Workers as well as users need to have hope if there is to be recovery following mental illness

Travelling hopefully

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Much has been written about the importance of hope in each person's journey of recovery, but much less attention has been given to the importance of hope in mental health workers. Hope is the belief that things can be different. For people experiencing mental distress, it lies at the heart of their willingness and ability to take on the challenge of rebuilding their life. Hope counteracts depression and diminishes the risk of a person giving up. For all of these reasons, it is essential not only for the individual service user to have hope, but also for mental health workers. Valuing the person, their hopes and dreams; understanding and accepting their version of events; believing in their skills and helping them to pursue their own goals in life are all essential if the mental health service user is to embark on their journey of recovery. Hopeful workers are more likely to inspire hope in others (service users, their families, friends and employers), which in turn facilitates recovery and increases hope and belief in others' potential. This paper discusses the crucial role of hope both for people with mental health problems and for people working in mental health services, and proposes a constructive cycle of hopefulness whereby hope leads to increasing opportunity. We conclude with some ideas for ways in which mental health workers can incorporate hopeful strategies into their work.

A young man, admitted to psychiatric hospital, is sent to see the psychologist, who tests his IQ. At the end of the session the psychologist informs the young man that his score rates him at 'genius' level, and adds in the next breath: 'We've finished now. Can you find the way back to your ward on your own?' This is a true story; it happened to Mike Lawson, survivor and former vice president of Mind in the 1980s. It is just one example of how the status of 'mental patient' has, historically, carried with it low expectations of an individual's strengths and abilities, regardless of evidence to the contrary.

Perkins[1] describes what she calls the 'you'll nevers': 'You'll never get a job', 'You'll never get better', 'You'll never have children'. These kinds of predictions from professional mental health workers are often presented as 'being realistic', as helping people come to terms with the limitations imposed by mental health problems. In fact, they are neither realistic, helpful, nor evidence based. Perkins highlights the way such 'realism' feeds off stigma and negative perceptions of mental distress more generally:

> 'To be told you have a "chronic mental illness" in a world that rejects, reviles and dehumanises madness is a devastating experience. It destroys hope, self-belief, confidence. If mental health workers, who are supposed to be helping you, reinforce these popular beliefs, then your personhood is further eroded …
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> 'The hopelessness of mental of mental health workers ensures that the services we provide are full of people who have "given up" on themselves and their futures: a tragic waste of human lives and potential.'

The British Psychological Society, in its ground-breaking report on psychological understandings of schizophrenia,[2] points out that working with service users who are very distressed and disabled and need their help can lead to workers themselves losing hope in the possibility of recovery. Positioned always at the sharp end of service delivery, they only see people in crisis; they never see the service users who recover and who don't need their services anymore, so unsurprisingly they develop the 'clinician's illusion' that people simply do not recover.

Rufus May, clinical psychologist and former patient, calls this a form of 'learned hopelessness':[2]

> 'Mental health workers... don't see the ones like me who got away. Therefore they have very little concept of recovery from mental health problems or the positive aspects of madness. Psychiatry and psychology have to ask themselves why, despite millions of pounds spent on researching psychosis, we have neglected to look at those who manage to rebuild their lives and live with their difficulties, who have positive outcomes. This neglect has the consequence of perpetuating a learned hopelessness amongst both workers and patients.'

May believes that one way to overcome this 'learned hopelessness' is for service users who have recovered to be involved both in working in mental health services and in staff training.

May describes how psychiatric hospital at least provided a safety net for him and his family when he was at his most unwell, but argues that the critical feature lacking in this safety net was what he calls 'springiness': any impetus to help him 'bounce' back on the tightrope. Indeed this was one of his main reasons for deciding to train as a psychologist: to find ways of enhancing this 'springiness' (or hope) in services and workers so that they feel more inspired to support, encourage and facilitate service users to strive to achieve what they want to do.

It is clear from the experiences of service users that hope is profoundly important and a key ingredient in recovery

Families and friends also recognise the importance of hope in mental health workers. Too often they feel that staff interpret situations negatively, are pessimistic and dispiriting. In the words of these parents of adult sons with mental health problems:

> '... the one thing we find most soul destroying about the whole issue is that nobody gives you any hope...You think to yourself "Jesus Christ, just somebody give me hope".'[3]

> 'Hope is an essential part of being able to care. It is hard to have hope after three relapses... you have lost all the hopes and dreams that you had for them.'[4]

The Psychosis Revisited training workshop specifically addresses the importance of hope in working with people who have psychotic experiences.[5] It looks at the role of hope as a key ingredient in successful treatment outcomes and the recovery of service users. It also highlights the positive impact of 'success stories' on workers' hopefulness: hope and hopelessness are 'infectious and catching'. Trainers running the workshop report anecdotally the surprise among participants at how hopeless they have become.

Inspiring hope

So, how can hope be inspired in workers so that they are more optimistic, positive and hopeful in their work with people who experience mental health problems?

The Sainsbury Centre/NIMHE training framework for the mental health workforce[6] includes 'Promoting recovery' as one of its ten essential shared capabilities. This is described as: 'Working in partnership to provide care and treatment that enables service users and carers to tackle mental health problems with hope and optimism and to work towards a valued lifestyle within and beyond the limits of any mental health problem.'

Bracken and Thomas[7] argue strongly for moving psychiatry and mental health work away from its current 'confused pseudoscience' towards a discourse that centres on issues 'such as hope, meaning, values and relationships'. They write:

> 'The language of psychiatry abounds with words like "relapse", "deficits" and "defects". Abandon hope all ye who enter here. However, it is clear from the experiences of survivors and service users that hope is profoundly important and a key ingredient in recovery... For too long science in [psychiatry] has been equated with biology, and because biology doesn't have the means to explore specifically human phenomena such as hope, we have ended up with confused pseudoscience in place of genuine enquiry.'

Wallcraft,[8] in writing about recovery, highlights the difficulty of pinning down in scientific terms concepts like hope and finding ways of proving its significance in an evidence-based era where evidence is equated with quantitative research:

> "Hope", like "recovery", has been seen by mental health researchers as an elusive concept that is difficult to use in evaluating services, and this has led to arguments that the "recovery movement" is evangelical rather than evidence-based.'

But Bracken and Thomas find plentiful evidence in the literature that points to the part played by hope alongside conventional treatments for mental illness:[7]

> '... there is substantial evidence that drugs such as antidepressants work largely through the generation of hope. It would appear that what is called the "placebo effect" accounts for most, if not all, of their efficacy. On the other hand, research on the outcomes of psychotherapy has consistently shown that it is not the therapist's theories or training that is most important but their ability to establish a relationship of trust and to generate a sense of hope.'

Cycle of hope

Taking mental health services past, with their institutionalised hopelessness, and mental health services present, where workers are seeking to foster hope as part of recovery, we have (with colleagues) developed a cycle of hope, in an attempt to illustrate how the processes of hope and its loss operate in practice. The cycle can

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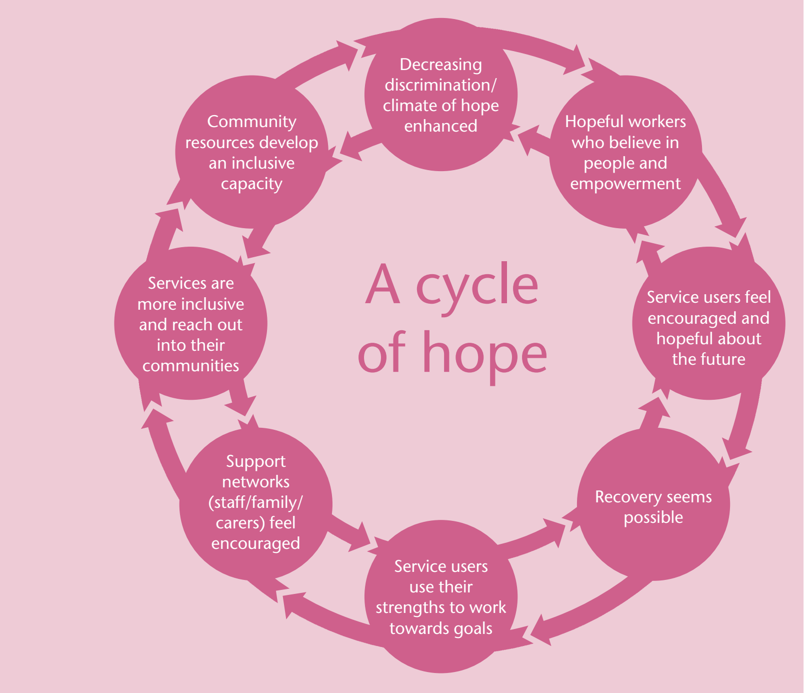
→ work in both directions and encompasses individual, family, neighbourhood and societal factors. If you start the cycle from the worker's position, you can see how workers are part of a crucial chain that can spiral towards hope or – conversely, in an obverse, negative cycle – hopelessness.

We would argue that the creation of hope should be a key role for mental health workers, and suggest the following ways for them to include hope-promoting activities in their practice.


A cycle of hope
Decreasing discrimination/ climate of hope enhanced
Hopeful workers who believe in people and empowerment
Service users feel encouraged and hopeful about the future
Recovery seems possible
Service users use their strengths to work towards goals
Support networks (staff/family/ carers) feel encouraged
Services are more inclusive and reach out into their communities
Community resources develop an inclusive capacity

One way for mental health workers to put more 'spring' into their practice is to create 'hope-inspiring relationships'. Repper and Perkins[9] have drawn on service users' own accounts and experiences to suggest a number of different ways whereby relationships between service providers and service users can inspire hope. These include:

- valuing the person for who they are
- believing in their worth
- seeing and having confidence in their skills, abilities and potential
- listening to and heeding what they say
- believing in the authenticity of their experiences
- accepting and actively exploring their experiences
- tolerating uncertainty about the future
- seeing problems and setbacks as part of the recovery process, and helping the person learn from and build on them.

Other suggestions for workers might be to:

- celebrate successes and achievements of service users – this could be incorporated into the Care Programme Approach review mechanism
- follow the progress of service users after they stop using services
- monitor levels of staff pessimism – this could be part of a team's ongoing evaluation and audit
- join service users and their families in fighting stigma and discrimination.

Hopelessness breeds hopelessness: mental health workers cannot inspire hope in others if they are themselves over-stretched, burnt out and feeling undervalued. They need support and regular supervision to sustain enthusiasm, develop skills and reflect on achievements. If they judge their own effectiveness and success in terms of service users' symptom reduction and discharge from services, then they may well become disheartened and convey their disappointment to the people they work with, thereby contributing to the downward spiral of hopelessness. If they adopt a recovery-oriented approach, and judge success by people's engagement in appropriate services, by their access to community facilities and activities, and by their inclusion in work, education and leisure, then the worker's goals will become more achievable and flexible and more consistent with the service user's own aspirations. The workers will find that it is possible both to be hopeful and to have that hope realised.

As poet and survivor Richard Lilly puts it in his poem 'About a Psychiatrist':

> 'I would talk of how I was.
> My application for jobs,
> My art work,
> My sleep,
> My depression,
> My inability to work consistently…
> He would listen, ask questions, and comment
> … Open-minded to treatment –
> Psychiatry is not an exact science –
> New ideas,
> New alternatives were not rejected.
> He realised the missing,
> The search for status,
> He kept up my hope.'[10]

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[1] Perkins R. The you'll nevers. *Openmind* 2001; 107: 6.

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[3] Repper J, Newman A, Saul A *et al.* Going the extra mile. Unpublished report. Sheffield: ScHARR, Sheffield University, 2004. (Available at www.nimhe-em.org.uk)

[4] Repper J, Nolan M, Grant G *et al.* Carers views on carers' assessments. Sheffield: School of Nursing and Midwifery, University of Sheffield, 2005.

[5] Basset T, Cooke A, Read J. Psychosis revisited. Brighton: Pavilion/Salomons/British Psychological Society, 2003.

[6] NIMHE/NHSU/Sainsbury Centre for Mental Health. The ten essential shared capabilities: a framework for the whole of the mental health workforce. London: Department of Health, 2004.

[7] Bracken P, Thomas P. Hope. *Openmind* 2004; 130: 10.

[8] Wallcraft J. Recovery from mental breakdown. In: Tew J (ed) Social perspectives in mental health. London: Jessica Kingsley, 2005.

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[10] Lilly R. About a psychiatrist. In: Clare A, Cuthbert SL. Developing practice in community mental health care. Trainer's manual. Brighton: Pavilion/MHF/City & Guilds Affinity, 2005.