My Supporting Roles in Stories of Recovery

By Mark Ragins, MD

I've spent a good deal of my life working to support people in their stories of recovery. Although I play the role of a psychiatrist in every story and I'm me in every story, my part varies from story to story depending on who is playing the lead and what kind of story they are living. There are some common story lines I've worked within including: 1) Battle stories, 2) Deliverance stories, 3) Journey stories, and 4) Gathering stories. Each genre has its own characteristics, challenges and rewards.

1) Battle stories

Many people view their story as a battle against mental illness – or at least against problems like voices and depression that other people label as symptoms of a mental illness. The simplest form of this story is that people need to "pull themselves up by their boot-straps". It's all in their minds so they should be able to use their will power or moral character to "beat this". Fighting harder is the key to success.

For some people, the battle is against the symptoms themselves: "I fight my voices every day. They try to get me to do bad things. . Sometimes I bargain with them because they promise to go away. Sometimes they are too strong. They threaten me. They make it so I can't think. They got me thrown in jail and say they'll do it again if I don't cooperate." " I have to fight my depression just to get up in the morning." "I tell the panic attacks to come and do your worst because I'm still leaving the house today and then I ready myself for their attack." "Sometimes I get tired of fighting the demons in the tenth dimension, but if I don't the world will end. I'm the lead angel." "The people who are tracking me on the internet are winning. They've ruined my whole life and I can't get anyone to help me because they think I'm crazy. I'm too weak to fight this alone." For these people, my role is to help them feel less alone in their battle, give them encouragement not to give up, and perhaps give them some weapons and strategy tips.

Some people view the battle as against an illness that is causing these symptoms. They want a diagnosis to clarify what the enemy is and a treatment plan to do battle with. I can have a large role for these people helping to prepare them for their battle with psychoeducation about their illness and with weapons to fight with like medications and coping skills. Dr. E. Fuller-Torrez is a powerful warrior of this kind in his classic book "Surviving Schizophrenia."

Many people would prefer that I fight the battle for them. They agree to follow my orders and turn their lives over to me, if I'll be their mercenary soldier or at least their commanding officer. After all, I'm an expert and a professional. I know more about this enemy than they do, so I should have a better chance of success than they do. Many professionals are more willing to take on this role than I am. Some professionals even insist on this role and are frustrated when they can't have it and seek more power to force more people to turn over their battles to them. Historically NAMI has encouraged this role.

The most popular battle stories are dramatic decisive battles. Long stories of siege or slow wars of attrition gradually take their toll and tend to lead to frustration, battle fatigue, spreading blame, and giving up. Unfortunately, few serious mental illnesses are vanquished rapidly.

In battle stories, the means tend to justify the ends. In a life and death battle, it is winning at all cost that matters. Civil rights, trauma informed care, empowerment, avoiding stigmatization, due process, consumer choice, etc. can be sacrificed to win the battle. The "survivor movement" has spread stories of unethical battle techniques and their resultant suffering both during the battle and often lifelong, much to the displeasure of most psychiatrists who feel deserving of gratitude, not scorn.

A popular compromise battle story line for people who are disturbed by those sacrifices is a two phase story: First the enemy will be controlled by whatever means necessary, and then when the illness is stabilized, rehabilitation and recovery can proceed using less heavy handed techniques. Let the military win the battle and then turn it over to the diplomats and politicians. A good deal of our mental health system, including the widespread practice of using different staff for inpatient and outpatient care, is designed to support this story line. Nonetheless, it may not be as common of a recovery story as its proponents believe it is.

2) Deliverance Stories

Many people view their recovery as a deliverance from the horrors and destruction of mental illness. They may not have vanquished their mental illness, but they have overcome it. They have regained control of their lives. The supportive role of professional in these stories is to be their deliverer. This is a fundamentally different role than that of battle commander or warrior. Success is not defined by winning the battle with the illness, but by the re-emergence of the person from their illness. The deliverer's most important function is an empowering one, to help people find and develop the strength and skills within them to overcome. This is an unnatural role for most professionals, including me, that our training is generally ill-suited for, and it often requires thoughtful work to develop the role.

The successful ending of a recovery deliverance story is: "I wouldn't wish mental illness on my worst enemy with its unbelievable suffering and destruction, but in a strange way it has made me the person I am today. It helped me find strengths within myself I didn't know I had. I learned what's really important in life. I have gotten gifts from my wounds. This illness has been a blessing in disguise." By contrast the successful ending of a battle story is: "I'm so glad I met you. You got me through the hardest times in my life. You have been the best doctor I've ever met. You always know what I need and how to help me. I'm so glad you'll always be there for me in case my illness ever returns. I know I can count on you." Because we emphasize battle roles and stories our present system creates far more of the second ending than the first - far more dependency than empowerment. It's not a coincidence that generals tend to remain as conquering leaders while deliverers tend to walk off into the sunset, leaving their charges able to care for themselves.

This difference begins in my very first scene. In a battle story I say, "You've done the right thing coming to me for help. I know what to do. I have power. I'm going to be able to help you." In a deliverance story I say, "I can already see in you the strength they are going to use to overcome your illness."

12-step recovery follows a deliverance story line. We admit to being powerless and turn over our lives to a higher power to be guided through a ritualized process of self exploration, cleansing, making amends, learning spiritual skills, and finally building enough spiritual strength to give back to the next person in need. Some sponsors and substance abuse programs play their facilitative roles better than others.

Some psychotherapy techniques, especially directive therapies, are more suited to battle stories, while others, especially Rogerian therapy, are more suited to deliverance stories. How the therapy is used, by both the therapist and the client, may be more important in determining the story line and the outcome than what kind of therapy is used.

Medications, though typically used to combat illnesses, can also become a tool for deliverance if the person learns to use them to recover control of their life. Generally, that involve would more than "following doctor's orders" often including a collaborative, experimental process of learning how to use medications in ways that support self-responsibly achieving life goals.

Failures in deliverance stories can come either in the beginning, if the person doesn't have the insight to know they are in trouble and need to change to recovery, in the middle, if the person doesn't accept responsibility for themselves and work to grow and change, or at the end, if the illness returns and the person is still too weak to manage and is again overwhelmed and destroyed. Classically, Moses struggled at each of those points, but God supported and delivered him through it all. A successful human deliverer uses their wisdom to help guide people through the process, persisting through multiple missteps, repeating as needed until integration and recovery has been achieved.

3) Journey Stories

Many people view their recovery as a journey. Recovery journeys have a common storyline of going away, experiencing discoveries and disappointments that change you, and then returning.

For serious mental illness, the going away part of the story is often caused by the immediate reactions to the illness itself. Because there is so much stigma and rejection that directly results from having a mental illness, including self-stigma and self-rejection and including mental health system stigma and rejection, people are often thrust out of their lives, whether they want to be or not, whether they are reasonably prepared or not, and whether they accept that they are on a journey or not. Many people's first response is either to deny they have gone away and want to go back to life the way it was or to maintain that there's been a mistake - they haven't really changed. My first job is sometimes to convince the traveler that they are indeed on a long and difficult journey. A great deal of work is before them before they can click their heels three times and go home. On the other hand, I shouldn't convince them they need to live in Oz forever either. Too many people get the message that their life is over if they have a serious mental illness. They'll never be able to work again or get married or raise children. They will be a disabled outcast forever.

Helping someone prepare for their journey even as they set out, including building hope and confidence, can be an important supportive role as can helping them restock along the way. WRAP plans are good journey tools that are often rewritten as the journey teaches us what we need along the way.

SAMSHA's consensus definition of recovery implicitly includes the return: "Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential." Society has given mental health professionals key powers in accepting or rejecting the return of people with mental illnesses. I've been told to decide if someone can leave the hospital, if they can return to work, if they can have their children back, if they can drive, own a gun, vote, or enter into contracts, if they serve on jury duty, if they are responsible for crimes they commit, can get on an airplane, move into an apartment, or go to a family member's funeral. Considering the enormous power involved in those decisions, I received a paucity of training about how to make those decisions. Yet their story line may be profoundly affected by how I play my role facilitating or obstructing their return.

The most popular journey story lines are solo journeys. We sometimes think it doesn't really count if we don't make it on our own. How do we know if we should get credit for our success if we had help? Going solo makes a journey story scarier and more difficult than it needs to be. Many family members are understandably frightened by "tough love" and "they need to learn from natural consequences" approaches to supporting a journey. What if they don't make it and no one is there to help them? John Wooden's line: "The main ingredient of stardom is the rest of the team" is striking because it contradicts common wisdom while being clearly true. The role of supporter in a journey story line can be difficult, but the opposite of caretaking is not abandonment.

A travel companion who is a peer is a common alternative to a solo journey. Buddy stories routinely have both buddies learn and grow, including form each other, more than either one would've learned or grown on a solo journey. We often design self help group therapy to help people learn from each other. We're also increasingly hiring people with lived experience of mental illnesses to be peer advocates, sharing in people's journeys, but that's moving more into the territory of guide rather than peer. Much of the role confusion for consumer staff stems from being unsure if they are buddies or guides.

Guide is a legitimate role in a journey story, but there is a point at which it becomes an escorted tour rather than a real journey. A safe, controlled trip is not a journey because it is designed to avoid true discovery or disappointment. It is often only in times of unexpected crisis that the opportunity for a true journey occurs.

Sometimes if the guide lowers their guard and becomes genuinely involved, they can find themselves being a buddy too as the journey unfolds, discovering that they've learned as much from their client as their client has learned from them.

There is some controversy over whether someone needs to have had lived experience of mental illness to be a guide. If we've never been through a similar journey ourselves, how can we guide someone on their journey? Some professionals respond that since we're all humans we've all travelled on similar journeys. This response is usually unsatisfactory both to peer advocates who insist that the experience

of mental illness is a unique experience that is at risk of being discounted by saying it's the same as other emotional experiences and to most professionals who insist that there is an important boundary between staff and clients that must be maintained. In the past all mental health professionals had to experience firsthand some mental health treatment as part of our training to make us more empathetic guides, but not anymore. Observing other people's journeys while giving them services is now the primary foundation for learning to be a guide. Professional staff who openly use their experiences with mental illnesses to support people on their journeys can be particularly powerful guides and may also be able to teach all of us how to be better guides.

In my view, the difference between a guide in a journey story and a deliverer in a deliverance story is that the fundamental purpose of the guide is to take someone to a place where they are likely to learn and grow, whereas the deliverer's fundamental purpose is to actively use their relationship to transform the person. The guide's main tool is the journey. The deliverer's main tool is the relationship. God didn't take Moses to Mount Sinai to discover the Ten Commandments. He gave them to Moses himself so he'd better understand what changes God expected in his "chosen people."

Hospice is a successful service system built upon a journey story line. As people approach their death, they go through common stages – denial, anger, bargaining, depression, and acceptance – hopefully on their way to a "good death", a "death with dignity." The staff, family, and even the community play roles in guiding and accompanying people on their journey. All of us are in the same position regarding empathetic guiding – we haven't died, but we expect to someday. The transfer between standard medical care and hospice marks a change in story line from a battle story to a journey story. "Are you done fighting?" is a common admission question. For many people with mental illnesses, they had to abandon a battle story line, abandon the likelihood of conquering their mental illness, to transition to a journey story line of how they returned from being lost in their mental illness to have a "good life", a "life with dignity."

4) Gathering stories

Many people believe that the most powerful thing in their recovery was finding a group of people who accepted them, where they felt safe and understood, and where everyone was trying to help each other reclaim their lives.

Within a battle story, a gathering can be a group of fellow soldiers meeting to share battle plans or fight together. Within a deliverance story, a gathering can be a group of people learning from their deliverer together and sharing their experiences of deliverance. Within a journey story, a gathering can be either a team of travelers exiled or travelling together or a homecoming. All of these may be powerful events, but in a gathering story it is the power of the gathering itself, the synergy of all of our stories coming together as one, and the remembrance that we are together more than we are apart, that is our shared recovery. This story line is much harder to conceptualize than the others for most people, because it involves shifting from describing my story to describing our story. It is the story of when a group of soldiers became inseparable and died for each other, when a group of worshippers became a church, and when a group of exiles became colonists.

The potential for a powerful gathering story exists whenever a group of people comes together. Sometimes a therapy group is much more than a way to be more efficient by seeing more than one person at once. Sometimes a NAMI group is more than an informational meeting. Some people get far more benefit from the camaraderie of AA, than from working the 12 steps. Clubhouses can become powerful gatherings.

Part of the power of the Village where I work is our gathering story line ritualized in our weekly Wednesday morning community meetings. Since I have been at the Village for over 20 years, I play a strong role in our gathering story. I have grown up there. I have raised my kids while there. I have shared personal joys and sorrows, like when our dog died, there. I have helped bring our story to the rest of the world and brought visitors to our gathering to expand it. We've built something special together.

A risk in gathering stories is that the gathering becomes limiting. Does the person feel renewed by the gathering and able to be more whole in the "outside world" or do the feelings of connectedness and wholeness dissipate when the gathering scatters? Is the outside community still experienced as an overwhelmingly a hostile place? Groups maintain confidentiality intentionally avoiding sharing outside the gathering. AA requires anonymity outside of the gathering, though some people openly advertise their membership, for example with bumper stickers, potentially widening the gathering beyond the small group. Clubhouses often forbid membership to people who don't have a mental illness and some members are frightened to leave the gathering in the clubhouse.

Some issues, like community acceptance, are likely only to be impacted with a gathering story line. A classic story is of the Belgian town of Gheel: Since the middle ages people have come to Gheel to be blessed by St. Daphne, a patron saint for people with mental illnesses and many have stayed to join the community. About half of all families have people with mental illnesses as adult foster care members of their families passing them on from generation to generation. Over the centuries, this gathering of people with and without mental illnesses created a community nearly without stigma or rejection of people with mental illnesses.

True community development, bringing together gatherings of people with and without mental illnesses to welcome each other, is a role all of us can play in our shared gathering story of recovery.

Afterword:

I think that one of the hardest things in helping people is to remember that they are the writer, director, producer, and starring actor of their own life. I am just a supporting actor. If I'm attentive to the story they are living – what kind of story it is, where in the story we are, where they want the story to go - and then learn to shift when they shift, I can be an effective supporting actor, fitting in to give them what they need for the story to work.

Note: Thank you to John Hart for his presentation "The Stories We Tell – and why we tell them" that I built upon in this paper.