# A Peer Support Guide to Mental Health Recovery for Individuals with Lived Experience

# Skills Workbook

***A Guide to Peer Support and Mental Health Recovery***



Representing:
Cambridge Active Self Help
Mood Disorders Association Waterloo Region
Waterloo Region Self Help
Wellington-Dufferin Self Help

Self Help Alliance
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# Introduction to Mental Health Recovery

## *What do you mean I can recovery my mental health?*

When many individuals with lived experience of mental health (individuals who have experienced mental health issues, previously referenced with the term consumer/survivor) are asked for the first time about recovering their mental health, they might return the question with a blank stare, or face you with a questioning expression of disbelief. For those diagnosed with a serious mental illness, years may have been spent learning that the illness is permanent, that medication will always be required to relieve symptoms, and that all elements of stress and risk in their lives should be reduced, if not eliminated. Mental health issues take a leading role in defining who they are. They believe that limited options or tools are available to help them. They cope with the stigma of mental illness from those working in the mental health system, sometimes family and friends, and often the general public. In time, they may become unmotivated, apathetic and withdrawn.

The purpose of this Guide is to provide individuals with lived experience an overview of mental health recovery from a peer support perspective. Through exercises and activities, we believe you will appreciate that everyone possesses inherent strengths, and that there are many ways of seeing our lives and the world in which we live. Most importantly, we hope that people will learn that mental health recovery is a journey that can be customized and be self-directed by each individual person.

Throughout most of the 20th century (and prior), many health professionals maintained that mental illnesses were permanent and incurable, with little or no chance of improvement. Diagnosis with a serious mental illness was often seen as a life sentence, where individuals were unable to make rational decisions, interact successfully with others, live independently, hold jobs or have meaningful personal relationships.

Individuals with lived experience have been writing about mental health recovery since the late 1970s. Many have known for some time that the conclusions on mental health determined by many health communities are not completely valid. There is now awareness that mental health recovery is enhanced through peer support and advocacy, among other things. In the last three plus decades, a number of research studies have proven that recovery is not only possible, but likely for those experiencing mental health issues.

***Throughout this Guide, you will have an opportunity (in a peer group setting if selected) to explore:***

1. ***Mental Health Recovery and What it Can Mean to Individuals with Lived Experiences.***
   This session introduces some basic definitions and themes about recovery and provides an opportunity to begin sketching out a personal recovery process.

2. ***How I See My Life and the World Around Me.***
   Here you have an opportunity to see how we all view the world in different ways. A chance to discuss the concept of a 'mental patient' as a 'job', is provided, along with the principles of group peer support.

3. ***Who Am I and What Motivates Me?***
   Identify your own personal level of motivation for recovery, and begin to look at who you really are as a person.

4. ***People Who Have Recovered Could Be Like…?***
   Let's not just think of mental health recovery from a medical or professional perspective. Let's explore other ideas around recovery.

5. ***The Good, the Bad, and the Stigma…***
   What environments and activities will promote your mental health recovery? What barriers might you face along the way? Also, introduced here is a discussion on the stigma associated with mental illness. Stigma may come from the medical community, friends, social workers, and even family.

6. ***What Will Recovering My Mental Health Look Like to Me?***
   Begin planning a personal recovery process based on your inherent strengths.

7. ***What Can I Do Next?***
   This Guide concludes with a brief summary of the Self Help Recovery Centre Peer Support Groups offered by the partner organizations that make up the Self Help Alliance. In addition, other resources will be listed that are available to you.

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The activities of the partner organizations of the **Self Help Alliance** are rooted in the values of self help, peer support and mutual aid. The Self Help Alliance is a partnership of four organizations in the Waterloo Region and the Counties of Wellington and Dufferin that are driven by individuals with lived experience. The organizations involved are **Cambridge Active Self Help, Mood Disorders Association Waterloo Region, Waterloo Region Self Help, and Wellington-Dufferin Self Help.** These four groups share common beliefs and values, and through their unique partnership they are able to combine many of their resources to better meet the needs of local individuals with lived experience.

# Section 1 – Mental Health Recovery and What it Can Mean to Individuals with Lived Experience

## Mental Health Recovery and What It Can Mean to Individuals with Lived Experience

How do we define 'recovery'? It is a very personal subject, but here are some ideas from other individuals with lived experience, and people involved in the mental health system.

William Anthony of the *Centre for Psychiatric Rehabilitation* in Boston, describes recovery as:

> "a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness."[1]

Patricia Deegan, world-renown advocate for individuals with lived experience, states that:

> "Recovery is a process, a way of life, an attitude, and a way of approaching the day's challenges. It is not a perfectly linear process. At times our course is erratic and we falter, slide back, regroup and start again….The need is to meet the challenge of the disability and to re-establish a new and valued sense of integrity and purpose within and beyond the limits of the disability; the aspiration is to live, work, and love in a community in which one makes a significant contribution." [2]

E. Leete, says that:

> "Having some hope is crucial to recovery; none of us would strive if we believed it a futile effort….I believe that if we confront our illnesses with courage and struggle with our symptoms persistently, we can overcome our handicaps to live independently, learn skills, and contribute to society, the society that has traditionally abandoned us."[3]

Prescott views recovery as:

> "Self-defined processes in which people are supported in their right to engage in uncovering and discovering that which can lead to transformation and healing."[4]

Priscilla Ridgeway states:

> "Recovery is…the awakening of hope after despair…moving from withdrawal to engagement and active participation in life…active coping rather than passive adjustment…no longer viewing oneself primarily as a mental patient and reclaiming a positive sense of self…a journey from alienation to purpose…." [5]

**Some Common Themes About Mental Health Recovery are Beginning to Emerge**

## *Hope*

All individuals have the capacity to grow and change in the future.

## *Self Determination, Empowerment, and Autonomy*

The process is defined and directed by each individual with lived experience, not dictated by others.

## *Personal Growth and Awareness*

Identifying strengths and limitations must occur before an individual can grow.

## *Self Acceptance*

Mental Health issues are just one part of your life to embrace, and move beyond.

## *Engagement in Community Life*

Strive to be an integrated part of your community, and see how others are living.

## *Individual Responsibility*

Engaging in a process that involves changes related to how we live our lives is entirely up to you.

## What Have You Heard About Recovering From a Mental Illness?

Many people who use this Guide have been involved in the mental health system for years. In your own experience, describe what you have heard about recovering from a mental illness by thinking about and answering the following questions:

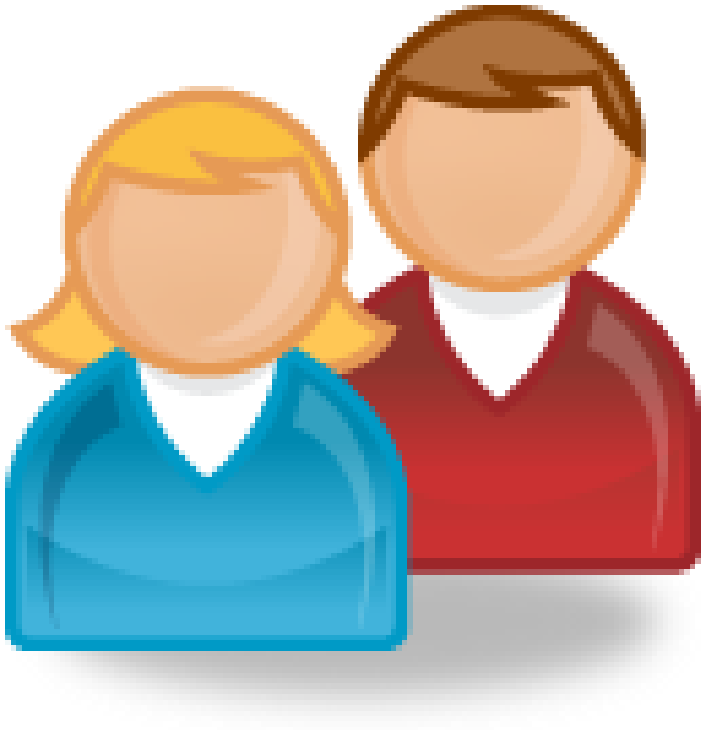
- Has the idea of 'recovering' from your mental illness ever been discussed? With whom? What did they say? (For example, a doctor, family, friends, counselors, support workers, peer groups, anyone else?)

- Even if you've never talked about it, what is your perception of what each of these people would say to you about recovery?

- How will you know if you are recovering? What will be happening differently in your life? What activities and relationships would help you lead a complete and fulfilling life?

- Discuss any similarities or differences in your answers from others (in the group).

***Now you can begin to think about formulating a recovery process that will be most beneficial to <u>you</u>!***



## What Do You Think Recovering From a Mental Illness Would Look Like?

***"There is a growing body of evidence to suggest that people with mental health issues do recover and carry on meaningful and productive lives. For example, a study in Vermont looked at hospital records of people with serious mental health issues. It showed that over time a large number do recover, in that they did not return to hospital. The researchers learned that they became involved in meaningful activities in their communities and that the illness was no longer the primary focus of their lives."*** [6]

For yourself, what do you think recovering from a mental health illness would look like?

Check off what applies in your opinion.

- ☐ No need for ongoing professional help?
- ☐ No negative symptoms?
- ☐ Doing meaningful activities?
- ☐ Focusing on what *is* possible, not on what *is not* possible?
- ☐ Using your abilities productively?
- ☐ Learning new skills?
- ☐ Making new friends?
- ☐ Joining new groups or clubs?
- ☐ Developing an intimate relationships?
- ☐ Volunteering?
- ☐ Working?
- ☐ Taking up a new hobby?
- ☐ What other things could you include here?



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# How Beautiful is Your Mind?

In 2002, the Academy Award for best picture of the year went to *A Beautiful Mind*, the story of a Nobel Prize Winner John Nash, a brilliant mathematician who faced a life-long struggle with the paranoia and delusions of schizophrenia. The following article about the movie is taken from the New York Times, and was written by the same person who undertook the Vermont Hospitalization Study mentioned earlier. The author offers a lot of support for the concepts of mental health recovery.

**Photo of John Nash**
(Source: http://alumweb.mit.edu/clubs/princeton/BrowseWeb.do?webSiteId=SI000337&webPageId=P008&eventId=3147)

# Beautiful Minds can be Recovered

Courtney M Harding, *The New York Times,* Copyright 2002
March 10, 2002
*Editorial Desk*

The film, A Beautiful Mind, about the Nobel Prize-winning mathematician, John F. Nash Jr, portrays his recovery from schizophrenia as hard-won, awe-inspiring and unusual. What most Americans and even many psychiatrists do not realize is that many people with schizophrenia – perhaps more than half – do significantly improve or recover. That is, they can function socially, work, relate well to others and live in the larger community. Many can be symptom-free without medication.

They improve without fanfare and frequently without much help from the mental health system. Many recover because of sheer persistence at fighting to get better, combined with family or community support. Though some shake off the illness in two to five years, others improve much more slowly. Yet people have recovered even after 30 or 40 years with schizophrenia. The question is, why haven't we set up systems of care that encourage many more people with schizophrenia to reclaim their lives?

We have known what to do and how to do it since the mid-50s. George Brooks, clinical director of a Vermont hospital, was using Thorazine, then a new drug, to treat patients formerly dismissed as hopeless. He found that for many, the medication was not enough to allow them to leave the hospital. Collaborating with patients, he developed a comprehensive and flexible program of psychological rehabilitation. The hospital staff helped patients develop social and work skills, cope with daily living and regain confidence. After a few months in this program, many of the patients who hadn't responded to medication alone were well enough to go back to their communities. The hospital also built a community system to help patients after they were discharged.

These results were lasting. In the 1980s when the patients who had been through this program in the 50s were contacted for a University of Vermont study, 62 percent to 68 percent were found to be significantly improved from their original condition or to have completely recovered. The most amazing finding was that 45 percent of those in Dr. Brook's program no longer had signs or symptoms of any mental illness three decades later.

Today, most of the 2.5 million Americans with schizophrenia do not get the kind of care that worked so well in Vermont. Instead, they are treated in community mental health centers that provide medication – which works to reduce painful symptoms in about 60 percent of cases – and little else. There is rarely enough money for truly effective rehabilitation programs that help people manage their lives.

Unfortunately, psychiatrists and others who care for the mentally ill are often trained from textbooks written at the turn of the last century, the most notable by two European doctors – Emil Kraepelin in Germany and Eugen Bleuler in Switzerland. These books state flatly that improvement and recovery are not to be expected.

Kraepelin worked in back wards that simply warehoused patients, including some in the final stages of syphilis who were wrongly diagnosed with schizophrenia. Bleuler, initially more optimistic, revised his prognoses downward after studying only hospitalized patients who were ultimately discharged.

The American Psychiatric Association's newest Diagnostic and Statistical Manual – D.S.M – 1V, published in 1994, repeats this old pessimism. Reinforcing this gloomy view are the crowded day rooms and shelters and large public mental health caseloads.

Also working against effective treatment are destructive social forces like prejudice, discrimination and poverty, as well as overzealous cost containment in public and private insurance coverage. Public dialogue is mostly about ensuring that people take their medication, with little said about providing ways to return to productive lives. We promote a self-fulfilling prophecy of a downward course and then throw up our hands and blame the ill person, or the illness itself, as not remediable.

In addition to the Vermont study, nine other contemporary research studies from across the world have all found that over decades, the number of those improving and even recovering from schizophrenia gets larger and larger. These long-term, in-depth studies followed people for decades whether or not they remained in treatment, and found that 46 percent to 68 percent showed significant improvement or had recovered. Earlier research had been short-term and had looked only at patients in treatment.

Although there are many pathways to recovery, several factors stand out. They include a home, job, friends and integration into the community. They also include hope, relearned optimism and self-sufficiency.

Treatment based on the hope of recovery has had periodic support. In 1961, a report of the American Medical Association, the American Psychiatric Association, the American Academy of Neurology and the Justice Department said, "The fallacies of total insanity, hopelessness and incurability should be attacked and the prospects of recovery and improvement through modern concepts of treatment and rehabilitation emphasized." In 1984 the National Institute of Mental Health recommended community support programs that try to bolster patients' sense of personal dignity and encourage self-determination, peer support and the involvement of families and communities. Now there are renewed calls for recovery-oriented treatment. They should be heeded. We need major shifts in actual practice.

Can all patients make the improvement of a John Nash? No. Schizophrenia is not one disease with one cause and one treatment. But we, as a society, should recognize a moral imperative to listen to what science has told us since 1955 and what patients told us long before. Many mentally ill people have the capacity to lead productive lives in full citizenship. We should have the courage to provide that opportunity for them.

***Courtney M Harding, The New York Times, Copyright 2002***

# Section 2: How I See My Life and the World Around Me

## What Do You See (Part 1)?

What people see is what they perceive to be real based on how their mind processes and interprets the information.

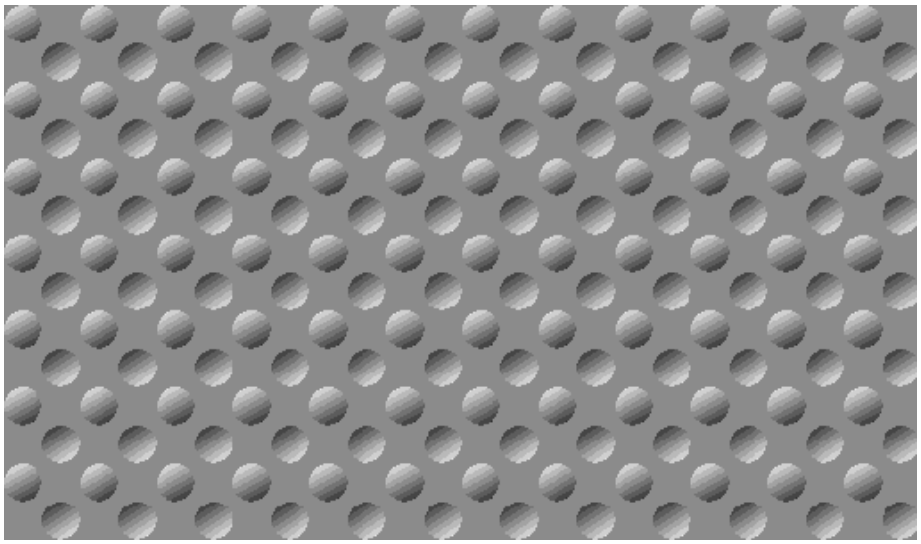
So what you see is not always what another sees, because everyone sees their world through different 'filters'. A filter is simply how our brain screens and interprets the information it receives.

For example, take a look at the following illustrations – what do you see?

Most people would say they see the profile of a face. Others might say they can easily see an Inuit person, dressed in a parka, walking away from them.

## What Do You See (Part 2)?

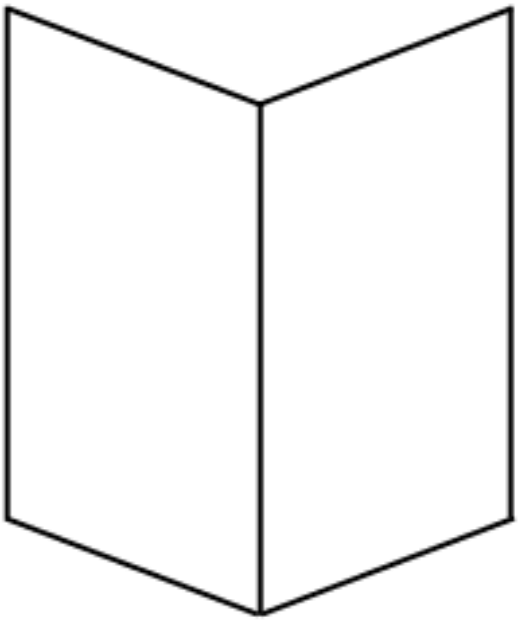
Let's try another one. In this diagram, which are the raised dots and which are the recessed dimples?



Depending on how you perceive the image, you might see alternating rows of dots that are raised and dots that are dimples. Which is which?

## What Do You See (Part 3)?

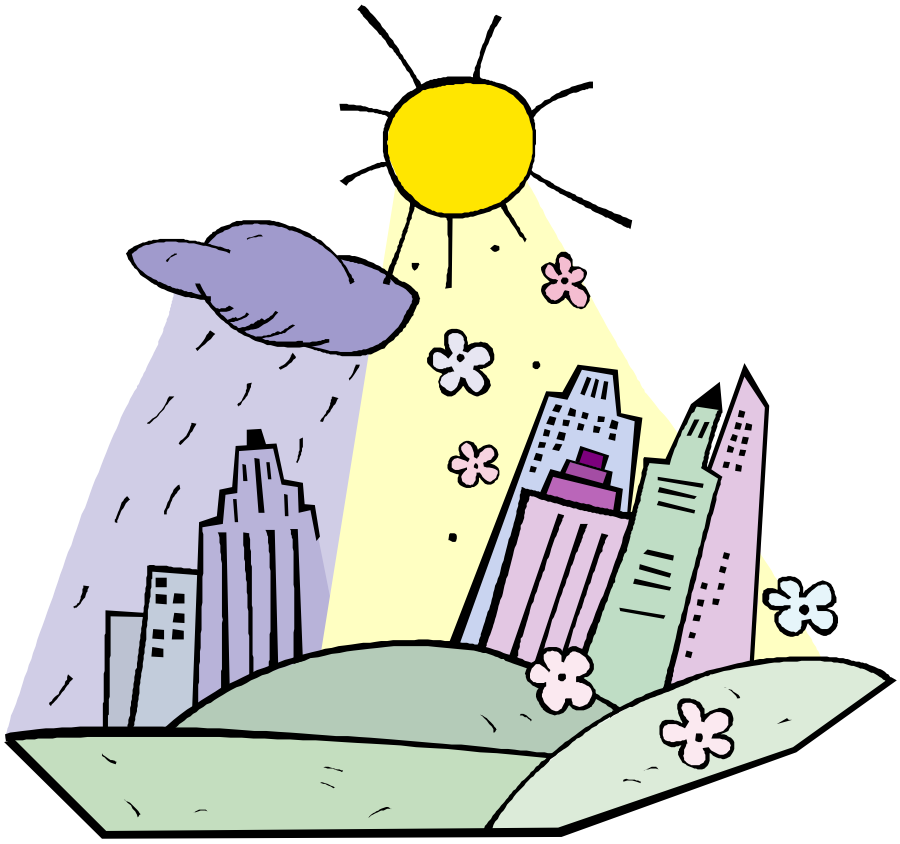
In this image of a folder, does it appear to be opening toward you or away from you?



These are very simple examples using images, but the same principles hold true for how people interpret situations or events. So, it is easy to see how people can see the same image, situation or event in two or maybe even more different ways. People perceive things as they do because we all learn differently from our own life experiences. We all have our own unique filters. There is usually no right or wrong way to what we perceive, it's just different.

## What Do the People Around Us See?

Just for fun, go around a group and ask each person what they think about today's weather. Is it too hot? Too cold? Too windy? Too cloudy? Too wet?



Ten people could easily have ten different answers depending on how they perceive the weather, how they acclimatize to weather changes, and how they've learned to interpret what they observe.

As with any situation or event, the same principles are true when we observe ourselves as a 'mental patient'. Popular individuals with lived experience from the United States, Mary Ellen Copeland, and her associate Shery Mead, have published a number of books and articles related to recovery and the value of peer support. In *Wellness Recovery Action Plan & Peer Support*, they use the analogy of a house as a means of relating how each of us sees the world differently based on our life experiences. Our perspectives change depending on which room we are in, and who we are interacting with.

## Understanding "the House"

**By Mary Ellen Copeland and Shery Mead[7]**

I've often used "the house" as a way of thinking about our personal culture and how each of us has learned to see the world, and also to help us remember that people are complex, unique, and forever changing. Not only do we speak from various "rooms" on the inside of our house, we may also change our "story" based on to whom we're talking.

Each of us lives within a house. It has an outside that others see and an inside no one else can see or fully know. Its basic framework is the physical, emotional and spiritual self that we are born with. Over the years, many changes are made to our house – both inside and outside. Its rooms become "decorated" by all the messages and experiences we've had. For example, if early in life we are adored, talked to, helped and told that we are the most wonderful person on earth, our house might include plush rugs, attractive furniture and a fireplace. If an important person then comes into our life and gives us negative messages, the interior of our house changes. Often negative messages and fears are put in our basement or closet where dark secrets are kept. More positive messages, create upstairs rooms with windows and doors where it is sunnier, where relationships are more transparent, and communication goes back and forth. Messages of "otherness" might create an attic. Needless to say, the view from the basement is different than the view from the attic and our perspective changes as we move from room to room.

For example:

If I'm in my basement, and I'm looking out a window, how will my location affect what I see?

If I'm upstairs in a sunny, warm room, how will that location affect what I see out the window?

If my "house" has lots of dark, tiny rooms and not much light, how will that affect what I see outside?

Or, if my “house” is full of light with not much dark, how will that affect my view?

The houses in the neighborhood look alike on the outside. We really can’t see their insides, but because they look similar, we think we know what they might look like. Then, when we talk to a person, we sometimes make the mistake of “over-relating”. We say: “I know what you mean, “I’ve had the exact same experience.” This is one of the mistakes often found in Peer Support Groups, where we over-identify and keep relating to each other from the ‘patient’ role.

For a long time, my house seemed to have nothing but a big basement. Although people thought I was upstairs, those rooms just offered the appearance of being lived in. As I got clearer about the ways I learned to see the world and to relate to others, I began to move out of the basement, into the living room and finally out to the front porch.

How would you describe the inside of your “house”?

What room do you spend the most time in? How has that changed over time?

What do you think has changed?

## What Do You See (Part 4)?

No matter how long you stare at this image, all you'll probably see is one four letter word. However, it's okay to look at it from different angles and perspectives. Now, do you see anything else?

Keep an open mind and look for different possibilities for your life.

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## How Well Did You Learn to be a 'Mental Patient'?

In addition to using the house analogy to describe how people see the outside world in different ways. Mary Ellen Copeland and Shery Mead also relate how people can learn to be a 'mental patient'.

We learn to tell our stories based on who's listening, how much we trust them, what impact we want to have, and our assumptions about the way we think.

Take a read and see if you can relate to this article?

### "To Be a Mental Patient"

By Mary Ellen Copeland and Shery Mead[8]

*Starting Out*

When we first opened the centre, it became clear that people who'd been in the mental health system for a long time had formed certain roles and beliefs. Through the years they had been told what they "had", how it should be treated, and to expect lifelong mental health treatment. For example, one man told me that he has been a chronic schizophrenic since the age of fourteen. He proceeded to tell me about the insulin shock treatments, the various state hospitals, and then he told me that he would never get better. He believed that in order to stay "functional" he'd have to depend on clinical help and psychotropic medications for the rest of his life. He had no language for talking about recovery and virtually no hope for a different kind of life. Basically, he had just learned to cope, and led a pretty uninteresting existence - case management appointments, weekly meetings with his payee, and monthly visits with the psychiatrist. Over the years he had gotten used to telling his illness story again and again as if that's all there was to his existence. In other words, he had taken on the role of the 'mental patient'.

In order to unlearn the mental patient role, we must first take a step back and think about how we have adopted it. How did we learn that we were "mentally ill"? When did we start to see ourselves as different from other people?

I've often told the following story of my own "learning to be a mental patient".

When I was four, I found it much easier to communicate with chipmunks. I talked with them and they spoke with me. I learned, connected and understood things in a world that was clearly "different". This became painfully true one day when a babysitter found

me talking to a stone wall, obviously deep in conversation with something or someone she did not see. Her reaction got bigger with each response. Making me more aware of the "craziness" of what I was doing. "What are you doing, Shery?" Then, "What ARE you doing"? And finally, "WHAT ARE YOU DOING?" By the end of her questioning, I had already learned that there was something "wrong" with me and that it was "bad".

This sense of myself also contributed to thinking that the abuse and violence I had been experiencing was my fault. I began to think being abused was pretty normal, as I was continuously being told, "it's for your own good, " "it's your fault," or finally, "you must be crazy, that never happened." The abuse then continued on and on and there was no language for it. More and more it supported that "something was wrong with me" theory.

Finally, I became overwhelmed and my ability to "act as if" no longer worked. I ended up speaking a language that others didn't understand, running around in the winter without socks or shoes, shaking and stuttering uncontrollably, or not being able to speak for days on end. Now the whole community told me I was crazy. I landed in the local psychiatric unit, locked up, in seclusion (with only a tiny observation window) and drugged when I started to shake. They told me I "had" something called schizophrenia. They never asked what had happened, nor heard my "story". Theorazine, at the time, was the drug of choice and it stopped any ability I'd had before to think, feel, participate in healthy relationships, or think about my experience in new ways.

My relationship with fellow "patients" were based on what they had learned in the hospital. Their stories were stories of illness. From them I learned how to "cheek" my medications, hoard razor blades and sharp glass, and how to survive an EEG . After the many months spent there, and after a series of shock treatments that erased most of my memory. I had learned to live the life of a mental patient. I had learned that I "had" something that others didn't, and then I learned how to hide it in the arts. It was somewhat easier being "crazy" as a poet and musician!

What would have been different about this story if talking to chipmunks had been seen as "normal"?

Can you remember the first time you felt different from others? If so, describe it here.

How do you think that's affected the way you see yourself?

How has it affected your relationships?

Many of us learned about our “otherness” or “differentness” in our first contact with the mental health system. This is due to the fact that the very first conversation we have when we come into the system involves an assessment.

Once we’ve been assigned a diagnosis, we talk about treatment for “it”. We’ve then lost who we are to a generic label. We begin to think about all of our experiences in relationship to illness: tough feelings such as depression, excited feelings such as mania, etc. No matter what we are feeling, when we talk about our feelings using this language, the conversation can only go in one direction.

Pretty soon everything we do, think, and say runs through the “mental patient” filter.

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***Being a ‘mental patient’ can become a full time ‘job’ and once we’ve taken it on, we really are tied into the system.***

***Our finances, housing, support, and job opportunities are dependent on our ‘job’ as a ‘mental patient’.***

## The 'Job' of Being a 'Mental Patient'

*Think about the 'job' of being a 'mental patient':*

What is the job description?

Who assigns the job and your role?

Who evaluates mental patients?

What does it pay and what are the benefits?

What are the drawbacks?

What happens if you quit?

***Many of us have done extremely well learning and performing this 'job'. Unfortunately, some of us have done it so well, and for so long, that it's impossible to even think about taking up another occupation, like recovery.*** [10]

## How Open is Your Mind…What is Group Peer Support and How Does it Work?

Group recovery sessions in a peer setting are very different from many traditional mental health services. It is not like clinical support that one might find in a hospital or other clinical setting; however it is more than just a group of friends getting together. Generally, participants in a group will come together to learn, discuss and support each other in their recovery journeys. Often, groups will have a particular topic of focus for the session.

Peer groups exist at all member organizations of the Self Help Alliance. Some are support groups for people with a particular mental health issue, while others focus on various aspects of recovery. A list of many of the types of groups held through Self Help Alliance partner organizations is provided at the end of this guide (Section 7).

Many people begin going to self help groups because they provide a safe and comfortable environment. Everyone in the group has in some way been involved with the mental health system. We share our own experiences and listen to the view of others in a mutually respectful and responsible way. We engage each beyond the stigma of our mental illness, where we were labeled as sick or disabled. Group peer support challenges us to change our way of thinking about ourselves, to change unhelpful and unhealthy patterns in our lives, to plan our lives based on our own goals and objectives, and to see ourselves as real people who are contributing members of our community.

For these things to happen in a group peer setting, Mary Ellen Copeland has identified a list of principles of what peer support is and what it is not [11]

| Peer Support Is: | Peer Support Is Not: |
|---|---|
| Being open to new ways of thinking about ourselves and our mental health experience | An expert telling you what your experience means |
| Re-defining help and helping | Telling someone what to do |
| A way of thinking about relationships and power that is mutual | Superficial power-down relationships |
| Considering the effects of trauma and abuse on people's self concept and relationships | Telling you that you are sick and socially unacceptable |
| Mutually supportive and mutually responsible | A one-way relationship where one person takes responsibility for another |
| Teaching and learning from each other | Being told or learning about diagnoses or treatments |
| An opportunity to challenge the status quo | Protecting people from taking risks that are 'too stressful' |
| About recovery and transformation | About stability and maintenance |

*All groups that are held at the Self Help Recovery Centre are based on these principles. In addition, all groups are held in confidence. In other words, <u>what is said in the group stays in the group</u>.*

*We are not coming together to judge how others lead their lives, but rather to accept that everyone sees the world differently and will find their own best path through empathy, trust and mutual support.*

# Section 3 – Who Am I and What Motivates me? What Exactly is Self Awareness Anyway?

Many individuals with lived experience have lost a sense of motivation – the ability to overcome obstacles, the inspiration to dream about life's direction, the commitment to set goals and the energy to move forward. Who you are now has resulted from myriad influences and experiences in your life. Regardless of who you are now, nobody is completely unmotivated. No matter how 'stuck-in-a-rut' you might feel, there are things we all do in life that require motivation. An American author and philosopher, Ralph Waldo Emerson, once said, "What lies behind us and what lies before us are tiny matters compared to what lies within us."

The challenge is to figure out what you want to accomplish, then couple that with whatever it is that motivates you. Self-motivation is a very important element of anyone's recovery in mental health. As we saw in the first section, all people can develop the capacity to grow, to take control of their lives, and to make decisions about how their future will unfold.

## Identify Your Personal Motivation Profile!

Use the following list to identify where you are on the motivation scale.[12] Check off as many items as you think apply, and add more items to the list if you like.

- ☐ Nothing I do makes a difference in my life. I have a mental illness.
- ☐ Nothing I do makes a difference to anyone I know. I have a mental illness.
- ☐ Nobody expects anything from me, so I never expect anything from myself.
- ☐ I feel like I want to move toward recovery, but that feeling never lasts long.
- ☐ I think things could be better for me if I worked, but receiving a disability pension is okay too.
- ☐ When I think of things I might want to do, I get a little excited, but then can't seem to get motivated to do anything about them.
- ☐ There are several recovery activities I would like to try, and may move on them soon when I feel more motivated.
- ☐ I have been motivated to start developing a plan to accomplish a few things, and am looking at ways of completing them, as well as looking for the support and resources I will need along the way.
- ☐ I don't care if I lose my disability pension. I have lots of skills and abilities to offer the world when I'm working, and that's what I'm going to do.
- ☐ My life goals are pretty clear and I am actively working toward achieving them.
- ☐ I have already accomplished a lot toward my mental health recovery and achieving my life goals, and want to share my energy and achievements with others to help motivate them.

Reflect back to Section 1 where you identified what recovery might look like for you. Now, relate where you are on this motivation scale compared to where you might be in the mental health recovery process. Do you see a relationship between motivation in achieving your goals and developing your own personal recovery plan?

## Self Awareness - Ask yourself, "Who am I and What do I do?"

Make a list of all the things you do as an individual, breaking it down into two columns. The first part is a list of things you do that are fun, challenging, and exciting. The second column is a list of things that you find boring, menial or mundane. As examples, your lists might include going for a walk, playing a sport, doing a craft or hobby, traveling, cleaning your home, shopping, gardening, volunteering, cleaning out the cat's box, or paying bills. Both sides can contain things that are necessary for you to do, or not. Try to make the lists as long as you can.

| Fun, Challenging, Exciting | Boring, Menial, Mundane |
|---|---|
| • | • |
| • | • |
| • | • |
| • | • |
| • | • |
| • | • |
| • | • |
| • | • |
| • | • |
| • | • |

However, there is a lot more to 'who you are' than 'what you do'. Next, make a list of your family members, for example your brothers, sisters, cousins, parents or children. How has each influenced you in the past? Present?

| Family members | How Have They Influenced You? |
|---|---|
| • | • |
| • | • |
| • | • |
| • | • |
| • | • |
| • | • |
| • | • |
| • | • |

As well, describe the environment in which you grew up.

## What Makes Up Your Network?

What group activities do you participate in? Going to church, exercise classes at a gym, going to a local community group, taking art or writing classes, attending peer support groups, meeting with friends at the local coffee shop, etc.

## Group Activities I Participate in Include:

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## Who Are the People Closest to You?

Finally, put down a short list of people who are very close to you. The ones that you trust, and that you feel you can talk to about your dreams, aspirations, or other personal things. The list might include a romantic partner, a close friend or relative, a person in your church, a health professional or someone else you are close to.

## People Who Are Closest To Me:

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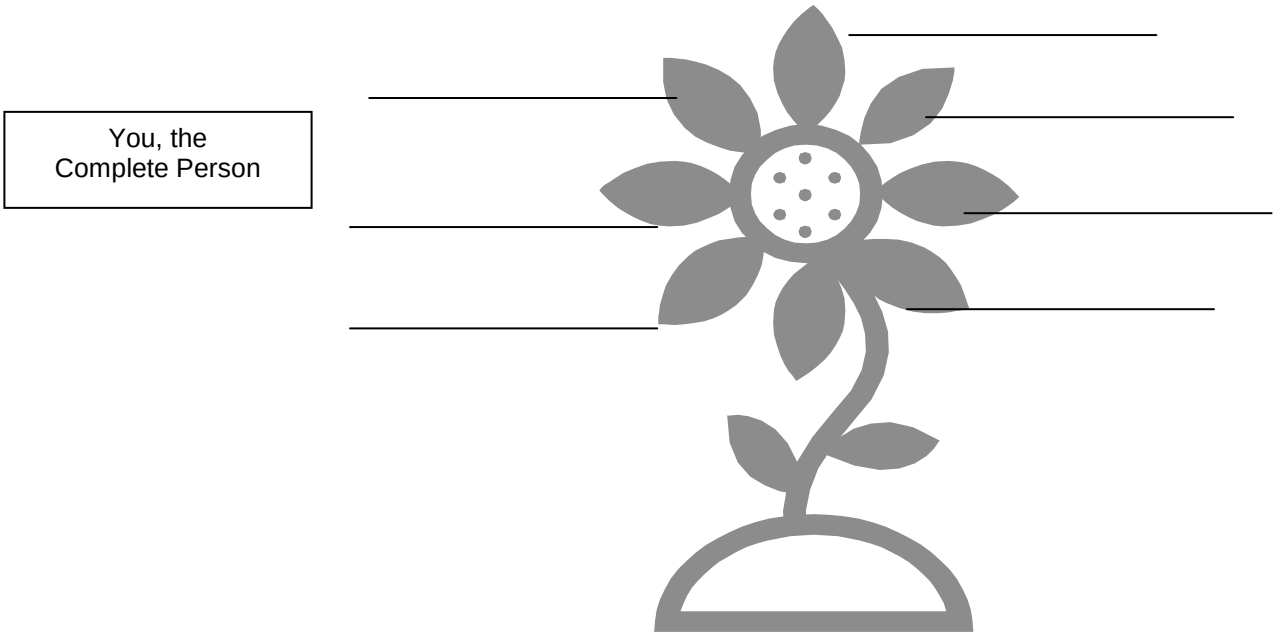
## The Complete Person

*Like the many petals on a flower, we are all multi-faceted individuals regardless of how we arrived at the current place in our lives. We can all be a complete person. A complete person has a physical part to them, as well as emotional and spiritual. We might be a friend, an employee, a lover, a member of a church, a volunteer, an athlete, a brother or sister, or a writer. You have been influenced by your cultural and family backgrounds, and your inherent values and beliefs.*

*Each aspect of your life is represented by a different petal.*




*There can be as many petals on your flower as you can think of.*

***Take some time to label your flower,***
***adding as many new petals to it as you need.***[13]

Many people begin to realize that 'who they are', 'what they do', and the environment they've come from are influenced only in a small way by their mental health issues. While mental health issues may be one piece of the overall picture of your life, try to see them as only one small part of who you are.

Begin to see yourself as a whole person, with skills, experiences, dreams and aspirations. The beginning step toward recovery is to view who we are as complete and capable people.

We all have inner strengths and talents. Your recovery will be heading in the right direction if you are motivated to draw on those abilities, thus allowing you to focus on the healthy and productive parts of your life.

## Section 4 – People Who Have Recovered Could Be Like…?









Self Help Alliance (representing: Cambridge Active Self Help, Mood Disorders Association Waterloo Region, Wellington-Dufferin Self Help, Waterloo Region Self Help)

Let's look at two very different views of recovering from mental illness. On one hand, there is a medical/professional perspective that has traditionally looked at mental illness perhaps, as incurable, but at least there might be some medicinal treatment for the symptoms.

Reflect back to a point in time when mental health symptoms were very predominant in your life. You may have been in a hospital or under a doctor's care during that time. In the traditional medical approach to mental health recovery from severe illness, the goal has been to alleviate symptoms through medication or other treatments. This would gradually reduce the need for subsequent medical and social care services. It would be similar to the professional approach to curing a disease or repairing a broken bone, where people are patients passively receiving treatment and services. And we often end up 'wearing' the label of our mental illness. Have you ever heard someone say "I'm a manic depressive" or "I'm a schizophrenic"?

Remember, that a self help recovery approach does not require people to experience reduced symptoms or have any less need for medical or social services. In this sense, it does not mean that the illness has been cured or gone into remission. Rather, over time people learn to come to terms with their mental health experience and move beyond it. You actively participate in the recovery process. Without your decision and commitment there can be no recovery under this approach. The focus is on the potential growth within each person.

## Comparison of People Who Have Been Labeled with Mental Illness with those Who have Recovered [14]

| Person Labeled with Mental Illness | What Difference DO you Vision for Yourself with Regards to…? | Person who has Recovered from Mental Illness |
|---|---|---|
| Professionals need to make major decisions in your life | Decision Making | You are self determined and make decisions for yourself |
| The mental health system provides social supports for you | Major Social Supports | You have a network of friends and others who provide support to you |
| Medication is the sole intervention, and must be complied with | The Role of Medication | Medication is only one tool among many that you choose to use in your recovery |
| Strong emotions are symptoms to be treated by a professional | How you Express and Deal with Your Emotions | You express your emotions freely and work through them by yourself or with friends |
| You are weak, and your sense of yourself is defined by people in authority | Your Sense of Yourself | You are strong and defined from within through peer interactions |
| You're a consumer, a schizophrenic, or mental | Your Social Role and Identity | You are an individual who might be a parent, a student, an employee or some other role |

Discuss and reflect on what would have to happen in your own life to move further toward the 'recovery' side of the table.

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# Section 5 – The Good, the Bad, and the Stigma…

*In this section, we will look at positive environments and activities that promote recovery, barriers that many people find impede them, and the stigma around mental health that shows up in the language that many use.*

## The Good – Positive Environments and Activities that Promote Recovery

### *Being in a Safe Place*

Regardless of where you are, or what you are doing, feeling safe and secure is probably the single most important factor to fostering a positive environment; which in turn, can promote your recovery. While Self Help Recovery Centres offer a safe place to interact with your peers, the strategies employed to enable your recovery are also quite safe and simple.

### *A Hopeful Environment Leads to a Sense of Personal Empowerment*

Hope is the spark of life. Hope is believing that your circumstances can improve, that you can and will get well, and go on to dream, have aspirations, and do the things you want to do with your life. We need to give each other messages of hope and encourage our supporters to do the same. Being responsible and taking care of your physical, emotional and mental health is self-empowering. You are in control of your life. For recovery to occur, it is important for you to take charge and make your own decisions.

### *Being Involved in Meaningful Activities*

Involve yourself in activities that are important to you. That could be working, pursuing your education, volunteering, attending community groups, or doing a hobby. There is always a certain level of personal satisfaction in a job well done; it's a sense of accomplishment.

### *Having Friends and Relationships*

Humans, by their very nature, thrive on personal interaction with each other. We might have close friends that we can relate to about personal things, or be in an intimate relationship with a partner. Even having casual friends or acquaintances to 'hang out with' reduces our chances of becoming isolated from our community.

### Adequate Opportunities for Peer Support

For those who benefit from working with people who have had a similar experience, peer groups can provide a positive environment for education and support.

### *Formal Services*

Although peer support is one avenue to pursue in your recovery, having adequate access to more formal services, such as counseling and medical advice, is very important to many. Depending on the area in which you live, there may well be other mental health-related organizations that can help you directly with life planning, housing, employment, and referrals to health professionals.

***What other environments and activities can you think of that would be beneficial to your recovery?***

## The Bad - Barriers to Your Recovery

There are many things that tend to get in the way of mental health recovery. Some are systemic. For example, the mental health system as a whole can be limited in its ability to foster recovery in people. Changes in how the system functions can and are occurring through group advocacy and its influence on political will. It's hard to see how one individual can affect change.

*Let's compare a number of aspects of the traditional medical or 'professional' view of mental illness, against the self-help recovery model*

### Medical Model vs. Recovery (Empowerment ) Model Overview [15]

| Medical Model | Recovery Model |
|---|---|
| Mental illness is permanent | People can recover from mental illness |
| Medication is the treatment for mental illness | Medication can be one of many helpful tools that aid recovery |
| Focus is on the deficits of illness | Focus is on an individual's strengths |
| Goal is to manage and cope with illness | Goal is to overcome and thrive beyond illness |
| Mental illness takes lead role in defining life | Mental illness is just one element of person's identity |
| People with mental illness need to be "cared for" by professionals for the rest of their life | People recover by taking responsibility to care for themselves and utilize a variety of supports (self-care techniques and support from peers, friends, as well as professionals) |
| Doctors and other professionals are the experts with the "right" answers | People are the experts on their own lives |
| Others make decisions on behalf of people with mental illness | Person makes decisions about their own care and life |
| People with mental illness should eliminate all elements of stress from their lives (relationships, working etc.) | People can learn to navigate natural stresses and participate in all aspects of life |
| People with mental illness do not have the same rights and responsibilities as others | People in recovery are seen as full citizens with equal rights and responsibilities |
| People with mental illness need protected and segregated social settings | People recover in natural community settings |
| Choices and options are limited to reduce stress on people with mental illness | People recover through a range of choices and options that best serve their needs |
| Risk-taking and the chance of failure is eliminated as a means to making life easier for people with mental illness | People learn from both success and failures by taking risks beyond their comfort level |
| Power and control is held by external forces (experts and professionals) | Power is shared between caregivers and people in recovery |
| Patient is the passive recipient of care | Person in recovery is involved in directing levels of care |

Spend some time thinking about this chart.
Do you agree or disagree with it? Where do you think you fit on each row in the chart?

# ***There are other barriers to recovery that each individual can really change!***

## Learned Helplessness

What we each learn as we go through our lives with a mental illness can adversely affect how we will progress in recovery.

In Section 2, we looked at "How Well Did You Learn To Be a Mental Patient". How we tell our mental health story depends on who's listening and how much we trust them. To be a 'mental patient' first means identifying ourselves with a 'diagnosis'. Have you ever met someone who said "I'm a schizophrenic" or "I'm a manic depressive"? Do we ever hear someone going around identifying themselves as a 'heart attack', or a 'cancer', or a 'broken leg'?

Once we have identified ourselves as an illness, we then begin to believe that we are in some way deficient and that others must always be available to 'help us' with our lives.

This is the principle of learned helplessness.

## Learning Just What Learned Helplessness Is…

In the following chart, fill in the right-hand column with whoever you think might contribute to the attribute on the left. Often, there will be more than one answer for each.

| People Who Have Learned to Be Helpless Might Think This | In Your Own Life, Who Has Delivered This Message to You? |
|---|---|
| I am sick with a mental illness | |
| I must be prescribed medication | |
| I have low expectations of myself | |
| My mental health can only be stabilized; I will never recover | |
| I will always rely on the system | |
| People tell me what I should do, then I do it | |
| If I comply, I am being 'good' | |
| Others know what is best for me | |
| I don't have access to good information about mental health | |
| Everyone I know with a mental illness gets treated the same way | |
| I have no options to help me improve my life | |

## The Stigma

*The Stigma of Being Involved with the Mental Health System – Fear, Shame, and the Common Use of Inappropriate Language*

When we meet people who seem very different from ourselves, we tend to see them in a negative manner.[17] And when society sees a group of people negatively, that group is said to be stigmatized. In other words, they are treated prejudicially by society. The Canadian Mental Health Association (CMHA) Fact sheet just referenced goes on to describe why there is stigma surrounding mental illness:

> *"We all have an idea of what someone with a mental illness is like, but most of our views and interpretations have been distorted through strongly held social beliefs. The media, as a reflection of society, has done much to sustain a distorted view of mental illness. Television or movie characters who are aggressive, dangerous and unpredictable can have their behaviour attributed to a mental illness. Mental illness also has not received the sensitive media coverage that other illnesses have been given. We are surrounded by stereotypes, popular movies talk about killers who are "psychos", and news coverage of mental illness only when it related to violence. We also often hear the casual use of terms like "lunatic" or "crazy", along with jokes about the mentally ill. These representations and the use of discriminatory language distort the public's view and reinforce inaccuracies about mental illness."*

As result of feeling stigmatized, people with mental health issues can feel fear and rejection. Some will have difficulty finding work because of their illness, some will lose friends and have trouble making new ones, and many will lose their self esteem. It soon becomes apparent why people with serious mental health issues become apathetic.

The language we use in our day-to-day interactions with others in the mental health system can be very powerful. How we are described can easily create "pigeon-holes" for people, simply for the sake of putting them into a category. As with 'learned helplessness', we learn to accept others descriptions of ourselves as the undeniable truth, regardless of what we know to be of ourselves.

## Choosing Your Words To Describe Others [16]

In the following table, Column 1 contains descriptive words used by many mental health service providers to label people with mental health issues. Column 2 re-words the terms in 'regular people' language. Fill in column 3 with another positive way of describing the term in Column 1.

| 1. Systemic Language | 2. Peer Support Language | 3. Another Positive Way to Re-Phrase Column 1 |
|---|---|---|
| Chronic | In Recovery | |
| Symptoms | Experiences | |
| High or low functioning | Having a good or bad day | |
| Manipulative | Strategic | |
| My client | People I work with | |
| Referred to by diagnosis (i.e., schizophrenic) | Person | |
| The chronically mentally ill | People | |
| Non-compliant or treatment resistant | Not in agreement with me, or considering other options | |
| Safety | Feeling supported enough to try new things | |



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## Book Reviews

To further augment our understanding of language, stigma and prejudice, the following book review provides a good overview of the issues. “Don’t Call Me Nuts! Coping with the Stigma of Mental Illness” is a well-known book that is used to teach people with a mental illness and their supporters that they do not have to feel ashamed or accept ridicule.

**Don't Call Me Nuts! Coping With the Stigma of Mental Illness**[17]

by Patrick W. Corrigan, Ph.D., and Robert K. Lundin; Tinley Park, Illinois, Recovery Press, 2001, 456 pages

**Review by: Moe Armstrong**

This is a book that many of us with mental illness have been waiting for. I hope that it is also a book that many professionals have been waiting for.

Stigma - or plain prejudice against those of us who have a mental illness, the people who work in the mental health care field, and the mental health system - is gigantic. We cannot get our services funded to the level of any other condition, such as heart disease and cancer, because of prejudice and stigma. But our mental health programs do work. The people who receive care succeed with their lives. Mental illness is still seen by many people as a social problem and not a health concern. Strangely, people with mental retardation or developmental disabilities have fared better - they have two or three more dollars per person for their care than the people in our mental health system. Why? Stigma.

Fear and shame about mental illness go back for centuries. It may be one of the oldest prejudices. Failure to fight stigma has left the mental health care system open to ridicule. Stigma-busting needs to be part of the training of all people who work in mental health.

Most people who work in mental health care are never taught that they will encounter so much stigma and prejudice. Most of us with mental illness know that prejudice and stigma exist, but go through life afraid to say anything, hoping that someday people will quit making fun of us.

*Don't Call Me Nuts! Coping With the Stigma of Mental Illness,* by Patrick W. Corrigan and Robert K. Lundin, is not just a book for reading. It can also be used as a textbook for teaching prejudice reduction. I have used this book across the Commonwealth of Massachusetts to teach people with mental illness, as well as caregivers that they do not have to accept ridicule.

In part 1 of the book, the authors discuss the experience of stigma from the perspective of both an individual person and the mentally ill as a group. They ask, "Who is the person with mental illness?" and discuss the language and past misunderstandings that have come from society's misconceptions about mental illness.

Part 2 is about individual strategies for dealing with stigma. The authors see people with mental illness as the real resource for combating stigma. Through the years, many

of us with mental illness have been hidden away and were not allowed to discuss our mental illness. We were not educated about what a mental illness is. There seemed to be a catch- 22 construct: If we know that we are mentally ill, then we must not be.

Through our educational support groups in Massachusetts, we are finding out that many people know they have mental illness and are trying to understand their psychiatric condition. Taking away the shame of mental illness leaves a person able to talk with more clarity about his or her experience. Corrigan and Lundin put the emphasis on the individual's learning and talking about mental illness. Individuals can open the door of understanding, acknowledgment, and recognition. People can then begin to tell their story fully, and we can have a better understanding of the range of experience with mental illness.

Part 3 of the book deals with how to foster real personal empowerment. In some circles, empowerment of the mentally ill has come to mean telling people off and becoming angry at the helping system. Corrigan and Lundin describe a way to gain empowerment through strengthening the person, not tearing down the system. They offer not a cure, but the idea that people can be strengthened and developed. For them, empowerment means being part of the mental health system and having a valued voice.

Part 4 of the book deals with how to change society's reaction to mental illness. Research has shown that the most effective way of changing stigma is through personal contact and that anti-stigma campaigns are not as effective. Corrigan and Lundin say that this social change will come from the trained and developed person with mental illness who is in contact with society, not from a billboard.

Mental health is at the beginning of a new era. Mental illness is being seen as a medical condition like any other condition. The idea that the family or the individual is to blame for mental illness is slowly fading. We are at the stage where people with mental illness can get the same kind of respect, care, and services as other people who have a disability. Training the people who receive care and the people who work in the mental health system about what prejudice is and how to cope with the stigma of mental illness is important. All across our mental health system, we should have staff training about how to reduce prejudice and stigma. *Don't Call Me Nuts!* should be the textbook for such training.

**Footnotes**

Mr. Armstrong is director of the Peer Educators Project at Vinfen Corporation in Worcester, Massachusetts.

## Your Personal History of Navigating the Mental Health System

Write down points about how you have successfully navigated through the mental health system. Mention medical interventions and hospitalizations, your experience with social support organizations (e.g. housing, mental health, income support, and peer support), or any other group that is connected with the mental health system. In peer support, we learn a great deal from the knowledge and experience of others.

If you feel comfortable, share these experiences so that others can learn.

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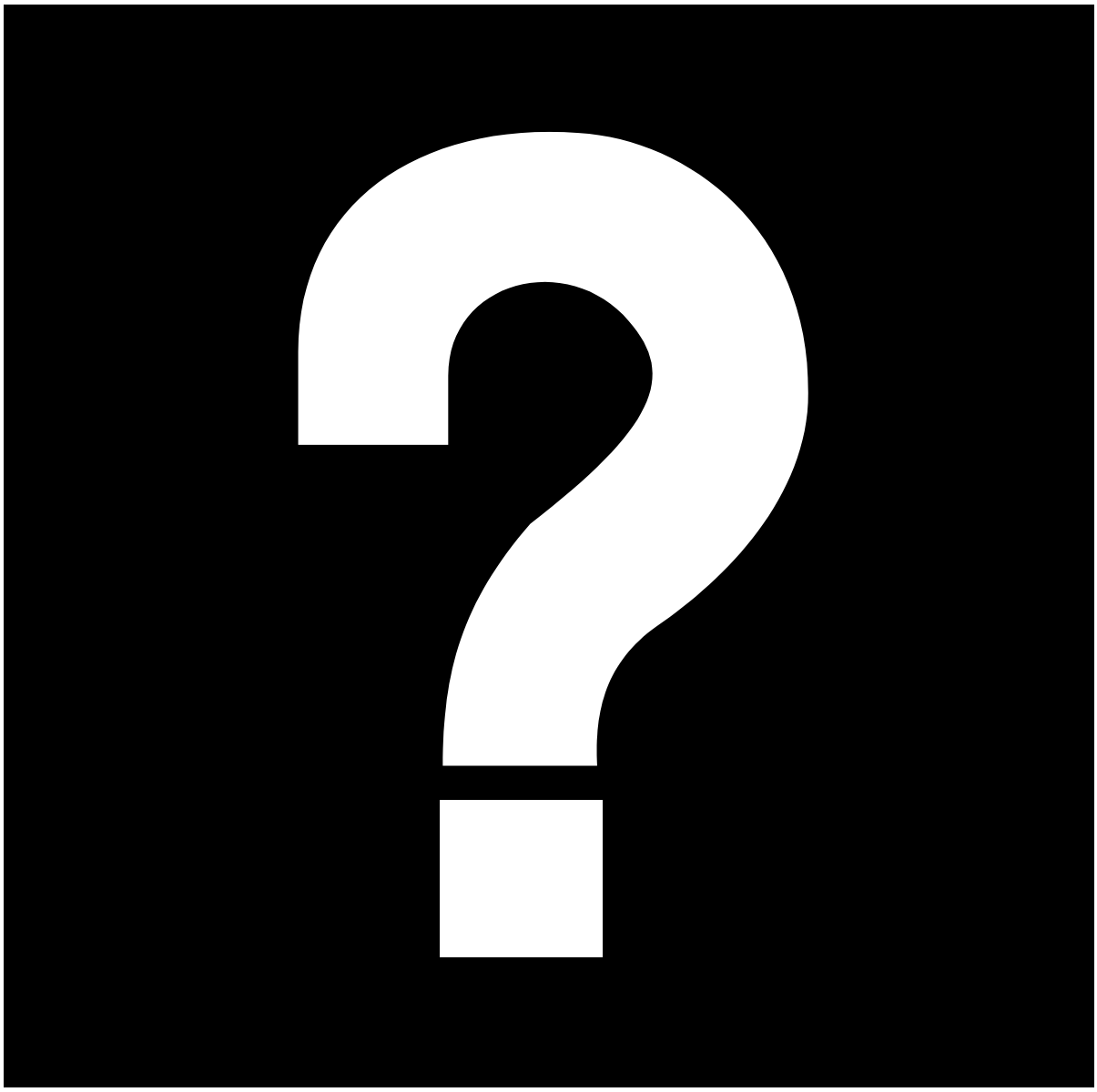
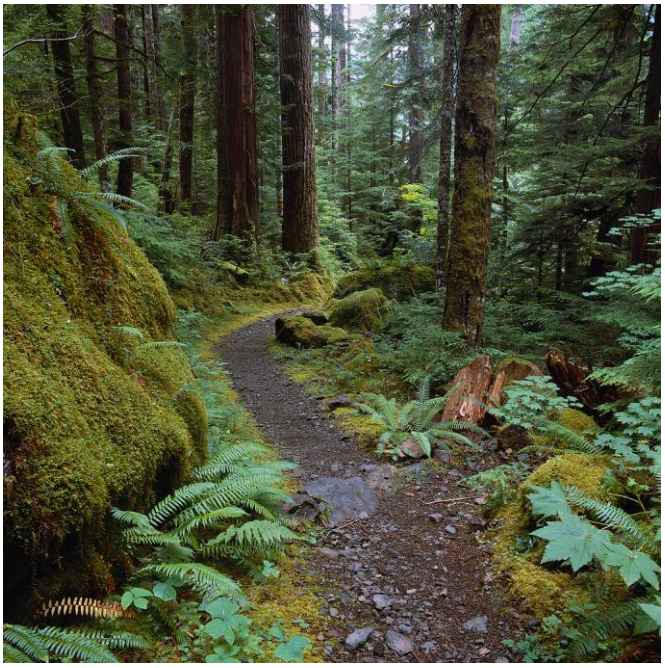
# Section 6 – What Will Recovering My Mental Health Look Like to Me?



In the previous sections, we looked at a number of different aspects of mental health recovery. We explored how people see the world through different coloured glasses; we called them 'filters'. We talked about learning to be a mental patient, and how difficult it can be to break away from that way of thinking. We looked at motivation and self-awareness, and have a pretty good idea of what recovery can look like for people. We also spent time looking at some of the positive environments and barriers people encounter during their recovery.

# So where to from here?



# What are the next steps?

The time has come to look more closely at what recovery will mean to us as individuals, and begin to set some clear and realistic goals for our futures.

One of your initial goals could be to move away from believing that everything is a problem or that you have a deficit, to seeing yourself as having strengths that you can draw from and build upon. By focusing on the negative, our symptoms, and what we can't do, we simply reinforce that our *dis-abilty* is where we devote our energy. That will remain our focus. By redirecting your energy toward your strengths, you turn to recognizing and developing your *abilities* and see new possibilities for your life.

*The following chart illustrates the shift in our thinking from everything 'being a problem' to focusing on our strengths.[18] As you read through this, think about how each applies to your own situation:*

| **How will you move from this side of the chart (problems, negatives and deficits)** | **TO →** | **This side of the chart (focusing on positives and your strengths)** |
|---|---|---|
| Instead of focusing on my problems, symptoms and deficits …. | → | I am primarily concerned with what I want, desire and dream of. |
| I don't spotlight my diagnoses and difficulties …. | → | I seek to understand, use and build upon my positive talents, skills, knowledge and abilities. |
| Rather than see myself as a diagnostic label …. | → | I see myself as a unique human being with a strong mind, body and spirit. |
| Instead of letting other's perspectives guide and sometimes limit my choices …. | → | I honour my own standpoint, values and beliefs. I know that life holds many possibilities. I can choose a positive direction. |
| I don't believe my past predicts a negative future…. | → | I am concerned with the here and now, and moving toward a positive future. |
| Rather than being preoccupied with what I can't do …. | → | I know I have many coping skills. I've made it this far and I know I will make it in the future. I have many skills and can learn new skills if I need to. |
| Instead of letting professionals who know 'what is best' for me control decisions in my life …. | → | I have the right to explore choices and make my own decisions. |
| Instead of thinking that it doesn't matter if I'm irresponsible, because that's part of having a mental illness …. | → | I take responsibility for the outcomes of my decisions. I have primary authority and ownership in my life and will self-direct my recovery. |
| Rather than focusing on my problems so that life seems limited, boring and stagnant …. | → | I am actively learning, growing and progressively changing at a pace that is important for me. |
| I allow people around me to reinforce my limitations … | → | I seek relationships, role models and helpers who support and encourage me in my recovery journey. |
| I see my contacts, my circle of friends and supporters as limited, and I rely on the mental health system to meet all my needs …. | → | I actively explore my community and find friendship, inspiration, help and useful resources all around me. |

## My Goals…

The ideas and concepts in the chart on the previous page are generic and could apply to anyone. The right side of the table lists what many people feel are the ideal solutions to recovering your mental health.

Write down some specific ideas, particular to you, that will indicate that you are recovering. Feel free to build upon the ideas above as they specifically relate to you. Write them down as goals that you will plan to achieve.

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# Section 7: What Can I Do Next?

The Self Help Recovery Centres provide people involved in the mental health system with opportunities to engage in group and individual activities to promote mental health recovery, peer support opportunities and leadership. They provide a positive and inspirational environment featuring tools, resources and peer groups that allow for individuals to take an active role in their own personal development.

A Self Help Recovery Centre provides educational resources in a variety of media, including videos, audio tapes and CDs, books, and formal or informal groups. A Self Help Recovery Centre strives to:

- **Be welcoming and safe**
- **Promote learning and growth**
- **Provide opportunities for contribution and feedback**
- **Provide creative and interesting activities**
- **Encourage inspiring and mutually supportive relationships**



Self Help Alliance (representing: Cambridge Active Self Help, Mood Disorders Association Waterloo Region, Wellington-Dufferin Self Help, Waterloo Region Self Help)

## Recovery Centre Peer Groups

There are monthly calendars to provide current and prospective participants with a description of group activities planned for that month. In addition to the facilitator based at each site, there are other staff that the Self Help Alliance can utilize for specialized topics. There is a broad spectrum of subjects from which to draw every month, and many of them rotate intermittently throughout the year. Check with the partner organizations for monthly calendars and other information on the scheduling of activities. See the list of member organizations in this section for contact details.

Pathways to Recovery

Participants engage in discussions based on the workbook titled *Pathways to Recovery*, which was developed by people who have successfully navigated their road to recovery. This workbook uses the metaphor of a journey to take the reader through a process of exploration, self-discovery, and planning, that helps one to set life goals and realize personal dreams. Participants can attend some or all of these groups as each topic can be addressed independently of others.

WRAP – Wellness Recovery Action Planning

Developed by educator and mental health advocate Mary Ellen Copeland, WRAP provides a format to address the unique self-care needs that individuals can build into their everyday lives in order to maintain their overall mental health. A Wellness Recovery Action Plan allows individuals to figure out what they need to do in a totally self-determined approach.

PAIR – People Acquiring Intimate Relationships

An opportunity to learn in a peer group setting about mental health and the challenges it presents to developing long term and intimate relationships. Structured as an education series, PAIR provides participants with information and a discussion forum on healthy relationships, self disclosure and risk taking, relationship planning, medication and sexual functioning, intimacy and sexual health.

Getting to Know Yourself

As a prelude to determining how to plan changes in your life, this series provides opportunities to discuss personal growth and development issues such as self esteem, understanding feelings and emotions, attitudes such as pessimism , negative self-talk and optimism, and spirituality.

Self Esteem

While Self Esteem is introduced in *Getting to Know Yourself*, it also runs as a separate series using a variety of printed and visual resources.

Exploring Your Beliefs and Values

We all have core values and beliefs that are part of our spiritual being. Some were instilled in us as young people, others through our interactions with the medical community, family and friends throughout our lives. Learn how to identify your core values and beliefs, and develop an understanding of how they influence our everyday thinking and decision-making.



Self Help Alliance (representing: Cambridge Active Self Help, Mood Disorders Association Waterloo Region, Wellington-Dufferin Self Help, Waterloo Region Self Help)

TLC – Talk, Listen and Communicate

Effective communication is the cornerstone of every daily activity that involves interaction with other people. Learn methods of communicating that will successfully get your message across, and help you to understand what others are communicating to you.

Coping With Anger

The group meets to discuss anger and how we can deal with our feelings of anger.

Boundaries and Respect

This series explores how setting healthy boundaries in your life can positively affect personal growth and improve interpersonal relationships.

Life Stories

We all have our own unique life story. This is an opportunity to come together to discuss the different ways and benefits of documenting our own story.

Living a Purpose-Driven Life

We often struggle to find meaning and purpose in our day-to-day life, and seem to be out of step with what is going on around us. This series explores ways that we can begin to see a life with meaning, and challenges us to live with purpose.

Helping Yourself

This series is a primer on advocating for yourself by learning to clearly identify what you want to attain, then taking measured steps to achieving it.

Advocacy

Through specialized instruction and discussion, a number of advocacy topics are addressed, usually decided upon by the group. They could include disability rights, what are community treatment orders, protecting your health records, or other areas of interest. This builds upon the *Helping Yourself* series by further developing your advocacy skills.

Video and Discussion

Together we view various inspirational or motivational movies and engage in discussions about how issues facing people with mental health issues parallel the topics explored in the movie.

Self Help Music Group

This is an opportunity to learn about the benefits and healing properties that many feel as they experience listening to and making their own music.

Exploring Recreation and Leisure

Important to all of us, these sessions provide an opportunity to learn about what leisure is, and how to make time for it. It will help you identify your leisure interests and promote awareness of leisure and recreational resources in the community.

In addition to the peer groups at Self Help Alliance partner organizations, each has a resource centre of books, videos and other printed resources that you may look at on your own at while you are there.

Member organizations of the Self Help Alliance are:

**Cambridge Active Self Help**
13 Water Street North
Telephone: 519-623-6024
Email: general@cambridgeactiveselfhelp.ca
Website: www.cambridgeactiveselfhelp.ca

**Mood Disorders Association of Waterloo Region**
67 King Street East, 2nd Floor
Kitchener, ON N2G 2K4
Telephone: 519-884-5455
Email: general@mdawr.ca
Website: www.mdawr.ca

**Waterloo Region Self Help**
67 King Street East, 2nd Floor
Kitchener, ON N2G 2K4
Telephone: 519-570-4595
Email: general@wrsh.ca
Website: www.wrsh.ca

**Wellington Dufferin Self Help**

24 Douglas Street
Guelph, ON N2G 2S9
Telephone: 519.763.4014
Email: guelph@peersupport.ca
Website: www.peersupport.ca

5 Faulkner Street
Orangeville, ON L9W 2G2
Telephone: 519.940.4811
Email: orangeville@peersupport.ca
Website: www.peersupport.ca

## Endnotes

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Prescott, 2002. Cited unreferenced in Copeland, M.E., and Shery Mead, 2004. Wellness Recovery Action Plan & Peer Support, Peach Press, Dummerston VT.

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Copeland, M.E., and S. Mead, 2004. Wellness Recovery Action Planning and Peer Support, p. 21. Peach Press, Dummerston VT.

8
Copeland, M.E. and S. Mead, 2004. Wellness Recovery Action Plan and Peer Support, p 12. Peach Press, Dummerston VT.

9
Although the acronym 'EEG' is used in her book, we believe she was referring to ECT (electro convulsive therapy), or 'shock treatment'.

10
Prescott (2002), in Mary Ellen Copeland and Shery Mean, 2004. *Wellness Recovery Action Plan and Peer Support*, p.14.

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Copeland, M.E., and S. Mead, 2004. Wellness Recovery Action Plan and Peer Support, p.11. Peach Press, Dummerston VT.

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Adapted from: Deegan, P.E., 2001. Recovery as a Self Directed Process of Healing and Transformation.

14
Adapted from concepts outlined in PACE: Personal Assistance in Community Existence, Laurie Ahern and Daniel Fisher, M.D. Ph. D National Empowerment Centre, Lawrence, MA.

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Book Review by Mr. M. Armstrong in Psychiatric Services – http://psychservices.psychiatryonline.org. January 2003, Vol. 54, No. 1.

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Adapted from *Pathways to Recovery*, p. 76.