are formed, they render people vulnerable to the threat of loss and to loss itself.

Anxiety, bewilderment and doubt are emotions associated with the threat of loss. Anger, the emotion of resistance, arises as loss becomes more likely and imminent. Depressive emotions – shame, guilt and sadness – emerge when a loss increasingly becomes an acknowledged reality (Culliford, 2007).

Taking a spiritual history involves enquiry about a person's primary attachments, whether to a spiritual reality, to family and other loved ones, to places and objects, or to ideas and ideals. Identifying the major attachments, and the spectrum of emotions arising in response to threatened and actual loss, encourages emotional flow towards acceptance and resolution. Taking a spiritual history is therefore intrinsically therapeutic. It helps to clarify for the patient that these emotions are normal and healthy, part of their pathway to psychological growth and maturity through the acceptance of losses and resolution of the emotional healing process (Culliford, 2007).

This reflects another principle of spirituality, that personal growth results more often through facing and enduring adversity, rather than from trying to avoid it.

In some cases of severe anxiety and/or depression, there is a profound sense of meaninglessness and personal insignificance, as described above. Spiritual advice and support may again appropriately be recommended, and spiritual practices helpful.

### Addictions

The value of a spiritual approach is specifically acknowledged by those who advocate or follow the twelve-step method of dealing with addiction. The best known organisations to use this approach are Alcoholics Anonymous (where it originated), Narcotics Anonymous and Gamblers Anonymous. Narcotics Anonymous, for example, describes itself as 'a non-religious fellowship, encouraging each member to cultivate an individual understanding, religious or not, of a spiritual awakening' ('What is NA?', <http://www.ukna.org>).

The heart of a programme of personal Recovery is contained in twelve steps that describe the experience of the earliest members of Alcoholics Anonymous, <http://www.alcoholics-anonymous.org.uk/geninfo/05steps.shtml>.

Newcomers are not required to accept or follow the twelve steps in their entirety if they feel unwilling or unable to do so. The key step for addicts is to recognise and respect some form of spiritual reality, manifested particularly as a higher power: 'Soon we came to believe in a power greater than ourselves' (<http://www.gamblersanonymous.org.uk/young.htm>).

### Others disorders

Psychiatrists see a number of other conditions that might have

<sup>1</sup> The twelve steps of Alcoholics Anonymous have been published in a previous issue of APT: see Luty, J. (2006) *What works in alcohol use disorders? Advances in Psychiatric Treatment*, 12, 13–22. Ed.



Lisa Sothern

a spiritual element in their aetiology. Absence or removal of meaning and sense of purpose affect drive and motivation. Having a damaged sense of belonging affects self-esteem and a person's true and healthy sense of identity. These elements may occur, for instance, in personality disorder, eating disorder and chronic fatigue syndrome, as well as in disorders already mentioned here. There may be persistent psychological resistance to loss, in the form of intense anger, often denied and either repressed or more consciously suppressed. Enquiry into these central and vital aspects of a person's life is part of spiritual history-taking, and it offers an important opportunity to reframe the problem in terms that may lead to reintegration and healing.

### Involving chaplaincy services

Sensitive enquiry is in itself helpful for patients whose needs and problems have a spiritual dimension, and it may allow them with greater clarity and efficacy to fulfil their own needs and find their own solutions. However, they may seek spiritual support and guidance, and therefore be in need of pastoral care. Referral to a chaplain or pastoral care advisor is often appropriate. Such a referral is necessary if more complex issues such as spirit possession are involved.

### Chaplaincy

After psychiatric staff have taken a spiritual history from a patient, a well-informed and experienced chaplain, prepared to see and assess the patient, should be available for consultation and advice.<sup>†</sup> Mental healthcare providers and trusts should maintain a multi-faith chaplaincy service with adequate staffing levels. Voluntary part-time as well as paid full- or part-time chaplains and pastoral care staff will be required.

Although many chaplains and spiritual advisors will be involved only in general and supportive work, some are increasingly valued as contributors to the work of multi-disciplinary mental health services. If they work in that capacity they should receive

<sup>†</sup> Collaboration between psychiatric and religious professionals has been discussed briefly in an earlier APT article: Dein, S. (2004) Working with patients with religious beliefs. *Advances in Psychiatric Treatment*, 10, 287–294. Ed.

appropriate training in mental health matters.

In return, chaplains will probably have made a point of establishing good relations with local clergy and faith communities, and will provide a knowledge base about local religious groups, their traditions and practices. They will be alert to situations in which religious beliefs and activities may prove harmful to individuals or groups, and suitably trained chaplains will also be available for advice on controversial issues such as spirit possession and the ministry of deliverance.

### Conclusions

According to the Australian writer David Tacey:

*"Enlightened people everywhere live according to the light of reason and logos, but we all also need a mythos, a spiritual belonging, to make life meaningful and bearable. Mythos provides a goal, offers dignity, and establishes a relationship to past, present and future."*  
Tacey, (2006).

In answer to Hay's question then, what is 'really there' is a spiritual dimension of human experience that provides the context for everything else. For those with any measure of spiritual awareness, this is both the source and the goal of existence. To take systematic and detailed spiritual histories regularly will enable practitioners to rekindle mythos in medicine and put the psyche back into psychiatry. The psyche, of course, is our soul.

### Declaration of interest

L.C. is on the Executive Committee of the Royal College of Psychiatrists' Spirituality and Psychiatry Special Interest Group.

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**MCQs**

**1 Spirituality:**

- a is something that applies only to a few special people
- b comes to the fore at times of emotional stress, loss and the threat of loss
- c bears limited relationship to a person's physical state, feelings, thoughts and relationships
- d usually divides people and is a source of conflict
- e depends on holding strong religious convictions.

**2 Taking a spiritual history:**

- a serves no useful purpose
- b does not require empathic engagement
- c concentrates on a person's beliefs
- d should only be undertaken by chaplains or ministers of religion
- e can be therapeutic for the patient.

**3 Spiritual practices:**

- a are mainly religious activities
- b do not include everyday activities such as gardening or walking in the country
- c tend to heighten a person's spiritual awareness over time
- d require repetition and ritual to be effective

- e can only be undertaken in groups.

**4 Practical ways of taking a spiritual history include:**

- a the HOPE questions
- b the Minnesota Multiphasic Personality Inventory
- c the Royal Free Interview for religious and spiritual beliefs
- d the Mini-Mental State Examination
- e The twelve-step method.

**5 A psychospiritual assessment may help patients by:**

- a resulting in a miraculous and instantaneous cure of symptoms
- b encouraging them to pray regularly
- c identifying specific spiritual practices that they should undertake regularly in addition or as an alternative to prayer
- d leading to an appropriate referral for pastoral care and spiritual support
- e encouraging passive acceptance in the face of divine will.

1	a	f	a	f	a	f	a	f	5
2	b	f	b	f	b	f	b	f	4
3	c	f	c	f	c	f	c	f	3
4	d	f	d	f	d	f	d	f	2
5	e	f	e	f	e	f	e	f	1

**MCQ answers**

# Whose Voice Should You Listen To?

by Jane Taylor

Hearing voices is a complicated experience. Traversing the mire of the voices is difficult enough, working out what causes them and whose explanation to accept as to why you are hearing them is virtually impossible. I should know, I heard voices for about 4 years. As a result I was given the almost obligatory diagnosis of psychosis and/or schizophrenia, high doses of medication and months of being sectioned on our lovely psychiatric wards.

I no longer hear voices or have to take any medication – I haven't done either for eleven years now. During that time, not only did I hear voices, I also, on occasions, would see visual hallucinations. I have been so intrigued and affected by the experience of those four years and by the success that I have had in keeping the voices away, that I have been compelled to try and unravel what happened.

This has taken me on quite a journey on which I have met with many others who have heard voices; spent time with them finding out what they think happened to them and where they think their voices come from. On the way I have completed an MA in Psychotherapy, during which I explored the psychotherapeutic perspective of hearing voices. As part of this course I was able to conduct research in Cambodia, where I met with traditional healers who hear voices and who use them as a positive tool of their trade. While I was there I also interviewed individuals from the psychiatric clinic who heard voices and, consequently, had been given the diagnosis of psychosis or schizophrenia.

## So what have I found out along the way?

I have found that there are no unified theories from the world of

science, psychology or theology regarding the hearing of voices. Also, there are a variety of ways to interpret the experience of hearing voices, from both an individual and a cultural perspective.

I have found that in Cambodia, as their cultural belief system is based on Buddhist and Shamanic practices, it is essential for society to have traditional healers who DO hear voices. These traditional healers undertake years of rigorous training where they are taught techniques to control or manage the experience of hearing voices. When I spoke to the traditional healers in Cambodia, they all said that they would have gone mad if they had not been shown how to manage their ability to hear voices.

In Britain, over the centuries, the cultural opinion towards the phenomenon of hearing voices has ranged from regarding hearing voices as a divine gift to symptoms of an illness. As de Bruijn (1993:40) discusses, 'the originators of the monotheistic religions, Moses, Jesus and Mohamed, all heard voices not apparent to others.'

So if the current predominant religions are based upon messages that were received through the experience of hearing voices, how have we come to perceive hearing voices as pathology?

Throughout history in Europe, the ability to hear voices was firstly considered the domain of the divine. You would have been revered for your ability. However, by the time of the Inquisition launched by the Church, the ability to hear voices meant that you risked being killed and, consequently, hearing voices became taboo. Fatefully, in 1908, with the advent of psychiatry and a desire to associate hearing

voices with a genetic or biological origin, the term schizophrenia was born and psychiatry assigned the experience of hearing voices a prized position in psychopathology.

## So where are we now?

Although psychiatry is still trying to keep 'hearing voices' to itself, its hold is slipping. There are many mental health professionals and service users who are pushing for the abandonment of psychiatric labels and, as summarised by Knight (2004), the recognition that 'hearing voices is a normal, though unusual, variation in human behaviour.' This body of people is gaining credence and their collective voice is creeping into scientific and psychological theories. There is also a large group of professionals raising the issue that there is no scientific evidence that can actually prove that schizophrenia or psychosis exist.

From a psychotherapeutic or psychological perspective, voices are often triggered by an external emotional or social trauma and are considered to be a tool or mechanism to cope with the traumatic situation. It is thought that the events of the trauma will often be found in the content of the voices, sometimes hidden within metaphors and messages.

I have also gone on to discover that 2% of the population hear voices, whilst only a third of that percentage seeks psychiatric help. So, with all these different theories, where should we turn? Ah, finally someone worked out that we should talk to the experts – those who hear voices!

## Experts by Experience

A few years ago I came across the Hearing Voices Network. This was set up by Professor Romme and Sandra Escher (1993:250), who had spent many years in Holland

working with and interviewing people who hear voices, both psychiatric patients and non patients. During the interviews they discovered that 'most voice hearers were convinced that their voices came from outside themselves.' Many of the interviewees described their voices as having either a mystical nature being part of a spiritual awakening, or as 'evidence of communication with energies outside or beyond our world of sensory perception' or physical reality. Romme and Escher (1993:250) identify this as Extra Sensory Perception (ESP). ESP is considered to be beyond normal perception or communication that occurs via the five senses, i.e. hearing, vision, touch, taste, smell.

Working together with the voice hearers, Romme and Escher (1999) created a talking therapy that attempts to meet and manage the most common experiences and problems that were described by the voice hearers. This talking therapy includes elements of psychotherapy, psychology, various mystical concepts and therapies, reincarnation, parapsychology and exploration of the use of alternative therapies.

In traditional psychiatry, the individual is actively discouraged from talking about the content or given much freedom to explore different ways of managing their voices, other than purely with medication. The philosophy behind Romme and Escher's approach is to encourage the individual to find their own frame of reference for their experience of hearing voices, and to create their own way of managing them. The individual is assisted to find their own interpretation of their voices and then to explore where or from whom they think the voices are coming. At the same time, the individual is helped to explore the content of the voices and reflect on any connections between the content and the individuals' life experiences.

### Coping

It has generally been thought that it is the content of the voices that leads the voice-hearer to feel overwhelmed by the experience. However, research now indicates that it is more the nature of the relationship and the explanatory model that the individual uses to describe the origin of the voices, that affect whether the individual copes with the experience or not.

The Mental Health Foundation (2007) 'suggests that if the individual believes that the voices are in control, the individual cannot cope – if the individual believes that he or she is stronger than the voices, the individual finds ways to cope with them.'

In light of these insights when trying to identify the best kinds of therapy for people who hear voices, the therapist, Tamsin Knight (2005:38), concludes that surely it would make sense to provide assistance *'that increases a person's ability to cope with the experiences' rather than providing them with therapy that offers belief modification.*

Romme and Escher (1993:20) interviewees identified many coping strategies to be useful. These include ignoring the voices, entering into consensual dialogue with the voices and only talking to the voices at designated times.

### Personal Recovery

As I commented at the beginning, hearing voices is a complicated experience and I've always thought that I heard voices due to multiple and separate causes, and each cause or origin triggered different types of voices.

Firstly, I think some of the voices were literally a result of my brain or mind malfunctioning, which, according to psychiatry, happens because of a chemical imbalance. Other voices were due to emotional traumas that I had experienced over the course of my life and a particular trauma that happened just before the voices started. Lastly, like Romme and Escher's interviewees, I too thought that many of my voices came from outside of myself and were coming from entities that were from beyond this physical reality. I sometimes wondered if I had ability similar to a medium or traditional healer or shaman.

It's hard to pinpoint exactly what led me to stop hearing voices – again, I think it was a combination of factors that also reflected my hypothesis that the voices originated from a variety of causes.

The first three years that I was hearing voices were spent in a cycle of heavy doses of medication and months of being sectioned. Every time I left hospital after being sectioned, the auditory and visual hallucinations had increased in frequency and, as a result, I had to take higher

doses of medication which did not ever completely eradicate them. It would then take several months for the voices to calm down. I would begin to slowly reduce the medication, get my emotional life back in order, then have an appointment with a psychiatrist who had never met me - and oh, then I'd be sectioned again...

A major turning point was when I was assigned one psychiatrist whom I met with fairly regularly and he assured me that he would never section me. He stated that he would leave it to me to tell him if I needed to come to hospital and, within reason, I could dictate how long I stayed for. He also gave me much more modern medication.

The medication helped, and I think calmed down the voices that were just 'pure madness'. But, as always with me, the medication never completely stopped the voices. The stability that came with the removal of being sectioned was enormous. Having this trauma removed enabled my emotional state to become more stable. Consequently, as a result of being more emotionally stable, I heard less voices.

The voices that I was left with I began to tackle in a completely different way. It is difficult to say whether this is because I'd been given some level of control over a part of my life (I was then encouraged to take control of the voices that were left – I definitely wasn't going to let them or psychiatry win), or whether because, once I was able to stop fighting the field of psychiatry, I was able to start fighting the voices. However, the voices that I was left with were the ones that I thought were coming from outside of myself and coming from outside entities.

I had always thought that some of the voices that I heard were coming from entities and I finally had a solid base from which to fight them. I did this by literally answering them back or telling them that I was not listening to them anymore. I found swearing at them particularly successful! I mainly spoke to them inside my head but on occasions, if alone and I felt it was a particularly strong voice, I would speak out loud. I began to see that I could have some power or control over the voices, as they diminished when I pushed them away.



I still today have a very clear image of the last 'person' or hallucination that was speaking to me. It was a little old lady. She wasn't threatening at all, but I didn't want her hanging round my flat and I told her this in no uncertain terms! It seemed to work as she never returned!

It is hard to know how to describe these images or hallucinations, or to know what or who they were, but for want of better words or theories, I often thought that they belonged to spirits, entities, or ghosts. It was, and still is, difficult to know what to do with these kind of experiences as they don't just challenge psychiatry or our version of sanity, they challenge western societies' concept of reality. To be honest, they challenged my concept of reality and I still find it hard to write about for fear of being judged as mad - but if it makes you uncomfortable to read about, you should try experiencing it!

What I do know is that when I began to tackle the voices as if they were coming from spirits or entities, there were actual techniques that I could use to shut myself off from them (these included shutting myself down psychically and many of the techniques I used are described in the Romme and Escher book 'Accepting voices'.) These techniques gave me control over the voices and they began to go away. Within a year of approaching the voices in this way, I was free of voices and medication and have continued to be free of both.

What I have also come to discover is that my experiences share much in common with the descriptions given by the people interviewed as documented by Romme and Escher, and with the Cambodian concept of reality and the experiences of Cambodian traditional healers.

**Cambodian version of reality**  
Cambodia has a completely

different concept of reality to western cultures. In Cambodia, due to a rich fusion of animism, Buddhist and Hindu philosophy human experience is influenced by a belief in the existence of multiple realities that are occupied by various entities, or spirits, including the spirits of ancestors. Society puts much importance on communicating with ancestor spirits and, consequently, has many traditional healers who use hearing voices as a positive tool to communicate with these ancestor spirits. These traditional healers undertake years of rigorous training during which they are taught techniques to control or manage the experience of hearing voices. When I spoke to the traditional healers in Cambodia they all said that they would have gone mad if they had not been shown how to manage their ability to hear voices.

Mental health problems in Cambodia are thought to be caused by a variety of reasons, including physical problems with the mind, as a result of thinking too much or due to angering the spirits.

### Questions that I have been left with

I still to this day do not know if I believe in the skills of mediums and traditional healers, or if I believe in entities or spirits etc. I have no answers relating to what I heard and saw, all I've been left with are the following questions:

I don't know whether I stopped hearing voices due to changing my relationship or explanatory model with the voices which then enabled me to feel stronger or in control of them... Or did I have the ability to speak or communicate with entities that are beyond our physical reality? Or perhaps, more correctly, did outside entities have the ability to communicate with me?

If the voices were a result of the traditional psychiatric model, i.e. chemical imbalance, do mediums, shamans, traditional healers and clairvoyants hear voices because they have a so called 'chemical imbalance,' or perhaps, more correctly, a 'different' chemical balance?

Shamans regularly take drugs or use rhythmic music to change the balance of their minds to open them up to what they call 'other realities'. Is this any different to a 'chemical imbalance'?

If a shaman was taken into

psychiatric care, would they be considered to be delusional? Many shamans or traditional healers across the world state that their voices started after some kind of trauma. 100% of the people that I interviewed related the onset of their voices to a traumatic situation, as did many of Romme and Escher's interviewees. Can trauma open you up to psychic experiences?

Many clairvoyants and mediums state that if a human being is emotionally or mentally low, entities or spirits can psychically attack the individual. If this is true, are the results of psychic attacks what we in the west label symptoms of psychosis? Many of Romme and Escher's interviewees used the same techniques that I used to make the voices stop. They learnt these techniques from mediums etc.

I do not advocate that only mediums or traditional healers should treat people who hear voices, but can we learn anything from their techniques that they use to control their experiences?

### Whose version of reality is correct?

#### Conclusion

The only reality that anyone has to work with is the voice hearers' interpretation of their experiences. What has become apparent to me is that these individual interpretations or descriptions of hearing voices seem to share many similarities, ranging from similar descriptions about the origin of the voices to different successful methods used to cope with the experience. These similarities are found across cultures. The descriptions provided by individuals in Holland seem to share much in common with the Cambodian cultural perception of reality and the underlying cultural concepts and classification of mental health.

Tamsin Knight, (2004) who has worked as a therapist with many people who hear voices and is at the forefront of pushing for the acceptance 'that hearing voices is an unusual yet normal human experience', concludes that: *"We cannot know all the answers. Perhaps we should be moving away from the idea that there is one reality; one set of beliefs that are acceptable and another that are delusional. Instead, we*

*could accept that there is not one correct way of seeing the world; rather, we all have different versions. The challenge, then, is to accept individuals' differences and offer them help in coping both with their reality and with living in a wider society that may not share their beliefs."*

Tamsin Knight's words are at the heart of what I am saying: *"Embracing that we cannot know all the answers and considering that there may not be only one correct way of seeing the world. I've come to discover that there are many different ways of viewing the world and consequently multiple ways of interpreting the experience of hearing voices."*

### What's yours?

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# Creating a Climate of Recovery

Even though Recovery has been described as an internal process, there are certain climates and environments where this is encouraged and drawn out.

As highlighted in the very different stories provided in this chapter, there is an internal process and an external climate that either helps or hinders Recovery. The power of the environment in Recovery is not to be underestimated, especially for those who are only just beginning their journey.

## Exercise

Working as a group, brainstorm and capture your thoughts on flipchart paper in completing the following tasks. If you are a mental health team, it would be of tremendous benefit to involve service users in this exercise as a means of providing insights into what helps.

This exercise opens up our thinking about the influence we all have in creating a climate of Recovery.

- **Task one**

How important is Hope in creating a climate of Recovery? – Discuss.  
List the ways in which Hope is communicated and demonstrated in your environment.

- **Task two**

How important is acceptance of others' perspectives in creating a climate of Recovery? – Discuss.  
List the ways in which acceptance is worked with in your environment.

- **Task three**

How important is personal responsibility in Recovery? – Discuss.  
List the ways in which you sensitively encourage personal ownership of the process within your environment.

- **Task four**

How important is support in creating a climate of Recovery? – Discuss.  
List the ways in which you draw on a person's current supports to assist their Recovery.  
List the ways in which you provide support that validates, encourages and respects the person's process.

- **Task Five**

How important is education in creating a climate of Recovery? – Discuss.  
List the sort of information you provide to the people you support.  
What other information can you supply?  
(Remember the importance of choice and different perspectives)

- **Task Six**

How important is personal meaning and understanding in Recovery? – Discuss.  
How do you support this process with the people you support?  
What resources do you draw on?

## Personal Recovery

Think of a time when you experienced a major troubling event which had a major impact on your life (serious ill health, loss, relationship break up, etc.)

Think about the effect this had on your sense of direction and purpose.  
Take a moment to remember how you felt.

(Note, only reveal what you are comfortable with, you don't have to discuss the actual event).

*Think about, and then discuss with your partner:*

- What helped at this time? What could you not have done without?
- What hindered, or could have hindered you?
- What did you learn from this?

*Now brainstorm on a flip chart*

- What helped.
- What hindered.
- What did you learn.

## Change Process

Think of a time when you weren't quite ready to do something (felt hesitant) and others were perhaps pressuring you. Examples include: giving up smoking, leaving a job or relationship or making a difficult decision.

This has to be something you eventually took action on!

Think about the effect this had on your sense of direction and purpose.

Take a moment to remember how this felt.

(Note, only reveal what you are comfortable with, you don't have to discuss the actual event)

*Think about and then discuss with your partner:*

- What helped at this time? What could you have done without?
- What hindered your progress?
- What helped? If you can, name two things.
- What have you learnt from this?

*Now brainstorm on a flip chart:*

- What helped?
- What hindered?
- What did you learn?

# Recovery and Spirituality

Training exercises need to be used in the context of a whole session. Below is an example of a very simple exercise I use with a Recovery and spirituality training session, and is used following a presentation on some of the issues. It could be used, however, in other contexts.

*In small groups of 3 –4, spend twenty minutes considering and discussing:*

- What sustains you or gives you strength in your daily life?
- (for people in employment) What does your employer do and what could they do better to support and nurture your wellbeing?
- What steps could you take to ensure you have access to these resources?

*The whole group then comes back together to share the main ideas from their groups and learn from one another's thoughts and views.*

I would highly recommend some well-rehearsed training exercises used by Thurstine Basset and colleagues, some of which can be found in the Pavilion training pack 'Psychosis Revisited', available from Pavilion Publishing at:

[http://www.pavpub.com/pavpub/trainingmaterials/interest\\_results.asp?Interest=Mental%20Health](http://www.pavpub.com/pavpub/trainingmaterials/interest_results.asp?Interest=Mental%20Health)

# Self Management

by Tanya Kennard-Campbell

This chapter will briefly introduce the concept of self management and its relationship with Well-being and Recovery.

It will provide some guidance about how, when and why to use this approach and will offer a series of exercises aimed at initiating the process.

A basic self management Recovery plan will be included for use.

There are a number of self management tools available in England and most provide a similar framework. These can include Recovery, wellness, early warning signs, crisis or Recovery action plans. There is a list of useful websites that give links to these resources at the end of this section.

This chapter is aimed at exploring the things affecting a person's general Well-being and takes a 'whole person' approach, taking into account emotional, mental, physical or spiritual Well-being, as all of these aspects are interrelated.

This chapter is aimed at those who wish to use this resource in their own lives and for those who think it may be of use to those they support.

You will need to read this chapter before completing the exercises and it is recommended that you read the chapters on Well-being, Recovery and the principles to give you a good grounding before you begin.

**What is self management?**  
*"Self-management entails both a positive mental attitude ... and positive actions that help you get on with living your life the way you want to. [It] includes knowing when to recognise the illness limitations and adjusting your way of life*

*to accommodate them ... and living your life to the full. ... The more you live your life and achieve goals, no matter how big or small, that is active self-management"*  
*(Research participant's definition, Rethink ) (footnote – [http://www.rethink.org/living\\_wit\\_h\\_mental\\_illness/Recovery\\_and\\_self\\_management/selfmanagement/](http://www.rethink.org/living_wit_h_mental_illness/Recovery_and_self_management/selfmanagement/))*

Self management is about taking control of your life, and is a means of discovering what helps and what doesn't in managing life's challenges.

It involves you reflecting on what your strengths, needs and goals are yourself and deciding what is of importance to you in your life now.

It does not mean that you have to manage all life's challenges alone, or cope with the symptoms of distress independently, but it does involve an active engagement in the process of learning what you can manage yourself and when and how others can be of help.

**Note** Self management is about learning to take the driving seat in managing life's challenges.

### **The difference between self management and care planning**

Care plans are a written requirement when working with someone from mental health services. They plan the type of care or service you will require as a user of this service. Part of this may include risk, crisis or even Recovery plans.

The main difference between self management and this type of care planning, is who drives or leads the process and who decides what is important.

In care planning approaches, what is offered is based on what the service provides, how well it

works in partnership with other agencies and whether you meet the criteria for receiving this kind of help or not.

Your mental health team couldn't possibly help support all your needs, support all your dreams and advocate all your behaviours.

In self management approaches, you are the one driving and leading the process and making the decisions. Therefore, this is an active process of reclaiming responsibility for your Recovery and Well-being.

The types of things you put into your self management plan, you may not dream of including in your care plan.

This is your plan that is led and influenced by you and your agenda.

However, it may well be of tremendous benefit to you and your mental health team (if you have one), to involve them in this process. They can be a valuable support to you in this process and it can inform the plans you make together, leading to a much more effective partnership.

**Note** You are the one deciding what is important and what you need.

### **Self management and Recovery**

Recovery is linked strongly with this process as one common factor in people's Recovery stories is a turning point, where things begin to change and a decision is made to do differently. This is often initiated by a determination to live life as fully as possible and not to let your condition or circumstances rule you.

Reclaiming control of one's life is an essential part of this and involves taking steps to regain one's personal power, by

discovering ways of coping and managing by drawing on one's inner resources and experience.

This is an active process which involves taking personal responsibility for Recovery and involves becoming your own advocate in order to access the information and support you need. This process is led by you and is supported by your self-determination and refusal to accept less than high standards for yourself and your life.

Self-management is all about taking control of your life and being active in your own Recovery. Therefore a decision to self-manage can be a key factor in a person's Recovery journey.

It is important to remember that self management is more than managing moods, symptoms and feelings. It is also about becoming more aware of what you have access to, who you are, what makes you tick and how much control you actually have over your decisions.

**Note** Recovery and managing your 'self' are inseparable. Both require action!

### Self management and Well-being

Any discussion about self management should include a healthy discussion about Well-being as this is something you will draw on daily to support, educate and lead you through your journey.

Well-being is discussed in greater depth, but in this context it can be described as what we all have hardwired into our systems, both physically, emotionally and spiritually. You may choose to call it something else, like health, peace, contentment or self esteem and it is important to use your own language to describe what for you symbolises good emotional, mental, spiritual and physical Well-being. Well-being is what you will draw on to power your Recovery, so it is important to remember that our bodies are hardwired to survive, to heal and to return us to a state of health. This is what our bodies are designed to do. There are no exceptions. Some of us do live with disabilities and limitations, but this does not mean we cannot live healthy, happy lives.

**Note** Well-being gives us a sense of immunity and it is always

available to us. See 'Wellness plan' and 'Well-being curve'

### Supports

One thing repeated time and again in stories of Recovery and Well-being is the importance of others in our life. Some of us only need one significant person, someone who believes in us, but for others, drawing on a wider range of friends, neighbours and relationships is an essential part of our Well-being.

Belonging to a community and being acknowledged in your local corner shop, or school playground all leads to a sense of connection with others.

Friends who can support us in times of need and share in our times of success, as well as offering a good honest opinion, can provide the strength, laughter and love that sustain us.

What you see reflected in the eyes of your friends and supporters provides the basis of knowing who you are in relation to others, and provides the essential source of esteem which comes from feeling needed.

Often, when we are under the weather or not at our best, we can isolate ourself and lose regular contact with our friends.

Maintaining healthy relationships involves communicating how people can help. Sometimes just knowing someone is there is enough of a support, but for others, regular contact is important.

**Note** No one can exist in isolation. Friends and supporters provide an essential energy source and foundation on which to build. See friendship circle.

### Learning about yourself

When we are living in a state of Well-being we think and feel a certain way and this is where our true nature shows itself. This, of course, is highly individual and for some of us, we have never taken the time, or felt we never had the opportunity, to find out what this really means.

'Who we are' involves an awareness of what motivates us, gives us pleasure, purpose and meaning. It also involves 'who we are becoming' as we change and develop as people.

An awareness of 'who we are' and how we think and behave in

a state of Well-being gives us a useful reference point to come back to when we are moving away from this place.

**Note** Who is the real me? See 'The real me' and 'Well-being curve'.

### Hopes and dreams

Everyone has dreams... We all want to believe deep down that we may have a special gift or purpose. At one time in our life, we all had a vision of how our life could be, but for many of us these dreams become hidden by frustrations, routines and doubt, so much so that we allowed them to fade and dissipate.

But just as a mighty oak sleeps in an acorn, so do the seedlings of achievement sleep in our dreams. To obtain, we first have to desire. To achieve, we have to dream. Part of our 'becoming' involves following the dream of the quality of life we desire and deserve.

Dreams draw us forward and give meaning and purpose to our lives.

By reawakening the dreams we dreamed and identifying the perceived barriers to achieving this, it makes the achievement of them more likely.

**Note** Believing in your dreams are an important part of believing in you. See 'The real me'.

### Journals and diaries

Keeping a journal or diary of your reflections may be a useful way for you to keep in regular touch with yourself and some people find them incredibly beneficial.

A diary offers us a concrete reminder of our thought patterns and processes and a useful resource to draw information from to help complete self management plans. It is also useful to those of us who have a less than ideal memory!

However, this does not suit everyone and some people are better at keeping these reflections in their heads.

**Note** Journals and diaries show us how far we have come and how our goals and thinking change over time.

### Alarm bells and early warning signs

Our bodies naturally provide us with warning signs to alert us when we are moving away from our natural state of health and

Well-being. These come in the form of physical and emotional alarm bells that are unique to each of us.

We may well be familiar with some of these already, but many of us often choose not to take these seriously until we reach a crisis point where our bodies and minds then refuse to play ball. For each of us, this crisis point is different as we all have different strengths and vulnerabilities.

By becoming aware of the things that challenge our Well-being personally, we naturally become more proactive in choosing the things that help rather than hinder us.

A sense of control is an important element in Recovery and Well-being. Becoming more aware of how you feel at any given moment, what affected this and what you can do about it, are wonderful skills that have lasting effects on our sense of self-mastery and confidence.

**Note** Awareness of our unique warning signs of relapse or getting run down gives us the power to do something to prevent the situation getting worse. See 'Early warning signs', 'Triggers' and 'Well-being curve'

### Crisis planning

A crisis plan is a system of planned responses to a pending crisis situation that outlines what you and others can do to help you regain your Well-being.

Crisis planning is useful for those of us that experience periods when we need extra help, support and perhaps time out from our normal environments to regain our Well-being. For some, this may mean extra support, increased medication or assertive support from expert services like crisis teams or inpatient units.

Crisis means different things to different people and it is important to be as clear as you can in its description, so you can get the support you need as soon as possible.

In order to ensure your crisis plan is used by others on your behalf, it is important to make copies easily available and accessible. It may be useful to allow your mental health team and supporters to have a copy, or have a copy somewhere in your home that family and friends can access.

**Note** Crisis planning gives you a voice, when others may be inclined to override your reasoning. See 'Crisis plan'.

### Free will

Free will is the luxury we have as adults to make our own decisions and choices in life. The choices we make for ourselves and others will always have consequences. As we become more aware of the things effecting our health and Well-being, we also become more aware of our ability to make choices that will support or damage our health and Well-being. We will also learn that some decisions and choices may not be ideal, but are ideal for now, knowing that in the future this may change.

Some people are able to make changes in their lives easily and quickly, but for some of us, we are more cautious and choose to take our time, going with our own comfort levels.

Part of this process will involve you choosing what pace is comfortable for you and what you need to retain right now.

**Note** We are responsible for ourselves and our decisions and in most cases this should be respected. See 'Well-being circle'.

### Where and when to start

The first stage of self management involves becoming more aware of some of your processes.

It's important to complete these exercises for yourself and then ask someone you trust and who knows you quite well, to help out. Others' insights can be particularly useful in helping us build up a picture of how we think and act when in our health, or moving away from it, as often someone else can see things that we can't and notice things we don't.

You may feel that you are different and because of your situation, symptoms or circumstances, you cannot achieve a state of Well-being, or that because you have struggled for so long you are not sure of how this would feel.

This should not put you off beginning this process, as you would be surprised how many people feel the same way as you. If you are not in a good state of health right now, it is possible that your thinking may well be putting up unhelpful barriers for you. It may well be useful to ask

someone you trust to support you with this when you are ready.

It is also important to review what you have written after a week or two and see if your thoughts have changed, or need to add things you may have missed out.

Some of the questions may seem very basic or silly, but it is surprising how little we think about these things and how much is revealed when we do. It is important to write things down quickly without thinking too hard about them, as you don't want to push this and become stressed by the process. You can always go back and add things as you remember them.

This is at the very least an awareness raising exercise. You may well be surprised how much or how little you know about yourself and your processes and may not have thought about some of these things before.

There are several potential gains in this process –

1. Becoming more aware of what you've got already – your Well-being, dreams, preferences, skills, strengths and what you have access to.
2. Learning how you look and feel when you are moving away from your Well-being.
3. Learning what you can do about getting back to your Well-being.
4. An awareness of free will and your ability to make your own choices.

### When is the best time to do these exercises?

The best time to start this process is when you have a clear mind and time to reflect on some of the exercises. If you are in a crisis situation, you are not as in touch with your Well-being as you could be and perhaps not thinking as clearly as you could.

This may mean you miss out some important perspectives.

A crisis plan is a way of having a voice of wisdom, health or Well-being present when you are in crisis.

Ultimately, only you know what is most helpful to you in crisis, but when in crisis, we are less able to articulate this clearly and credibly. By completing the crisis planning aspect of your self management plan when you are 'well', you are more likely to include more detail

and seek more support from those around you.

It is important to be able to reflect on crisis from a distance.

However, you should decide when to start this process and remember it is a work in action and the answers you give will change with time, circumstances and new experiences and insights.

When completing any of the self management plans offered here and elsewhere, it is important to review and update these regularly to ensure that they are fresh and current.

It is important to remember that you should take your time with this process and not feel under pressure to do this to make others happy. You should do this if you feel it would be useful to you.

Self management plans can be a useful reflection tool, or an important action plan. You decide how you will use them.

Please see the **Whole Life Recovery Plan** featured in the final chapter of this workbook.

# 'Moving On': A Self-Management Programme for Individuals

by Jan Woodward

The inner resources of a person with mental health issues can actually be depleted by service provision when it takes over completely their sense of autonomy over their own life. While this can be appropriate when a person is very unwell, it can have negative consequences if care does not evolve to respond to changing situations. The aim of support should be to help the person reclaim and equip themselves for their future growth and potential, when they may feel they have lost confidence in their own skills.

'The Whole Life – Moving On Programme' has been developed precisely in order to support a person's belief and confidence, and the need to regain control of their life. It was compiled on the basis of a personal coaching programme, where the staff member/coach is a resource to be accessed to support the service user's identified need – not to determine in advance what this need might be. This is undertaken within a partnership approach, with the service user as the expert on their own life, and the expertise of the staff member as a resource to be utilised by them.

The personal coaching concept was developed out of the Whole Life Programme under the auspices of the National Institute for Mental Health in England (NIMHE), who had noted information from the World Health Organisation (WHO). According to this, services in Britain and other developed countries do less well compared to other countries in the developing world, around Recovery, social inclusion and return to work for those with mental health issues. The NIMHE project involved a range of mental health stakeholders from England visiting European countries to compare mental health services. A frequent observation concerned

the amount and level of control and responsibility that service users in other countries maintained for their mental Well-being. This meant ensuring that, throughout any intervention, those with mental illness were able to maintain the skills and resources they already had, so as not to disrupt existing social or community-based support mechanisms – be they the church, friends, family, or a supportive partner.

## Goals of personal coaching

Personal coaching facilitates a change in the beliefs, values and culture of mental-health services towards a Recovery-orientated service, which encourages and supports service users in taking control and responsibility for their mental Well-being. The hypothesis behind this is that despite the closure of large mental health institutions in Britain, professional response still has its roots in an institutional model of care. The geography might have changed, but had the ideology?

The programme also aims to validate and appreciate the interventions made by professional staff in order to encourage independence for service users, but to increase awareness that some of what we do creates professional dependency. Service users now live in the community, but they can feel as if they are observers on the sidelines, as they watch those around them having meaningful roles with a sense of identity, purpose, structure and belonging as they go about their daily routine. They observe others around them who live with control and choice, and who are part of the throb and pace of mainstream life; whereas service users can feel marginalised, that they are on the edges of society and not fully part of it: that they are not socially included.

The Whole Life – Moving On Programme gives service users of Hertfordshire Partnership NHS Foundation Trust the opportunity to create their own personal development plan, which will cover all aspects of their life, address their needs holistically and deal with more than just their symptoms. Service users are invited to participate in a 15-module personal development course that looks at all aspects of their life. The programme begins with the service user's self-assessment of where they feel they are in their life at present, where they want to be, what support they need for this, and what skills they might need to acquire. The Whole Life staff worker spends time around the service user's own agenda, and does not focus on their mental health issues. The programme has introduced hope and the belief in Recovery from mental illness, and this has empowered and equipped service users to move toward self-management of their life.

Modules in the programme (see end of section) include *"You Can Have Dreams and Aspirations – Creating New Horizons"*; *"Your Journey – Choose the Destinations – Explore Options"*; *"Managing Time, Change and Disappointment"* as well as modules on personal skills required to achieve their specific goals such as assertiveness, stress management, etc. (see Programme Outline). The skills and tools needed for goals are resourced in mainstream services in the community, with the Whole Life worker and service user. This encourages social inclusion and self-motivation to aid them in their journey of Recovery.

The programme has dignified and validated participants as contributors to society rather than passive recipients of care. It has also provided a structured programme for staff to undertake

with their service users. This has enabled professionals to combine support around mental-health issues, but also focus on the abilities and strengths of service users.

As staff have supported people in realising their hopes and expectations in life, they have changed their beliefs and values around Recovery from mental illness. Whole Life staff are drawn from a range of professions; Community Psychiatric Nurses, Occupational Therapists, Social Workers, Employment Consultants, Community Support Staff; and representatives from Community Mental Health Teams, Assertive Outreach, Supported Employment Services, Drug and Alcohol and Community Support Teams.

This project is radical. It is not just trimming the edges of the services we offer, which are good and professional, but has gone to the core and heart of what we do. What does a service user of our mental health services require to live a fulfilling life in the community as we ourselves would want? Its focus is not on an institutional response with professionals in charge, directing service users' lives, but using our professional input to support them to develop their own skills and resources to manage their lives, including their mental health.

It is giving service users hope and a belief in their future; a future of fully participating in the community, being socially included, a paid up citizen, not stigmatised and excluded.

### It is becoming a Rally for Recovery!

Quotes from service users who have undertaken the Whole Life Personal Coaching Programme: *"The WLP is not just 1.5 hours a week for me; I live the project every day. I use the ideas it gives me in every day life and I am improving both personally and mentally every day".*

*"It has helped me understand myself more and identify areas in my life that I need to improve and develop."*  
*"It has helped me write songs and helped motivate me to get onto my National BTEC Diploma in Music Course."*

*"It has made me feel like me again."*

And the following: *"I have been attending the Whole Life Programme since August last year, and I am writing to inform you of my personal experience, and to express how beneficial I find the programme to be."*

*"I have suffered with depression and anxiety since I was 16, and have tried many forms of psychiatric therapy, none of which proved to be helpful or even appealing to me. I consequently found it difficult to commit myself to these types of therapy."*

*"From my first Whole Life session, I felt confident that I had finally found something that could help me move on with my life."*

*"For me, other talking therapies I have tried (such as counselling, psychotherapy, and life coaching) centred too much around working out why I feel the way I do, or what happened in the past to make the way I am. With the Whole Life Programme it's refreshingly different. You focus on realising your strengths, who you are and where you would like to be –*

*and then make realistic plans to achieve this. This approach has been tremendously effective in helping me to battle my mental health problems."*

*"However, if I have felt the need to discuss my past, sensitive issues or express intense emotions, I have done so with ease. This is probably because my Whole Life worker is a qualified counsellor who has been able to offer me appropriate advice, understanding and support."*

*"The programme has helped me identify my aspirations, prioritise my goals, and realise what I can realistically achieve. Before Whole Life, I'd never been so enthusiastic and optimistic about the future."*

*"Since working with him, my confidence has increased along with my self esteem, and I have felt confident enough to stop taking my medication completely."*

*"Steve has referred me to an employment programme designed for people like myself, and so now I'm*

*planning and preparing a return to work."*

*"I'd like to think that the Whole Life Programme could be offered to everyone with a case similar to mine. If it can help me, surely it can help others, too?"*

### Conclusion

Service provision should build on the individual's inner resilience and coping strategies and not on interventions that suffocate, undermine and stifle these innate qualities of hope and potential.

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## Moving On Programme Outline

- > **Module One**..... You can have Dreams and Aspirations  
– Creating new horizons
- > **Module Two**..... Your journey: Choose the destinations  
– Explore options
- > **Module Three**..... Physical Environment
- > **Module Four**..... Communication Skills
- > **Module Five**..... Assertive Behaviour
- > **Module Six**..... Self Esteem
- > **Module Seven**..... Action Planning (including goals and decisions)
- > **Module Eight**..... Managing Time, Change and Disappointment
- > **Module Nine**..... Health  
– Anxiety and Stress  
– Including relaxation, lifestyle choices etc
- > **Module Ten**..... Physical Health  
– Diet, weight, exercise, sleep
- > **Module Eleven**..... Understanding and managing money
- > **Module Twelve**..... Examining my beliefs and values  
– What I believe about myself and others  
– What I believe about life  
– How my beliefs and values help and hinder me
- > **Module Thirteen**..... Pathways to education and work
- > **Module Fourteen**..... It's ok to have Fun  
– Leisure interests and improving social life
- > **Module Fifteen**..... Personal Relationships  
– Emotions  
– Resolving relationship problems  
– Friendship  
– Anger Management