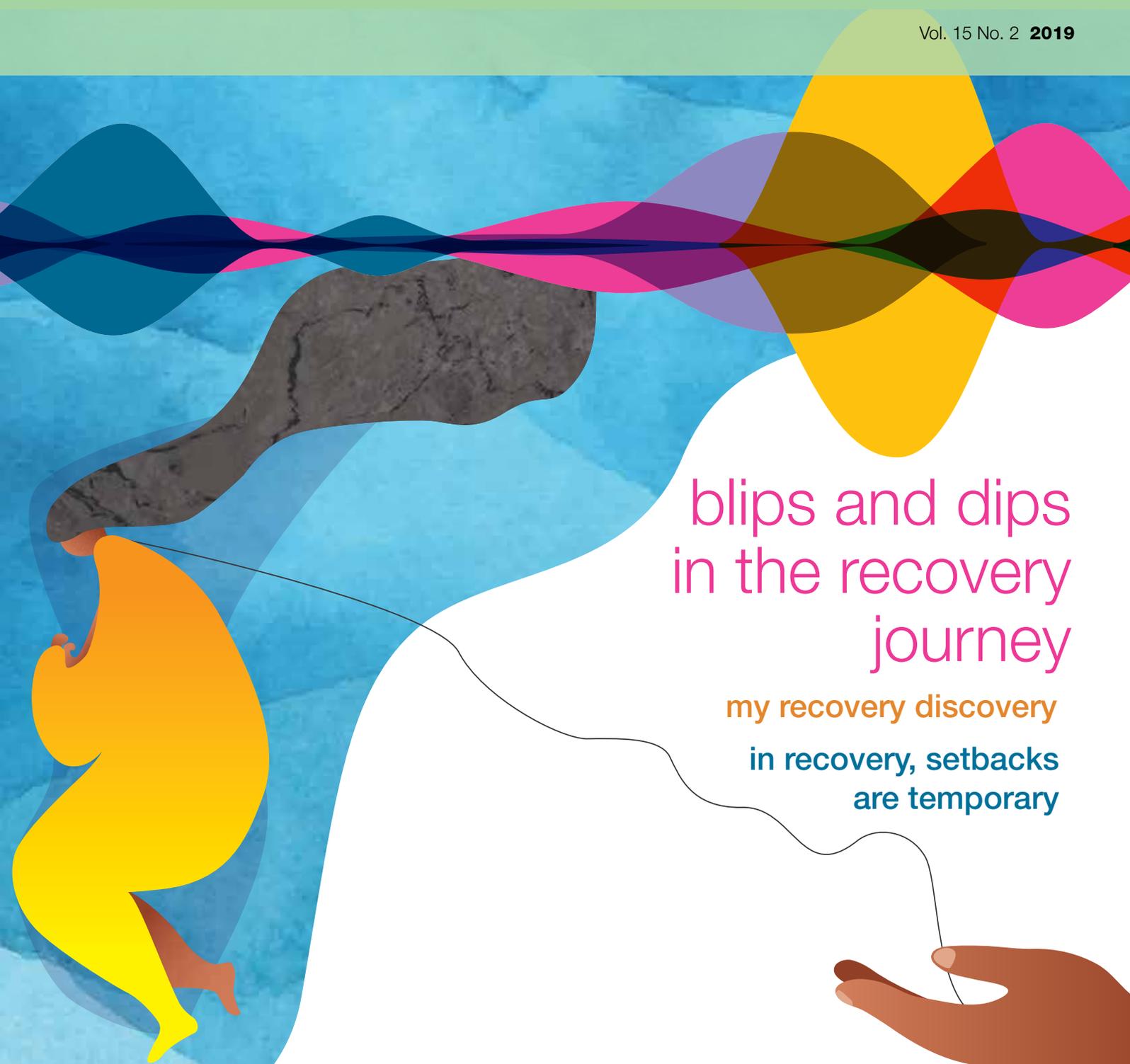


visions

Vol. 15 No. 2 2019



blips and dips
in the recovery
journey

my recovery discovery

in recovery, setbacks
are temporary

visions

Published quarterly, *Visions* is a national award-winning journal that provides a forum for the voices of people experiencing a mental health or substance use problem, their family and friends, and service providers in BC. It creates a place where many perspectives on mental health and substance use issues can be heard. *Visions* is produced by the BC Partners for Mental Health and Substance Use Information and funded by BC Mental Health and Substance Use Services, a program of the Provincial Health Services Authority.

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editor-in-chief	Sarah Hamid-Balma
substantive editor	Jillian Shoichet
layout	Justyna Krol
issn	1490-2494

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contact us

mail c/o 905 - 1130 West Pender Street, Vancouver, BC V6E 4A4
phone 1-800-661-2121 or 604-669-7600
fax 604-688-3236
email bcpartners@heretohelp.bc.ca
twitter @heretohelpbc

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The recent issue of *Visions*, “Supporting Adult Children,” included inspiring accounts of family caregivers of their adult children with serious mental illness. As a parent caregiver for my 40-year-old son who suffers from refractory schizophrenia, it is good to be reminded that I am not alone. However, I’m also frustrated that the BC mental health system fails those who suffer from severe, persistent mental illness.

Here in British Columbia, we have a mental health care system based on what is called the ‘recovery’ model. Recovery is a noun and is defined as the process of becoming well again after an illness or injury. Under the new ‘recovery’ model, people with chronic mental illnesses are excluded from this definition which states the mentally ill are all in a state of recovery which means they must advocate for themselves. By excluding so many like my son who remains pre-contemplative and who is not in recovery, from the official bureaucratic model, government doesn’t have to provide the level of care he requires. Canada’s dirty little secret is that when institutional or tertiary care ended, no equivalent level of care took its place. That leaves those with chronic, severe mental illness, arguably one of the most vulnerable populations in Canada, under the veneer of a working health care system.

—*Riada Roch, Nanaimo, BC*

editor’s message

Warning: Metaphors ahead. Metaphors work because recovery is abstract and very individual. It’s hard to talk about setbacks, hiccups, dips, blips, ups, downs, ins, outs, relapses, crashes and the myriad other terms we use to talk about the shape that moving forward takes. Because that’s what recovery is: moving forward. It may feel like falling forward sometimes, but it’s still forward. If recovery isn’t your preferred term, what’s clear is that whatever your words, we all know the process is not a straight line. My art teacher in high school forbade rulers in her class. “There are no perfectly straight lines in nature,” she would say. So, too, with recovery. And yet sometimes our service systems and our own inner critics act as if it is a straight uncomplicated line between ill health, intervention or treatment, and —poof!— health. It’s never that simple.

I have lived experience of mental illness and although I am well, I still live the journey. I know I can’t take my mental well-being for granted or it will tap me on the shoulder and remind me in unpleasant ways. There are two metaphors I find personally relevant to getting through a rough patch:

1. When I feel close to a setback in my health, I sometimes refer to it as a wobble. Staying in balance all the time is hard. Sometimes I feel a bit off-kilter. It’s not a fall though (or yet), just a wobble. I usually brace myself for a fall (and that gets me into trouble sometimes if I brace too much). But mostly I need support. That’s a big theme in this issue: the capacity to ask for and receive help. And, frankly, to be kinder to ourselves when we do.
2. I bike to work everyday. I love going fast downhill, and I dislike most uphill. Fighting gravity is like fighting the inertia or the unhealthy thoughts of mental illness. It takes work, sweat, gearing down. But the energy-save, memory and momentum of an easy downhill helps get me started on the next uphill. Plus, the uphill will transform into a downhill when I turn around to go home (read: how I approach things matters).

As always, I’d love to hear your reactions to this edition. Write to us anytime.

PS. If the terrain metaphor hits home, I would recommend reading the brief poem “Autobiography in five short chapters” by Portia Nelson.

Sarah Hamid-Balma

Sarah is Visions Editor and Director of Mental Health Promotion at the Canadian Mental Health Association’s BC Division

Well-Being as a Non-Linear Journey

REFRAMING THE BLIPS AND DIPS THAT COME WITH BEING HUMAN

Jenn Cusick, CPRP, WRAP ALF

As a mom who works from home, I have learned to revel in whatever quiet time I get, even if that means stealing a few minutes in my car listening to David Bowie after running errands. A few months ago, I returned home after grocery shopping and I sat in my car and listened to “Heroes” five times in a row. I needed to gather myself before I faced the potential chaos waiting for me when I walked through the door—a feeling I’m sure most of you with children can understand.



Jenn has over 25 years of experience in community mental health. In 2015, she started Luminare Wellness, which offers mental health trainings and consulting for organizations. She trains WRAP facilitators and presents workshops on self-determination, self-nourishment and burnout prevention for practitioners, appreciative inquiry, self-compassion and WRAP. Recently, she wrote the peer support training curriculum for Alberta Health Services. She works with PSR (Psychosocial Rehabilitation) Advanced Practice (Douglas College) and oversees communications for PSR Canada

Photo credit: Michele Phillips, *What Dreams May Become Photography*

Jenn Cusick

On this particular day, the heaviness of my emotions weighed on me. Sitting in the car felt more like an act of desperation than of self-care. All I could think was, “Is that dark cloud coming back? If it is, I really don’t think I can manage.” I was worried that I was being transported back to a long season of struggle in my life—a time that I am very glad is in my past.

In that moment, I made an intentional choice to stop fighting the difficult feelings. I chose to accept the fact that I felt sad, overwhelmed and anxious. It was a relief to sit with my discomfort and struggle for a moment,

instead of fighting it. I had a wee cry and gave myself a little hug as an intentional act of self-soothing. It was validating, and it allowed me to offer compassion and kindness to myself: essential parts of my self-compassion practice.

After a few minutes, and some reflection on all the amazing parts of my life, I had an “Ah-ha” moment—a sudden understanding that slightly yet profoundly shifted things for me. I realized that just because I feel a blip that is reminiscent of a really difficult time doesn’t mean I’m headed straight back to that dark place.

Through much dedicated study and effort, I am learning to allow myself to feel pain without getting mired in self-pity, the way I did in the past. I am learning to feel all my feelings and not be afraid of the darker ones. I have learned to view my feelings like weather patterns. Like the sunshine, the wind and the rain, my feelings come and go. I can choose to feel what I'm feeling without being defined by those feelings, or judging them. I know now that nothing in this life is permanent.

The importance of self-compassion

Author, teacher and Buddhist practitioner Jack Kornfield writes, "If your compassion does not include yourself, it is incomplete."¹ As someone who has spent almost my entire adult life working in mental health, I have learned to feel deep compassion for others who are suffering. But a few years ago, I started noticing that I didn't have much compassion left for myself. When I messed up, I allowed my inner critic to reign supreme. I constantly ruminated on everything, from mistakes I made to uncomfortable social interactions.

I began learning about mindful self-compassion through the work of Kristin Neff² and Christopher Germer.³ Self-compassion is about having compassion for ourselves when we are suffering. I believe that my critic is trying to protect me from future failures. I know that I can never fully silence my inner critic, but I have learned to change the way I engage with it. I challenge it, and I have learned a more effective form of self-talk—one that is compassionate and kind. I have also learned techniques for self-soothing. The practice of self-soothing as an adult is not all that different from what a baby does when she

self-soothes by sucking her thumb. As adults, we don't generally go around sucking our thumbs, but we can still retain the essence of intentional self-soothing by tapping into our mammalian care-giving system. Self-soothing techniques are connected to the senses and can help calm our sympathetic nervous system. They can include actions like placing a hand on the skin close to our heart, deep breathing, rubbing an essential oil on our skin, having a warm bubble bath or sipping tea under a cozy blanket.⁴

The only way out of something is to go through it. Being present, learning how to sit with our difficult feelings when we are in struggle is an essential step. Processing pain means that we have to let ourselves feel it first.

I have also come to understand the importance of community and support. As human beings, we all experience struggle: it's our birthright. I have noticed that when I talk about my struggles, my shame melts away and I know that I am not alone.

How WRAP can help

WRAP (Wellness Recovery Action Plan) is a self-designed wellness program that we can all use to get well, stay well and shape our life the way we want.⁵ It's a simple program that encourages the deepening of self-awareness. WRAP has supported me in my efforts to crack the code of self-care on my 17-year journey of exploring how my daily choices affect my overall well-being. With the help of the mindfulness I have learned from WRAP, I know now in my heart that even if I have to go through another dark season, I can get through it because I am resilient.

I have had the opportunity to co-facilitate many WRAP facilitator trainings and to listen to hundreds of recovery stories from people from across North America. I can only compare the experience to suddenly being able to see new colours in the rainbow—colours I could never have imagined, except by witnessing the telling of those powerful stories of resilience.

In most of these recovery stories, the person experiences a major shift when they let go of the fear that can come with having a mental health diagnosis, they find support and they realize that they can actively choose hope instead of fear.

Finding and holding onto hope is not subscribing to a simplistic Pollyanna optimism. Real hope is the profound paradigm shift that happens when we believe that we have some control of our life choices and there is a reason to get out of bed in the morning. Hope is the first of the five key concepts of recovery in the WRAP program.

The key concepts of recovery

The research of Edward Deci and Richard Ryan on the idea of self-determination suggests that human beings have three basic needs.⁶ We can summarize these needs in figure 1 on the following page. WRAP builds on this theory of self-determination to formulate a simple, yet not always intuitive, process for recovery. The five key concepts of recovery that are the foundation to WRAP are hope, personal responsibility, education, self-advocacy and support. The intentional choice to actively incorporate these concepts into our daily lives can cause a few significant things to happen:

- When we choose to look for hope every day, we most often tend to find it—even in small, seemingly insignificant ways, like breathing in the scent of a wildflower
- When we step into the driver’s seat of our life and take personal responsibility for our circumstances, we get to steer, and choosing the direction of our life feels like freedom—even when we experience bumps in the road
- When we choose to educate ourselves and get curious about our feelings, our thoughts and where we fit in the world, we can find the courage to face challenges instead of ignoring them or sweeping them under the rug
- When we believe we have value, decide what we want and need in life, choose to equip ourselves with what we need to know and assertively self-advocate, we can do amazing things
- When we accept that as human beings we are wired for connection and community—when we both give and receive support—we find that we can live a full life
- When we choose to mindfully notice and shift the implicit biases and long-held beliefs that are rooted in our past experiences and get in the

way of relationships, we can choose compassion over judgement

Setbacks as part of the recovery process

Going through a setback is scary. It’s especially terrifying when everyone, including the person in the midst of the struggle, is seeing the event through the dire lens of “relapse.”

But setbacks happen. If we give into fear when we experience a setback, we can go crashing into a downward spiral. The antidote to this downward spiral is normalizing the fact that setbacks come with the experience of being human. When we stop and choose to see setbacks through a different lens, we experience a powerful paradigm shift. We can choose to see setbacks as opportunities for learning and growth, introspection and self-awareness.

Isolating ourselves when we struggle keeps us stuck. Reaching out when we are suffering creates the opportunity for connection and healing. Sometimes we might find ourselves in a desperate place, feeling too broken to hold onto hope. We can remind ourselves we are not alone. Everyone hurts. When we intentionally seek to build community and relationships, we can take solace

in meaningful connections. Shame is destructive to our well-being, but it has a hard time surviving in the light of an empathetic connection.

It’s easy to let ourselves become defined by our perceived deficits. However, when we learn to gracefully accept the fact that we make mistakes and have imperfections, when we practise self-compassion, we are more equipped to sit with the pain and discomfort that comes with difficult times. We can offer ourselves “loving-kindness” and tenderness, knowing that while a particular period may be difficult, it is not going to be our reality forever.

Blips and dips are just a part of living. I’m constantly making peace with that in my own life.

I need to remind myself of these truths, as I did in the car that rainy spring day in April. Now, many months later, I sit at my kitchen table, writing and listening to the pounding rain against the side of the house. I am reminded that, like the rain, pain and struggle will inevitably come my way again, and that’s ok. When that time comes, I will choose to remind myself that I am not alone, though it might feel that way.

I will choose to linger in the car a bit longer if I need to.

I will choose to listen to some comforting music, while sipping tea under my hand-knit blanket.

I will choose to reach out to someone I love.

Because I know that the sun will shine again. ▽



FIGURE 1. Adapted by author.

Addiction, Wellness and Language

HOW THE WORDS WE USE SHAPE OUR EXPERIENCE AND UNDERSTANDING OF SUBSTANCE USE

Gaëlle Nicolussi Rossi

The language we use to talk about substance use and addiction is important. Words are powerful: they can include or exclude. Unfortunately, our language around addiction is often negative and impacts the way society perceives substance use and people who use substances. The language we use also frames what the public thinks about recovery, potentially discouraging people from seeking treatment and leading to labels that can affect whether or not they can access life needs, including employment, health care and housing.

Gaëlle is a research associate for the Canadian Institute for Substance Use Research at the University of Victoria. Gaëlle's work focuses on developing resources that engage communities in dialogue about drugs and gambling. Her interests include health promotion, dialogue and social justice



Photo credit: Warchi at ©iStockphoto.com

Addiction language through history

The history of our language around addiction is complex. Prior to the late 19th century, “addiction” was rarely associated with drugs; it meant being “given over to” or devoted to something. However, in the late 1800s, the word came to be linked to addiction to drugs, vice, withdrawal symptoms and dependence.¹ There was also a moral component to the language around

addiction: people who used substances were often thought of as sinners.

By the 1930s, “addiction” was used mostly in relation to illegal substances, regardless of whether or not the people who used drugs experienced harmful effects. As medicine became increasingly influenced by science, the language around addiction shifted. People who used certain substances

were regarded as having a “disease” that could be treated rather than being regarded as people who lacked self-control or were unwilling to change.

Nowadays, our use of language around addiction tends to blend the constructs of sin and sickness. These two ideas have very different implications. In the first construct, we tend to focus on addiction as the result of individual choice, and often adopt moralistic or judgemental language. In the second construct, we see people as subject to forces outside of themselves; we tend to regard them as needing our help—and in the process, we often deny them agency.² The two constructs don’t work very well together: on the one hand, we blame people for making poor choices; on the other hand, we deny that they are capable of making their own choices.

Today, language around substance use often implies that using drugs is a bad thing. For example, we use the phrase “getting clean” when referring to someone who stops using drugs, which implies that those who use drugs are “dirty.” Unfortunately, such language stigmatizes drug use and drug users, which can have devastating consequences. It can prevent people from seeking treatment by increasing stigma and shame, making people fearful of seeking support. Using words such as “substance abuse” is also problematic. We do not call people with diabetes “sugar abusers,” for example, so why do we use the terms “substance abuse” and “substance abuser” to talk about substance use and substances users? There are other ways to talk about drug use and its potential benefits and harms—ways that don’t label

people as bad, wrong or different in a negative sense.

Challenging our black-and-white thinking while we move towards wellness

When we talk about addiction, our language tends to lack nuance and precision. For example, “recovery” is often framed as complete abstinence from substance use, and “relapse” as the use of any substances at all. However, the recovery path for one person can look very different from the recovery path for another. For many people, recovery does not necessarily mean abstinence, or only abstinence—or even abstinence at all. The concept of recovery goes beyond abstinence to include an ongoing process of growth, self-change or simply making the choices that work best for the individual in the circumstances at the time. Defining recovery as a “lack of use” is narrow and stigmatizing, as it frames people who might occasionally use substances as “relapsing” and, once again, unable to control themselves.

Such black-and-white thinking also leads us to see certain drug use as acceptable—often drugs that are legal, such as alcohol and prescription drugs. Other drug use—often the use of illicit drugs such as methamphetamine or cocaine—is framed as bad, unacceptable or even “evil.” In addition, when people think of “using drugs,” the practice is almost always seen as negative. However, many drugs have greatly benefited humanity. In fact, most drugs are useful in some way. Unfortunately, we rarely discuss how “illicit” drugs may actually help people. For example, some drugs can be used as part of traditional or religious rituals, or can help people who are homeless cope with the trauma they experience from the conditions they live in.

Our language also tends to blend people’s drug use with their personhood. Words like “addict” and “druggie” are dehumanizing. People are more than the drugs they might be using, so it is important to use language that reflects that: “people

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Phrases like “falling off the wagon” can imply that the person is a failure by not remaining alcohol-free. This understanding overlooks the many routes that someone’s path to wellness may take and what “recovery” might look like to different people.

who use substances” is always preferable to stigmatizing, reductive labels.

Changing our language frameworks to support wellness

For some people, achieving wellness or well-being might include managing drug use in a way that helps them thrive. It might mean finding ways of increasing their social supports so that drug use complements their life instead of filling a void or serving as a means to avoid painful situations or feelings. Often, the language we use around recovery is not only stigmatizing but also implies that any drug use means the person has failed.

Phrases like “falling off the wagon” can imply that the person is a failure

by not remaining alcohol-free. This understanding overlooks the many routes that someone’s path to wellness may take and what “recovery” might look like to different people. Even the term “recovery” is problematic as it implies that substance use is something that requires healing or a cure, or that a person who uses substances is somehow “sick.” Within this framework, people who don’t choose to “recover” do not meet a social standard and are judged negatively.

The concept of harm reduction is often brought up as a response to substance use. But while harm reduction is an important tool, it is often framed by law makers in a way that implies drug use always leads to serious harm.

For example, harm reduction policies tend to focus on the implementation of safe consumption sites, access to clean needles and the availability of naloxone kits. Part of the problem might be related to language, as the words “harm reduction” imply that substance use necessarily leads to harm. But harm reduction as a model is much more than a tool to minimize injury and death. Harm reduction also focuses on wellness and recovery by providing for social and emotional supports and by making referrals to health and treatment services.

It is important to recognize that our words matter, and that the language we use to frame the discussion of substance use and wellness has real repercussions in terms of our policy decisions, our health care systems and our communities. We must move towards reframing our language to be more inclusive and less judgemental of others. We should strive to use language that doesn’t portray all drug use as bad or that assumes the complete absence of drug use is the only path to wellness. By thinking critically about the language we use around addiction—by asking ourselves, “What are the assumptions implicit in the words I am using?”—we can ensure a more open, varied and inclusive dialogue about substance use, addiction, recovery and wellness. ▼

Operating Instructions

HOW YOUR LOVED ONES CAN BE YOUR SAFETY NET

Daphnée

I crush the instant ice pack as hard as I can, then press the cold pack against my eyes and forehead. My heart rate drops, my anxiety decreasing at a fast speed. I need to calm down, and feeling as if my face is submerged in cold water helps me stay grounded.



Daphnée studies English Literature and counselling psychology at the University of British Columbia. She works at BC Children's Hospital, enjoys volunteering with inner-city kids and tries not to take life too seriously

I carry ice packs in my backpack at the suggestion of my therapist, so I can self-soothe anywhere I go. This is particularly helpful when I find myself hyperventilating right before an exam. As a student, I am familiar with the stressors that come with having to write midterms and academic papers. I've experienced mental health challenges since early adolescence, and transitioning to adulthood has exacerbated my symptoms.

My recovery journey

Self-soothing is a skill I learned through dialectical behaviour therapy

(DBT). I completed the 15-month program eight months ago. After seven years of active symptoms, a dozen medications, three hospitalizations and a course of electroconvulsive therapy, I figured that I had exhausted all my other options.

The main goal of DBT is to build a life worth living, and I feel grateful I've been well for some time now, because recovery is a privilege denied to many. Part of me is terrified of getting sick again and believes that I will never be able to survive another depressive or hypomanic episode. Then I wonder,

On a logical level, I understand that to maximize my chances of wellness, I need to keep my stress level low, engage in daily self-care and not isolate myself. Yet when I lose my insight, having a safety net prevents me from falling through the cracks as my loved ones can intervene before things get worse.

“What if the past few years have just been a test run, and there are much bigger challenges ahead?”

One of the biggest challenges for me in my recovery process has been learning how to recognize what “illness” looks like and what “wellness” or “recovery” looks like. Illness and wellness look different for different people. I’ve learned what each one looks like for me, and I’ve learned that there are some things that I just need to do in order to stay well. For me, this includes eating well and taking medication.

For me, wellness is being able to walk along the beach in the evening, enjoying the beautiful pink and orange ribbons in the sky. On those summer days, I wear cute polka dot dresses instead of wearing sweatpants and fleece hoodies—practically my uniform when I’m not feeling well—and spending most of my days in bed. I work at BC Children’s Hospital and I need to stay healthy, so my eating practices have changed—I’ve started to cook my own meals instead of ordering pizza late at night.

When I wake up in the morning now, my bed sheets are not soaked in

sweat from my nightmares, which is a symptom of post-traumatic stress. I still experience intrusive thoughts and mood swings, but I can cope with them better than I did before. It took me eight years to accept the fact that psychiatric medications reduce my symptoms. After stopping my medication abruptly and experiencing withdrawal effects, I learned my lesson and gave up my resistance. Nowadays, I take my medications as prescribed.

The recovery process isn’t all about positive experience, though. Recovery also looks like grief. When I sit in my therapist’s office and begin to speak, my raw emotions spilling out, I confess how angry I am, and I contemplate the number of days I’ve lost to an illness I never chose to have. I whine at the unfairness of it all and curse my friends with their seemingly perfect lives. Underneath the anger, there is a profound sadness.

Mindfulness, or accepting reality as it is, has been a key part of my recovery. When my thoughts spin out of control with worry about the future or I find myself judging others, I try to simply notice these thoughts and then let them go. I imagine them as giant soap

bubbles that I release and let float upwards to burst in the air.

Creating a relapse prevention plan

For me, having a relapse prevention plan has been a useful tool. My relapse prevention plan is a document that I wrote exclusively for myself. It includes my emergency contacts’ information, a list of coping skills that have worked for me in the past and a series of concrete steps that I should take when I experience a crisis. I’ve brainstormed calming activities I can engage in when I’m distressed and I’ve listed positive affirmations I can tell myself.

Here’s the thing, though: even the best plans are not bulletproof because nothing in life really is. You can have titles in boldface and subheadings in italics, a colour-coded cheat sheet with self-care activities, a list of early warning signs and late warning signs, but all that information can become useless when you fall ill. There is no user manual for life, and sometimes a relapse is inevitable. Sometimes, despite my best efforts, I miss my warning signs or get triggered unexpectedly.

Setting up a safety net

That’s when other human beings need to step in. At some point, I have no other choice but to rely on my support system or, as I lovingly refer to them, my safety net. The concept of a safety net was introduced to me by my DBT therapist, when I told her that having a relapse prevention plan and “coping ahead” is very different from actually being able to act on the plan when things are going wrong. I have a tendency to pretend that everything is fine when it’s not; my biggest struggles are recognizing when

I need to put a plan into action and then actually doing it.

I know my symptoms by heart. I know myself so well that I can predict which self-destructive behaviours I will engage in when I become overwhelmed at school, find myself in conflict with my boyfriend or have difficulty getting up in the morning. When I experience intense painful emotions, I will do whatever it takes to avoid them, even if it means taking action in an unhealthy way.

On a logical level, I understand that to maximize my chances of wellness, I need to keep my stress level low, engage in daily self-care and not isolate myself. Yet when I lose my insight, having a safety net prevents me from falling through the cracks as my loved ones can intervene before things get worse. My therapist said that when I can't count on my brain anymore, when I'm at home unable to get out of bed, I need someone to "come over and stand beside me while I put some clothes on."

I call my loved ones my safety net because they are friends who also have lived experience, and they know me better than anyone else. I created and shared a document outlining instructions so they can better support me when I fall ill. I often feel like a burden to those around me, but I have found that giving guidelines to my peers lessens the guilt I feel. It brings relief to my loved ones because now they are more confident in their ability to help me during difficult times. It gives them concrete tools and protocols to follow and tells them exactly what my future self will need from them. For example, I have given them permission

to contact my psychiatrist or call my parents in the case of an emergency.

My safety plan acts like a template, providing guidance. It has statements such as "If I tell you I've stopped taking my medications, this is a bad sign. Remind me that last time, I ended up in the hospital due to withdrawal symptoms. Call me out and say, 'What would your wise mind tell you?'" And "If I start to obsess over academic papers, *this is a really bad sign*. Check in with me immediately. It means I am depressed and something is going on." And "If I appear high and can't stop talking, this is a dangerous sign. Gently assess whether I am having suicidal thoughts, and ask me if I can keep myself safe. If you suggest I might be hypomanic, I will most likely snap at you. Please forgive me."

Giving up control and having faith in the future

So, I relinquish power and let others hold space for me until I can hold space for myself. When I'm sick at home or in the hospital, and my loved ones tell me that it will pass, I don't believe them. But they hold my hand even when I resist, stick with me regardless and never let me go. And I try my best to do the same for them.

Even though it requires an incredible amount of trust and vulnerability, if there's one thing that has helped me, it's *interdependence*. It's acknowledging that we can't do everything on our own. The bonus is that when my friends are struggling, I am willing to do the very things for them that I can't do for myself. In the end, it benefits everyone involved.

Ultimately, what motivates me to stay well is my desire to model recovery, to

foster hope by sharing my story, and to help children and families as well as my peers navigate the mental health system. I want to give to others what I needed the most back then but never had, in the hopes that they will be able to access resources and get the help they desperately need and deserve.

Once, after a particular difficult setback, I felt hopeless, convinced that I would never get better. Despite her reassurances, my therapist could tell I was still upset, so she grabbed an erasable marker and turned to the whiteboard in her office. She drew a graph of my progress: a jagged line moving upwards to the right. Even though I had experienced a relapse, I was still heading in the right direction.

She stepped away from the board and considered her work. After a moment, she erased and re-drew the line of progress, softening the angles and adding elegant curves and loops, her marker like a plane in aerobatic flight.

She turned back to me and half-smiled.

"Just trust the process," she said. ▽

The Haunting

Mike Alexander

A few years ago, I was in a different, darker place in my life.

Mike is an Anishinaabe triathlete and artist, originally from Swan Lake First Nation. When not illustrating graphic novels, writing or painting in his current home of Kamloops, BC, Mike spends the best moments of the day with his loving partner Natika



Mike Alexander, left

Every night, I would sit in a dimly lit room in Victoria, BC, alone at my desk, drawing or writing. I was invisible in a city where almost no one knew me. I told myself I was comfortable there. The nights were long, the work was hard and I could be alone with my thoughts. During those long, solitary nights, if a tear were to fall from my eye, it would strike the bottle of alcohol that I cradled in my trembling hand. This was the poison that had imprisoned me in this small, quiet corner at the edge of the planet, there on the island I called home. But at that time, eight months sober, I had resolved not to open that Last Bottle.

One night, I found myself clinging again to that Last Bottle. It glared at me under the light of my desk.

Whatever small spark of strength I had left waned in the presence of that bottle. I felt angry at a world that had abandoned me. I felt disgusted by my selfish feelings and my weakness. I felt sorrow, I felt loss. I placed the bottle on the desk before me. It was too heavy. It wasn't simply a bottle of alcohol. It symbolized much more than that. Its weight had become too much to bear.

I felt utterly and completely alone.

For some reason, in that moment, I picked up the phone. I called one of the few people I felt I could trust. Someone I knew might listen, someone who might possibly talk me out of reaching for the bottle opener on the desk.

The person I called was in bed; I had likely woken them up. I wasn't even sure what to say. Through the hurt, pain and fear, I started talking. I felt like a mess, babbling, incoherent. I explained what was happening and what I was at risk of doing next. I felt powerless. It was a terrible feeling. I didn't expect the person to understand, but I kept talking anyway. I knew enough to know that I couldn't be alone in my head at that moment. I needed to remain accountable. Even if no one else cared what I did when I was alone, I would know.

That phone call saved me that night. That person was there for me.

Trading one cycle for another

The process of my recovery has been a long one, and there have been setbacks along the way—including the relapse that I described above. Over that period, there have been several important factors in my efforts to disrupt the cycle of alcoholism and become a healthier person. One was cycling.

When I started riding a bike, I immediately felt the mental health benefits. I had lived with major depression for half my life, and I started to see there was a link between cycling and how I felt on a daily basis. I would feel the endorphins on a good, long ride, and that would affect my mood and, in turn, my body. As I started to feel better, I started to feel more motivated to keep pushing myself to see what would happen next. I began to challenge myself to go longer distances and to get myself working harder.

Eventually, I had shed tears and sweat across thousands of kilometres. Climbing the hills that ripple across

Vancouver Island built a physical and mental strength that I had not previously known. The discipline of riding almost every day meant that over time I developed my ability to ride farther and faster. I started half-seriously referring to myself as an athlete; the title gave me a sense of mastery over my choices. My sleep improved; I began to eat better. I lost 130 pounds and was able to manage my type 2 diabetes. And my depression began to lift.

Honouring self, past and present

Another important factor in my recovery process has been reaffirming and honouring my Indigenous identity and heritage—something that has particular significance as I take on the task of personal healing.

I am Anishinaabe, from what is now called Manitoba. In Manitoba particularly, Indigenous peoples have not had an easy time. I myself am a Sixties Scoop survivor. Very shortly after I was born, I was forcibly separated from my biological parents by a government agency, removed from my community and adopted by a non-Indigenous family. As a result, I lost all connection to my language and my culture.

Today, most people in Manitoba don't really understand what a Treaty is or that, for the Anishinaabe, there is no life without the land on which to live it. This fundamental relationship that the Anishinaabe have with the land is broken; the impact of that has been felt mentally, physically, emotionally and spiritually for many generations. But these issues have never been properly addressed by the provincial or federal governments. Colonization has been allowed to flourish, and

there is no real way forward until the reasons for that are acknowledged and the problems that stem from colonization have been resolved.

As an Indigenous person, I have not found counselling to be particularly helpful—at least, not the counselling typically offered by our current mental health services. The counselling I've received lacks substance and cultural sensitivity and understanding about Indigenous issues and the factors that affect Indigenous mental and physical health outcomes. As much as I want to encourage Indigenous people to find a professional to talk to if they need it, there are a lot of gaps in the current mental health system when it comes to providing adequate services for Indigenous clients. I've also had Indigenous people report to me that they have a hard time even accessing basic services, let alone services that are meaningful to them.

It's easy to see how Indigenous people are overlooked, viewed as inferior or with pity. Our wisdom, our history and our culture are in the process of being extinguished. If our ways were viewed in the holistic, democratic and community-driven ways they were intended to be viewed, and practised in the way they were traditionally practised, then I think that our people—no matter their age, gender or sexual orientation—would experience the benefits of inclusive, culturally sound mental health practices.

As a nomadic people, the Anishinaabe used to continually move around the prairie. While I may have romantic notions of chasing buffalo and riding horses all day, I know that it took

Even then, I knew instinctively that when a person's basic needs are not met, they are vulnerable to old habits.

community, determination, hard work and discipline for our Nations to survive and flourish. When I am cycling now, on a group ride or on my own, I exercise the same principles. When I ride, I think that my ancestors see me and are pleased. There's no better way for me to connect with my Anishinaabe roots than doing that work, owning that effort and that pain. I feel freedom when I ride, and I like to think that I get a taste of what my ancestors knew.

The art of recovery

Several aspects of becoming sober have been attractive and affirming for me. My friends who live far away could hardly believe I'd stopped drinking. I felt their admiration. The messages were positive. People saw the new me, and they liked it. But I wasn't trying to be sober for anyone else. I had embarked upon this journey for me and my future dreams.

I began to tell my story through art. I worked to develop a better relationship between my brain, my eyes and my hand, with a pen nestled comfortably between my fingers. These drawings felt like the best way for me to communicate with the outside world. I sold a few of my drawings to complete strangers. My adoptive mother encouraged me to keep going.

I decided to seriously pursue art as a career. It was an ambitious goal, but

I already had a framework: I applied the same discipline that I had applied in my cycling and my recovery from alcohol addiction to developing and maintaining my artistic practice.

I was applauded for making better choices. It was a great feeling. But like recovery and physical fitness—and any other challenging pursuit—eventually the applause died down. Once the initial wonder and admiration subsided, I was no longer in the spotlight and people moved on.

Soon enough, the darkness returned to challenge me once again, and I found myself battling familiar demons. That's the way depression works.

But as an artist, I started to appreciate the pattern, watch it with an artist's eye. I realized that it's important to observe the storm clouds rolling in. It's important to acknowledge their force and potential for causing damage. I started to better understand how to prepare for the darkness and the oncoming storm. There will always be moments when we face disappointment or rejection; in the past, I have turned to the safety of alcohol because it ends the negative feelings. Now that I no longer use alcohol to cope, the pain can feel sometimes as if it is amplified. It is a monumental challenge to deal with that pain in a meaningful and healthy way.

But then I remember that night long ago, when I reached out and made that phone call. In that moment I knew the nature of relapse. Relapse is the feeling of being lost. That state was fuelled by my loneliness—needing, but not having, human connection. Even then, I knew instinctively that when a person's basic needs are not met, they are vulnerable to old habits. I knew I needed encouragement. I needed to know that my absence would be felt. That night, I looked beyond myself and found a voice in the darkness.

All it took to snap out of my relapse was to talk. To believe in the possibility that tomorrow would be a new day. When the call ended, I felt appreciation and gratitude. I let myself feel the dark feelings. I observed them the way an artist observes the storm roiling across the sky and over the horizon.

At some point during the telephone conversation, the bottle that I held in my hand had fallen under the bed. It had lost its dominance over me. It was just a ghost. Nothing more. ▾

The Recovery Mindset

A MOTHER'S INSIGHT INTO MENTAL ILLNESS AND RENEWAL

Heidi Kilham

As we experience recovery alongside our daughter living with bipolar 1 disorder, what wellness looks like and feels like is becoming easier to recognize. We have learned that recovery is really a mindset and a series of lifestyle adjustments—not a single event. Choosing the recovery mindset is much like doing housework and laundry, in that it never gets done permanently. It's best to think of recovery as maintenance—and to think of a way to make that maintenance feel fun and rewarding.



Heidi lives with her family in North Vancouver. She loves being a co-active coach, supporting her clients to embrace change and live their authentic selves. She also teaches in the NAMI Family-to-Family Education Program sponsored by Pathways Serious Mental Illness Society of West Vancouver. You can contact Heidi at heidi.kilham@gmail.com

Heidi Kilham

Recovery is a commitment to one's well-being and to developing personally meaningful contributions to family and community. Together we've learned that this commitment also directly supports our daughter's growing self-confidence.

During a high-school camping trip in her Grade 10 year, after many years of intense and increasingly unpredictable mood swings, our daughter was

hospitalized with a severely elevated mood (known as mania). We know now that she had dealt with high levels of anxiety since Grade 5, which led to many trips to the school nurse for stomach aches and headaches. For Grade 12, she switched from an academic school across town to a high school near home, where she could work part-time as a barista, continue her counselling, develop her music abilities and graduate early with the

I have come to see my daughter's recovery journey as having patterns and stages—instead of ups and downs, it's more like “ins” and “outs.”

minimum number of credits. Here, she was able to renew her passions for art, music, sewing and coffee, building confidence away from the pressure of the university application treadmill.

Three years after her diagnosis, her wellness is now reflected in her engagement in music, art and performance and in her emerging mental health advocacy. At her own pace, she spreads hope to others by telling her story. She continues to work part-time in a café that runs as a social enterprise supporting those living with mental diagnoses.

What wellness looks like

For my daughter, wellness is having a firm footing—some confidence that when she applies herself, she will get results, something solid she can trust. Many times, she is surprised and heart-broken by the results of her efforts—like when she signed up for a class and, after attending the first one of the semester, realized the reading load wouldn't work for her. Reading is a tedious and difficult task, even on her best days. She dropped the course in the first week. It was hard at the time for her not to feel failure. And now she has come to see it as a good result because she realizes that coursework that requires a lot of reading just isn't for her.

She is learning that she can use these experiences to build more confidence, to help her step beyond the hamster wheel of her mind, her scared self,

with its hallucinations and negative self-talk. Her recovery is energized by small and uncertain baby steps, when she is aware of being curious and takes time to explore her interests.

Wellness for her also feels like gratitude, taking pleasure in the small stuff: the lingering aroma of a delicious meal, an exclamation point on a text asking her to play a board game, having something to look forward to, and the loving pause from a friend when she shares with them her feelings of disappointment or pain. To remember to breathe, feel and relate ... these things come like the first snowbells of spring, rising above the melting snow after a long, dark, stormy winter.

The language of experience

Sometimes I find it difficult to separate my own emotional experience from my daughter's; this can lead to me being less responsive and empathetic than I would like. At times, I feel ashamed because I feel like I have done something wrong to cause her distress. I have come to understand that this thinking blocks me from connecting with her and myself emotionally.

It is a natural part of my being to be uncertain about the origins of my emotions. Now that I am more aware of this personal trait, I can talk openly about it with my family. I have also

discovered that the words I use have an impact on my ability to pick up on emotional cues. For example, if I think I am “disturbing her privacy,” this belief can stop me from checking in with my daughter after her work or a date or a party. But if I think of it as offering her the opportunity to share her experiences with me, then I don't hesitate to reach out. If I frame my thoughts in language that focuses on connection and what I am feeling, rather than presuming how she is feeling or what she doesn't want, we are more likely to have a loving and meaningful interaction.

I have come to see my daughter's recovery journey as having patterns and stages—instead of ups and downs, it's more like “ins” and “outs.” The ins are degrees of internal preoccupation—with her own emotions and with inner voices, hallucinations, delusions and impulses. In this stage, I've found that what works is to ask the hard questions, like “What are the voices saying?” If she is non-verbal, I sit close and help her to feel physically comforted, doing what I can to reduce her fear in the moment. She tells me that this helps her release her feelings, especially when I can just be with her and listen and say something like “Wow, that must be very difficult to deal with; thank you for telling me.” Often, I feel unsure that my actions will help; I just know I have to show her she is not alone.

The outs are degrees of manipulation of objects, people and situations—like the many times she has experimented in the kitchen or left the house without telling me and found herself alone, at a bus stop far away. Once, she wanted to make spaghetti carbonara immediately

and we didn't have the ingredients. There was no talking her out of it. After over an hour of feverishly concocting something that was ultimately inedible, she broke down and spent over an hour cleaning it all up, inconsolable, crying over all the ingredients she had wasted. Such emotional upheaval on a school night threw the whole family off-balance. The storm left behind damage to her self-esteem and an emotional debris field that we all had to clean up. At times it felt that we had barely recovered from the last storm before the next one hit. Having a diagnosis allows us to put these frequent upheavals in perspective and heal past wounds.

Supporting a child through the ins and outs of the recovery process

I am grateful to have been able to work part-time close to home so that I could be available for our daughter during the most difficult transition times of the day: mornings, after school and bedtime. In many ways, caring for our daughter was, in itself, a full-time job. Usually, the only way I could get her to fall asleep at night was to give her a bath after dinner, read her a story and lay in bed with her until she drifted off—a process that took at least two hours every night from the time she was in preschool until she was about 11. She needed 10 to 12 hours of sleep regularly all the way through high school. My experience with my daughter inspired me to adapt my career plans: I pursued mental health education, coaching and leadership so that I could be a healthy support for myself, family and others into the future.

I am also grateful to have found the Family-to-Family Education Program, a 10-week course developed by NAMI

(National Alliance on Mental Illness) for families dealing with mental illness. Both my husband and I participated in the program seven months after our daughter was hospitalized. This course made all the difference for us in terms of being able to better understand the context of our daughter's mental state. It also provided us with tools to respond with empathy to each other and our daughter.

Our daughter is now 20 and our bond is strong, yet it often gets tested during times of change. Late last year, most of her closest friends moved away to attend university or to travel. Though she lives in our ground-floor suite, she still felt keenly the absence of her closest companions. She struggled with boredom, hallucinations and impulses to self-harm. All of this triggered a depressive cycle.

This time, she responded to her harmful downward swing by voluntarily checking in to a short-term mental health facility in a nearby neighbourhood. She stayed there for almost three weeks, with in-and-out privileges to help her adjust to changes in medications, get counselling and get her connected with other support services in our community.

This experience inspired a simple action—one she took immediately after coming home. She began leaving the door between our living areas open. It is a visual cue to check in with each other, to wander into each other's lives and make a physical connection.

Her recent experience also resulted in her taking up the ukulele, writing songs about living with bipolar disorder and depression—even setting

up her own website as a way to market her music. Music has been a great healer for our daughter. At the same time, it has given us a window onto her inner experience. Her album *My Bipolar Brain* is available for sharing. Two songs—"Get Up" and "Magnolia Tree"—are specifically about her recovery experience.¹

My daughter and I are also involved in promoting mental health education and telling our story to high-school students and service organizations. Our dream is to create an organization of "listening groups," promoting healthy active-listening skills in communities to increase awareness of mental health, empathy and the power of connection.

If you or someone you love lives with mental health challenges, or if you are facing significant change in your life, I invite you to think about the words you use to describe your feelings or your interactions with your loved ones. When we use words that focus on our natural need for human connection rather than our negative feelings about the challenge or the change, we have the opportunity to deepen meaningful and nourishing relationships. Leaving the door open for connection is the first step of the next recovery journey. ▼

My Recovery Discovery

Jillian P.

This is a story about how I figured out what I needed for recovery, what works for me and what doesn't. It is also a story about the challenges of maintaining a new mindset, and how I manage setbacks and prevent relapses. Ultimately, it's a story of self-discovery.

Jillian lives on Vancouver Island with her husband, two kids, two dogs and a cat. She is passionate about her work as an outreach worker. She is devoted to growing and evolving in her recovery journey to best help herself, her family and friends, and those she meets in her professional role



Photo credit: pixelfit at ©Stockphoto.com

It has taken me seven years to accept and understand that recovery cannot always be done on your own. It's okay to allow yourself to build a community in your recovery, whatever you're recovering from, and in whatever way works for you.

I have struggled with mental health issues and substance use since I was a teenager. My chronic depression and anxiety disorder were never diagnosed—I had no idea I was depressed and never knew I was experiencing anxiety until I grew older. As a teen, I would take any pills I could

find from the medicine cabinet. As the years went on, my self-medicating got progressively worse.

As an adult, I was drawn to outreach and support work. Although I am passionate about what I do and I know that the work I do is valuable, I am exposed daily to clients' trauma, addiction, sadness and pain. Over time, and through many consultations with counsellors and a psychiatrist, I've come to realize that I also have post-traumatic stress disorder (PTSD), perhaps complex post-traumatic stress disorder (CPTSD). My PTSD may be

rooted in my childhood experiences, but there is no doubt that my work has intensified it.

I know now that initially my substance use was largely due to my need to self-medicate, to find something to numb myself. Over the years, my addiction has morphed from one substance to another, getting worse during most years, and better during some. In the past, I have been able to achieve “clean time” for many months, sometimes even years.

But addiction is a progressive disease: if you ignore it, it gets worse. It is also chronic, and it’s an ongoing process to stay in recovery. Recently, I’ve learned the difference between abstinence from substances and recovery from substance use. For me, abstinence means avoiding a substance completely but not necessarily exploring the reasons the substance may have taken the place of other coping skills. Recovery, on the other hand, means actively trying to understand the factors that led to substance use in the first place, whether we were trying to fill an emotional void, cope with stresses or escape from traumatic memories. For me, recovery includes facing those triggers, feeling comfortable with myself, healing and moving on.

There is not a “right” approach; neither abstinence nor recovery is better than the other, and they aren’t necessarily mutually exclusive. What works for one person may not work for another. The healing process is like a fingerprint: unique to each individual.

It took four leaves of absences from work over two years, severe depres-

sion and panic attacks, major anxiety, turbulent nightmares and flashbacks, as well as troubles in my personal relationships, for me to finally see that maybe I couldn’t single-handedly tackle the big issues that had been brewing since childhood. Maybe I couldn’t “just deal with” my trauma by myself.

One particular day, something clicked. I knew things had to change. For the first time, I knew that there was more to life than just barely holding on, clinging to the sides of an emotional black hole. I knew instinctively that on the other side of that hole, there was light. I made a phone call to enrol in outpatient treatment. It was the best thing I ever did for myself and my family.

Recognizing and preparing for setback

Today, I know that a setback is brewing when what I call my feeling of darkness starts to become overwhelming. I may appear okay on the outside, but inside, something feels off. If I don’t respond right away—by reaching out to a member of my support group or using one of the self-care techniques I’ve learned in the past few years—the darkness quickly takes over.

I’ve learned to pay attention to my body’s signals. When a slip begins, I may start feeling more tired, more sensitive, more irritable, more on edge.

I may isolate myself, my sleep may become irregular or I may feel the need to sleep all day. I begin to feel hopeless, like no one cares. If I don’t notice these signs or choose to ignore them or minimize their importance, I slip down that rabbit hole of self-loathing and despair.

A few years ago, I wouldn’t have had a clue how to pull myself out of these dark, dingy places. But I have begun to find different resources and learn new skills to fill my self-care recovery tool belt. I’ve listed below the seven most valuable steps I’ve taken to connect with these resources and learn these skills.

1. I found counsellors that I respect. Recovery is much easier when you make a good connection with a counsellor and develop a therapeutic relationship based on safety and trust.
2. I read books ranging from self-help to biography, true stories I can relate to, particularly stories of recovery. I’ve learned to acknowledge and accept that others have dealt with or continue to deal with similar pain.
3. I’ve turned to creative outlets like painting, drawing, colouring and writing to release what’s going on inside.
4. I’m developing my spiritual side. I’ve embraced my love of nature,

One of the most important things I’ve learned is to set boundaries. Learning how to identify what I will and will not tolerate, learning how to say “no,” is a profound act of self-love.

going for walks in the woods or by the ocean. I've started to meditate to help calm my heart and mind and encourage continuing self-discovery.

5. I've begun writing. One journal prompt I use frequently is "What am I grateful for?" I list everything I can think of. Six months in, I'm grateful for more things than ever before. That realization in itself is healing.
6. I go to support groups and hear others' stories and share my own. The sense of community connection has been integral to recovery. I reach out more to others now than I have in the past. It was scary at first, but it gets easier each time.
7. I completed an intensive eight-week addictions outpatient program. The program taught me how to increase my self-awareness and recognize the triggers that make me want to use. It gave me the tools I need to deal with the emotions that make me want to escape by using substances.

Learning how to love myself—and showing others how to do the same

A woman who helped me begin my recovery journey once posed a question that I now ask myself on a daily basis, both when things are good and when they are going horribly wrong. I've asked it over and over until I can now ask it with warmth and a smile: "What would someone who loves themselves do?" When I ask myself this question, it serves as a reminder to be kind and gentle with myself, and to love the person I am.

The seven steps I've listed above are steps I have taken—and continue to take—to love and accept myself, to

advocate for myself and my well-being and seek support when support is what I need.

When I was in my dark place, I would never allow anyone to help. I was too scared to let anyone in or to talk about what was going on. I did not want to upset anyone or allow them to hear what was hurting me. I thought that substances were the only thing that would mute that constant battle in my head.

I have learned that while I thought my emotional turmoil was invisible to my loved ones, it really wasn't. When we are in a dark place, we aren't aware that the pain we are feeling seeps out of us and infects others, who just want so bad for us to feel okay. I didn't realize that sharing that pain with others would have lessened it—for them and for me.

As I have taken steps towards building what I call my "recovery community," learning how to receive help from those who want to help, I have discovered that a lot of people struggle with the same things. They face the same sort of challenges identifying negative self-talk and redirecting it, standing up to that nasty inner critic who tells them they can't handle things. I've learned that, actually, yes, I can handle it. I've learned to accept that others love me, that I am worthy of that love, and that healing together is far better for the soul than trying to heal alone.

One of the most important things I've learned is to set boundaries. Learning how to identify what I will and will not tolerate, learning how to say "no," is a profound act of self-love. Knowing how to say "no" tells the world—and yourself—that you are worthy. Taking

care of yourself, loving yourself—and not allowing people, places or things to make you feel bad—reaffirms that one of your biggest responsibilities in life is making sure you are able to live your best life. Each of us deserves inner peace and serenity and the opportunity to live our best life.

Learning how to love myself has also made me a better mother. I used to try to hide my struggles from my children. I had a strong need to make sure everyone else was okay, and this meant trying to hide from my children anything that might make them worry about their mother. I hid things as best I could—until the pressure became too much and I would crash hard.

While I was in treatment, I learned that my need to "people-please" was keeping me from sharing myself fully with my kids. Now, as a recovering individual and a mother in recovery, I am able to be fully present with my children. They get to learn from my experiences, and I am not ashamed to tell them about my struggles. From me, they learn that we all struggle sometimes, and that when we struggle, it's important to reach out for support. I teach them how to use the tools I've learned, to recognize their triggers and their emotional cues, and how to love themselves. Together, my children and I are breaking my family's intergenerational cycle of mental health issues and substance use. I am beyond excited to be able to do this learning with them. ▽

Navigating through Mania and Depression

Leslie*

My manic depression, or bipolar disorder, is an incurable illness. But the combination of medication and self-care now helps me stay well.



Photo credit: FangXiaNuo at ©iStockphoto.com

It took me years to accept treatment. I was a hyperactive child; my attention span was limited and I often lost things. At 18, mania and depression reared their ugly heads. Every two years, stress would build up in my life and then, in May of the second year, I would cycle into mania. I would have trouble sleeping and eating as my mood got higher. My behaviour would become impulsive and reckless; my decision-making would become impaired, resulting in dangerous choices. Money ran through my fingers like water; I used all my available credit. I gave away money. I would not listen to the concerns of my family and friends as my behaviour became increasingly erratic. I spent time living on the streets. As my mood got higher, it would culminate in a rage against the people I loved

the most. Then, in August, I would sink into a dark, paralyzing depression that would last until December.

Many years ago, our family doctor gave my parents good advice: “Keep the lines of communication open.” I was sure that if I accepted a diagnosis of bipolar disorder, then I would be considered “crazy” and would be locked up for the rest of my life. But even though I actively ran away from the diagnosis and treatment, I always knew I could call home. I could count on my family.

I was finally hospitalized at age 36 after an acute episode of mania. At that point, I finally accepted that I needed daily medication to balance my mood. I have been on medication

Leslie is a retired teacher with a BA and TESOL Certificate (English as a Second Language) and has also worked in radio. She is an active volunteer with her local Mental Health Advisory Council. She advocates for mental health awareness in her northern British Columbia community

Addendum:

Just before this issue of Visions was published, Leslie had a debilitating reaction to a new medication. She spent many hours in the emergency room and was unable to leave the hospital without the aid of a cane. Luckily, she and her sister realized early that something was very wrong and advocated successfully for a medication change. Leslie now believes even more strongly in the need for people living with mental illness—and their family members—to be well informed about the illness and their medication options, and to not be afraid to advocate for changes to their health care

**pseudonym*

ever since, for the past 30 years. This also means no more using marijuana for me. Previously, I had self-medicated, thinking that marijuana helped with my symptoms. But more recent research suggests that THC can cause mania. It is not worth the risk. At my age, another episode of mania will impair brain function.

Learning how to manage symptoms

Since I've been on medication, my mood swings have been shorter and more easily managed, and I have not had many full-blown manic episodes. The medications have caused problems themselves, however. Nineteen years on a high therapeutic dose of lithium salt caused moderate kidney damage. Restricting potassium foods in my diet has helped with that. Then, a rare

reaction to divalproex sodium caused me to lose all my teeth. But these are prices I consider worth paying for my continuing sanity.

For 12 years, I was lucky to live in a city where I had the opportunity to see three different psychiatrists for different types of therapy. With their help, I learned how to recognize and cope with recurring symptoms. If I have trouble sleeping and eating, I now know to take clonazepam to arrest the mania before it escalates. But because clonazepam is potentially dangerous if it is used inappropriately, I only have a prescription for a few at a time—I use it only as an emergency measure until I can see my doctor or my psychiatrist.

Eventually, I made the decision to move to a more rural community. I

wanted to live with less traffic and be closer to nature. But while living in a smaller community has its benefits, there are also drawbacks. At the time, there was no full-time psychiatrist in the small town where I had decided to make my home, so I only had access to a psychiatrist periodically. This meant that there were periods when my mania escalated before I could access appropriate medical assistance. It was a relief when my community finally got a full-time psychiatrist. Now, I benefit from the care of a full mental health team—a counsellor, a doctor and regular psychiatric appointments.

Those of us with bipolar disorder have to be vigilant and watch our mental health closely. We have to take responsibility for monitoring our moods and we must be alert for telltale signs in our behaviour—danger signs. If I am hungry but cannot eat or tired but cannot sleep, those are my danger signs. If I sleep less than 7 hours that could mean mania is starting. If I sleep 10 hours or more, this can indicate depression. My mother and sister and husband can tell by how I talk and by my tone of voice if I am ill or well.

Once mania has begun, it is difficult to put the brakes on. My mind plays tricks on me. Mania has led me to say things and do things that I believed were necessary or true at the time. I realized only later that these words and actions were a result of my manic state—and not what I wanted to say or do once my manic state had passed. In some cases, I expressed anger towards friends who did not understand why I was treating them so poorly—until my sister explained that my explosive anger is part of the illness.



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I believe that if emergency rooms were staffed with clinicians who were better able to recognize the symptoms of bipolar disorder and the early signs of mania, then we could ensure that individuals in distress received appropriate care quickly, before the situation escalated.

When the system falls short

Once when I was manic, I managed to get myself to the hospital emergency room. The reality of triage in the emergency department means that filling out prescriptions for psychiatric medications is often the last thing on the emergency clinician's mind. But the stimulus of a busy emergency waiting room is often very difficult for someone with bipolar disorder who is experiencing the onset of symptoms—it can even make symptoms worse. In this particular case, the doctor sent me away with a prescription, but because I was already experiencing a full-blown manic episode, the prescription wasn't helpful. I was talking quickly, my thoughts were racing and I spent a lot of money. In retrospect, I know if I'd been admitted to the hospital, my manic "high" could have been arrested by calming medication. I would not have alienated friends and I would not have given my husband such a hard time.

Another time when I was manic, I was brought by two counsellors to the hospital. No doctor was available until the next morning, so I couldn't be prescribed any calming medication. I couldn't sit still, and I kept rearranging furniture in the lounge. In the middle of the night, a frustrated nurse told me that if I wanted to travel east, I should just go. I took those words to heart and headed out—without shoes and in the dark. I went straight to the bank. One of the symptoms of mania is financial irresponsibility. I am fortunate that my family has always helped me untangle the financial mess that I seem to find myself in after a manic episode. At the bank, a kind teller let me wait in the staff room and contacted my husband. When I cashed in an RRSP and bought traveller's cheques, my friend was

there to take them away from me before I gave all my money away.

I believe that if emergency rooms were staffed with clinicians who were better able to recognize the symptoms of bipolar disorder and the early signs of mania, then we could ensure that individuals in distress received appropriate care quickly, before the situation escalated. It's important that we advocate for change.

The ups and downs of recovery

Life has been rocky, even when I've complied fully with a medication regime. Luckily for me, my workplaces have allowed me time to recover after difficult episodes, with short-term disability.

Sometimes the trigger for a mood swing has been external. For example, the death of my father and, later, the death of a beloved dog sent me spiraling into mania and depression. For these episodes, grief counselling helped a lot. As did self-care. After my father died, I binge-watched 127 episodes of the *Rockford Files*, interspersed with walks with my dog around the pond. I knew from past experience that the depression would lift in time—as I walked towards the light. Light is both spiritual and religious for me. Swimming, yoga, watercolour art, writing and being taken on sight-seeing drives have all helped in my recovery from depressive episodes. Healthy eating and exercise and daily medication help keep my moods within a normal range. Blood tests every three months help my medical care team monitor my body's responses to medication therapy.

After a relapse I always feel mortified and embarrassed at the way I have

behaved while ill. I feel like I have to apologize again and again. I have no confidence.

I have been so fortunate to have family members who have always been extremely understanding and supportive, despite the vitriol I've often directed towards them when I am manic. My family helps explain to new friends to ignore and forgive the raging anger that accompanies the peaks of my mania.

The unexpected value of mental illness

Not everything about having bipolar disorder is bad. I have reaped many benefits from my sometimes-wonky brain. I have a remarkable gift of observation, I am intelligent and make connections with people easily, and my experiences living and working across this vast country have given me insights and understanding that I'm not sure I would have if my brain worked in any other way. I never want to risk losing those things.

But it has taken the outside world a lot longer to recognize that someone who has a mental illness can offer valuable insights that no one else can provide. Labels are important. I was first called a "mental health patient," then a "mental health client." Then the label changed again and I was called a "consumer of mental health services." Now, I am a "person with lived experience." Finally, a label I can accept: I feel respected for the valuable knowledge I have gained from learning how to cope with my illness. ▼

Recovery as a Collective Process

HOW EMPATHY FOR SELF AND OTHERS MAKES THE JOURNEY POSSIBLE

Samantha Stambaugh

“Every time you pick up food with your fork, your mouth opens.” This silly statement, made to me by a family member at a family function, was meant to be funny. Sarcasm, quips and dark humour were standard in my family. You laughed at the statements made about you and carried on. Everyone chuckled and that was the end of it—for everyone else.

Samantha is Co-Chair of the Family Committee for the Adolescent Day Treatment Program (ADTP East), and is a caregiver support and peer support worker. She serves on committees at Foundry-Abbotsford and the Board of Directors of the Matsqui-Abbotsford Impact Society. She loves working with youth and families with mental health challenges



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But not for me.

Growing up as a competitive figure skater, I had a long love-hate relationship with food, the shape of my body and the process of eating. I was self-conscious about the way I looked and about the way people saw me. This has left me with digestive-system problems and a body that is, ironically, overweight. Abuse in my pre-teens and early 20s intensified my need to crawl out of the body I was in.

I was always very self-conscious about the act of eating. I was a slow eater. When I sat with friends or family, they would finish quickly and I would be left alone with my food. Comments about my slow eating made things worse. I started to take smaller servings so that I'd be able to finish eating more quickly.

In junior high, the school cafeteria provoked anxiety—almost as much as the gymnasium locker room. Eating in front of people I didn't know very well

was out of the question. I discovered that drinking a couple cans of Coke instead of eating lunch gave me enough false energy to get through the day until dinnertime. I skated several hours a day and exercised off-ice as well. When PE class was running long-distance, I could sprint out my compulsive competitiveness by racing the boys to the finish line.

But there were two main problems with my approach: I hated my body no matter what I did, and I couldn't stop my stomach rumbles from echoing loudly in whatever class I was in, adding to the shame I already felt. In time, I developed anorexia nervosa.

Controlling how I dealt with food became symbolic of my desire to control other aspects of my life. The only times I felt completely free were when I was skating and when I was writing. Both activities let me bare my true self to the world with pride, not caring what anyone thought of me. I withheld judgement of myself until I was done, and no words could take away the freedom and wonder I had just experienced—the euphoria of being the real me.

But off the ice, and away from the written word, I felt I had no control of how I was seen by others. I felt invisible. Controlling my food intake and my body shape gave me a false sense of fitting in, a false power in a life where I felt powerless.

It took a lot of inner strength to pull myself out of those destructive eating patterns. I substituted with obsessive organizing and cleaning and, later on, drinking and pain killers. I experienced addiction and alcoholism and I lived

with anxiety, depression and PTSD. It took hitting rock bottom and getting clean for me to realize that my body and my mind were both important to me, and I wanted to heal. I didn't want to be invisible; I wanted to take how I had survived in life and share it with others. If I can help just one person in my lifetime, then everything I have gone through will be worth it. That sentence became my mantra.

In my 20s, I connected with a few friends who accepted me for the person I am, and they became the family I needed and craved. Their strength and belief in me helped me to eat better, get stronger and realize my passions in life. And I realized telling my story could do the same for others.

Being a good parent means taking care of yourself

It is one thing to struggle with mental health issues as a young, unattached adult. It is another thing to struggle with mental health issues when you become a parent.

My mental health challenges suddenly magnified when I became a mom. For a long time, I managed to mask how I was struggling—until my daughter started to show signs of her own mental health issues. My fear of what might be in store for her intensified. For many years, we battled our issues together—each triggering the other's anxieties and pulling each other deeper into depression. I decided to homeschool my daughter for several years: a good decision in the beginning but one that became a daunting task as time went on. I became exhausted all the time, feeling useless, like I had failed my child. My daughter became increasingly anxious of the "big bad

world" outside our doors, the crime in our neighbourhood that made the evening news. We switched the television off, but the sirens still told us what a scary world we lived in.

It was hard to reach out for help. When I did, the promised testing and resources never came through. I was left to my own devices. Computers became a crutch for my daughter and me, whether it was researching information or procrastinating on schoolwork or taking care of ourselves and our home. We had a hard time leaving our apartment—our Hobbit Hole, as I affectionately called it. When we hadn't left to go anywhere except the garbage bin out back for three weeks, I knew we were in crisis. I reached out for help again, and this time I was heard. Plans were made for each of us to get counsellors and attend classes. I realized that I needed to show my daughter—and myself—that it is okay to ask for help. Our tiny world began to open up.

I still remember the feelings of emptiness, loss of control and shame when we were in crisis. It was lonely and scary because I felt like such a failure. I couldn't give my daughter the education she needed on my own, had trouble getting us help and felt the dark pit of depression deepen as my daughter fought her own fears of failure and of letting down those she loved. Those feelings still appear periodically, but they no longer rule our lives. We have tools to work through those times, and we can help each other.

Recovery is a process

One of the most important things I've learned in my recovery process

Recovery is not something that just happens one day and then you move on. Recovery is something that I work on every day. Some days I feel more recovered and some days I feel less so. Recovery is a lifelong process.

is that the challenges I faced earlier in life have provided me with several powerful and positive recovery tools. For example, I now know the signs of when I might be battling with my eating issues and other anxieties. And I have learned to listen to the people close to me when they take the time to point out the truth about my behaviours.

I am also able to talk frankly with my daughter about her own eating issues. Together we can work out what might be in the way of her developing healthy eating patterns and practising compassion for herself, and what she might need to discuss with a therapist. Right now, we are working with the tools we have learned. My daughter does breathing exercises to control her panic attacks, and I like guided meditation to help me release stress and concentrate on the positive aspects of all situations. If, and when, we need to see someone, we have therapists we trust. I try my best to keep communication with my daughter open so that she and I both feel comfortable discussing our emotions, our mood, our eating and body-image issues and so much more.

But recovery is not something that just happens one day and then you move on. Recovery is something that I work on every day. Some days I feel

more recovered and some days I feel less so. Recovery is a lifelong process.

I have learned to listen to my own thoughts and challenge them, as well as just be there to actively listen to my daughter. It is very hard to not be in “fix it” mode when my daughter is hurting, but she is learning that she has to go through the emotions and hard times herself in order to mature and become who she is meant to be. When I forget that and give her advice, my daughter does her best to tell me not to fix it. Communication, sharing our emotions and creating a strong bond has brought us the closeness we were missing, an attachment that my daughter yearned to have. I adapt the skills I’ve learned when I work with youth who need to talk to someone they can trust, as well as with family members who need a peer who “gets it” and shows empathy without judgement.

One of the things that helps me retain a positive perspective is working with youth who are experiencing mental health and addiction issues, and their families—providing support to caregivers, young people and peers who are experiencing some of the same things that I have experienced. Being able to provide this support to someone who needs it makes me realize—in unexpected ways—how far I have come on my own recovery journey.

There isn’t a shortage of people who need a listening ear, a shoulder to cry on or a high-five for living the best day they could have lived under the circumstances. I feel blessed and deeply honoured when I can be there to give empathy to a struggling youth or a caregiver who has nothing left to give.

At the same time, when I hear the caring words I give to others, I remind myself to take my own words to heart. Anxiety, depression, addiction, eating disorders and other mental health challenges affect the mind, the body and spirit of those who live with them, as well as the loved ones who are part of their support system. It takes a lot of energy to fight for yourself and those you love—but while we are caring for others, we need to make sure we are also caring for ourselves.

My recovery is not just about me. My recovery is also the act of being there for those I love and care about, who may be affected by something that has taken over their life. My experiences can help others, and that makes my recovery journey worthwhile. ▼

In Recovery, Setbacks Are Temporary

REACH OUT FOR HELP, STAY POSITIVE AND FIND WHAT WORKS FOR YOU

Jason Zulyniak

The main reason for addiction in my life was to [help me] cope with the trauma of sexual abuse, though [the connection] wasn't blatantly obvious for me at the time. It was more of a subconscious thing. I started drinking heavily at around age 15, and soon after, when that wasn't enough, I turned to other drugs, many drugs, which became a severe problem later into my 20s. I used these drugs to cope with my feelings regarding the trauma I experienced in my life.



Jason is a 46-year-old male living in Surrey, BC

Interviewed by Darryl Lucas, Mood Disorders Association of BC (a branch of Lookout Housing and Health Society), and Kristy Allen, Canadian Mental Health Association, BC Division

I started having antisocial issues. Basically, I got in trouble when I was a kid, siphoning gas and stuff like that, committing crimes of opportunity. I never planned anything, but if something was there, I would just steal it. It was a hard go. I was in and out of jail for most of my adult life, from 15 all the way up until I was about 40 years old. It didn't just impact me. I have a wife and kids [and] I was away from [them]. My wife stuck by me, and my kids were always there so I had family around me, but it was tough on them. It was tough for my wife to survive for, like, a year while I was in jail. My career and plumbing business suffered, too—a lot

of things suffered along the way. And if you're not working, you're not going to have a place to live, either. I have personal experience with homelessness because of this.

I've never been diagnosed, but depression is one of the issues I face. And that's been pretty much for my entire life. For me, depression meant a focus on negativity. Negative thoughts overwhelmed my life. I would find the smallest negative thought and dwell on it all the time. I was extremely emotional and lost motivation in life. I had no drive to do anything. I felt my life had no meaning or purpose. My



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Reaching out to professionals greatly helped... I just got sober and started going through the paces of living a sober life instead of a drug-addicted life. Having safe, predictable and affordable housing in the last six months is the best part. That's definitely been a big help.

negativity affected everyone around me. I suffered, as did my family and friends. My negativity affected my social life, my housing and my income. It eventually led to the breakdown in my marriage and the breakdown in my housing and my estrangement from my children. I was my own worst enemy. At times I focused on negativity so much that everything else was shut out.

Reaching out to professionals—in my case, outreach workers at Al Mitchell Place and residential substance abuse treatment at Phoenix Society—greatly helped. I was at Phoenix for four months and I felt that my time there was useful. I just got sober and started going through the paces of living a sober life instead of a drug-addicted life. Having safe, predictable and affordable housing in the last six months is the best part. That's definitely been a big help.

For the last couple of months, I've also been attending counselling at Mood

Disorders Association of BC and at BC Society for Male Survivors of Sexual Abuse. My probation officer, back when I still had one, recommended [the program] and gave me the numbers to call. I go once a week. I'm just at the start of it, so it should be good being able to talk about [the past] and deal with the feelings that go along with it.

Wellness has many facets. Wellness to me is having a purpose and meaning in my life. I needed to find that again. Still, working towards my recovery is foremost in my life. What I had to do was be honest with myself, look inside and discover positive things that bring me peace and happiness. It was important to me to find my higher power (whatever or whoever that is), a connection to a deeper spirit. Basically, it's a part of my daily life now.

But things go up and down. Drug addiction has been the biggest factor in my life. Just last fall, I was struggling

to survive to keep my drug habits going. You know, I was stealing stuff from work, going into work just for a couple hours and then quitting a job so I could get paid the next day. And just stuff like that, basically. The last rock bottom I hit, back in the fall, I started using heroin. Or fentanyl, rather. Now, I've been drug-free for the past seven months.

When I experience problems again, [I've learned that] what helps is to talk to people or go to a meeting, find something positive to do. [I've learned that when I get into a place] where I don't feel comfortable, I pretty much just take myself away from that.

I have also learned not to take things so seriously but to realize some setbacks are only temporary. I have had to focus on not getting stuck in the moment, never giving up and always moving toward better health. I remain active. I exercise as much as I can. I also reach out to my supportive network so I don't fall back into negativity. My network includes people that I work with, pretty much all the people that are in my life nowadays: my dad, my friends at work, the guys I live with. I feel healthiest when I'm at work, actually—when I'm helping other people, either in my business as a plumber or as a peer support worker with homeless people.

My advice to others? Drugs are a problem, so find a way to get sober or reach out to somebody and try to find a way to get out of it. And be honest with yourself about the whole situation. Honesty helps. When you find problems returning, keep close to what you know works for you. ▽

When Psychosis Comes Back

HOW TO MAKE AND USE A RELAPSE PREVENTION PLAN

Tom Ehmann, PhD, RPsych

Psychosis is characterized by delusions, hallucinations or other phenomena that decrease an individual's contact with reality. It is a condition found in many disorders, including schizophrenia.



Dr. Ehmann has researched and facilitated service development involving psychotic disorders for over 30 years. He was lead author of the BC EPI Standards and Guidelines and the Dealing With Psychosis Toolkit. Currently he serves as consultant to the provincial EPI Advanced Practice, introducing evidence-based practices and improving services across the province

Developing a first episode of psychosis is a frightening and highly disruptive event. People who experience the onset of a psychotic disorder may be unable to go to work or school, maintain or develop social relationships, play sports, engage in hobbies or keep up with everyday activities. In short, life gets put on hold for weeks, months or even years. Since psychotic disorders usually begin in the late teens and 20s, developmental tasks—such as entering the workforce, attending advanced education and developing intimate relationships—get derailed.

Fortunately, there are Early Psychosis Intervention (EPI) programs in much

of BC. These programs operate according to provincial standards and guidelines¹ that provide the best chance for a person to recover and successfully reach developmental milestones. Other early-psychosis services may also be available in more rural areas.

What do we know about relapses?

“Relapse” is the term used to describe what happens when psychosis returns. This may include a return of hallucinations, delusions or other symptoms. Relapse is common and creates ongoing problems. The relapse rate has been reported to be as high as 80% over the first five years among persons who

were successfully treated for a first episode of psychosis.² One study done before the establishment of specialty early-psychosis services found that about two of three people treated for a first episode of psychosis had a relapse within 15 years, and one in six of these did not get better again.³

Relapses, like the first episode, disrupt life and can be demoralizing. The experience of a hospital stay, having to take time off school or work, and the stress that a relapse places on families and other relationships can lead to disappointment and fear for the future. More relapses are associated with poorer long-term outcomes, especially when the relapses are more severe and longer-lasting. The psychotic symptoms become harder to treat over time and the person becomes less able to achieve developmental goals and function reasonably well.⁴

The factors that trigger a relapse in one person may not be the same as the factors that trigger a relapse in someone else. Some factors may not affect one person at all but may be significant enough to cause a relapse in another.

One factor that contributes to relapse in many people is stopping antipsychotic medication. For example, a recent study found that 67% of first-episode clients who discontinued medication relapsed after one year.⁵ Other studies reported that poor adherence to medication can increase the chances of relapse fourfold, while substance use can increase it threefold.⁴ On the other hand, many persons who show good functional recovery may benefit over the long term with physician-monitored dose reduction or discontinuation.⁶ Other common

factors associated with relapse include the following:

- the use of drugs such as amphetamines and cannabis
- psychosocial stressors such as interpersonal problems, poverty and homelessness
- being male
- not being actively involved in education, employment or training after onset
- slow initial onset of the psychosis
- treatment delays at onset of psychosis
- previous psychiatric-hospital admissions^{3,5}

What can be done to avoid relapses?

The problem of relapses means that prevention, or at least the goal of making relapses shorter or less severe, should be an important part of a treatment plan. The following steps can help:

1. Getting into an EPI program. Specialist early-psychosis programs like EPI prevent relapses, lessen the severity of relapses and decrease the need for hospitalization more than typical mental health treatment services.⁴ Specialty services consist of a set of intensive interventions, supports and principles that consider the age and stage of the person and are delivered as a complete package with frequent contact from knowledgeable staff. Research has yet to determine exactly what elements make services like EPI better, but we do know that if the package is properly delivered, then the outcomes are superior to those we can expect from typical mental health care services.

2. Following the treatment plan. If reducing antipsychotic medications is part of the treatment plan, the client should work closely with the psychiatrist to do it exactly as planned and with very close monitoring. Besides regular visits with a clinician, knowing how to monitor response to the treatment plan is important.
3. Developing a relapse prevention plan. Within EPI, every client must have a relapse prevention plan. This plan is used by the client, the clinician and the family. The clinician should provide a written copy to the client and the family, and include the plan in the client's chart. Relapse prevention plans should be reviewed and updated regularly. Even if the client doesn't have access to an EPI program, the client and the clinician can work together to develop a plan.

What does a relapse prevention plan look like?⁷

A relapse prevention plan acts as an individualized blueprint for monitoring when a relapse might be starting so that intervention can happen quickly and effectively. The plan starts with having a good treatment team and includes identifying early warning signs of a relapse and options to minimize the factors that could be triggering the relapse.⁸ The plan requires that the client look back at what happened in the months before they became psychotic, think about what symptoms and changes they first experienced and consider how they coped with those symptoms and changes. Every person is different when it comes to triggers, warning signs and the best ways to cope or intervene.

A relapse prevention plan includes three sections: a list of potential triggers, early warning signs that a relapse may be starting and descriptions of supportive plans in the event that a relapse occurs.

Triggers are factors that increase the risk of psychosis flaring up. Triggers vary but often include drug or alcohol use or different kinds of stress like conflicts; work, school or family problems; poor sleep; and disturbing events.

Early warning signs are signals that something is not right. Many people experience changes in behaviour, thoughts or feelings before other symptoms of psychosis appear. Common early warning signs can include

- changes in sleeping patterns
- changes in mood
- difficulty concentrating
- increased sensitivity to sound, light or colour
- increased or decreased talking
- lack of enjoyment
- decreased personal hygiene
- lack of desire to do things or spend time with family or friends
- increased annoyance with others
- increased suspicion of others

Early warning signs may be normal responses to stress. Responding to early warning signs by doing things that reduce stress helps reduce the risk of relapse.

The third section of the relapse prevention plan is devoted to supportive plans, which can include plans to

- contact people who can provide support, like an EPI clinician

or psychiatrist, family or close friends, and share the plan with them

- increase contact with a clinician
- stop drug use other than prescribed medications and avoid other potential relapse factors
- reduce stress by using relaxation strategies, minimizing stressful tasks and engaging in calming or enjoyable activities
- engage in medication strategies (pre-arranged with a psychiatrist)

such as increasing the dose or using another type of medication for a short time

The return of psychosis doesn't mean that watching for early warning signs won't be helpful. Sometimes it takes time to figure out which early warning signs to watch for and how best to intervene. The relapse prevention plan provides the tools to do just that. ▾



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Inpatient Occupational Therapy

A TOOL FOR OVERCOMING RELAPSE AND CONTINUING THE RECOVERY JOURNEY

Shu-Ping Chen, PhD, OT Reg (Alberta)

When people stay in inpatient settings (that is, stay a period of time in hospital and receive hospital mental health services), they experience particularly tough times when symptoms return because they have lost contact with their everyday lives and familiar routines. The primary role of an occupational therapist (OT) is to help people resume their lives in the community quickly following short-term hospitalization and to ensure the continuity of their recovery journey.

Dr. Chen is an assistant professor in the Department of Occupational Therapy, University of Alberta. Her research focuses on promoting recovery of individuals with mental health issues and enabling them the freedom to engage in meaningful activities. She is the author of Recovery Education Program for Inpatient Mental Health Providers



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Occupational therapists care about what people want to do, what people need to do, the skills people need and the environment that impacts a person's ability to do the things they want and need to do. When a person cannot concentrate on a task due to psychiatric symptoms, the occupational therapist works with the person to find their preferred way to manage or cope with symptoms, and changes the environment to help the person accomplish the task.

For example, occupational therapists teach people how to drown out voices in their heads (by listening to music on headphones, for instance), to actively distrust the voices (by questioning them) or to change their environment (by finding a relaxing, safe place, for example) so that the individual can undertake a meaningful activity. We understand that an episode or relapse of psychotic symptoms can be a traumatic life crisis that results in feelings of loss and shame. Occupational

therapy helps people find meaning for what happened (making the psychotic experience meaningful and acceptable in people's recovery journey) so people can integrate the understanding into a new sense of self and retrieve a sense of control.

In the words of one patient, occupational therapy "gave me something else to ... focus on. I had my mind off of my problems basically and my feeling of being a nobody and I could focus on doing this and it was something that I'm learning to do and that I can do it... it was a step I took to self-confidence."¹

Occupational therapists collaborate with people to develop their goals and to create action plans to achieve those goals. During this process, an OT supports the person to discover and identify their strengths and to promote a positive sense of self, with a focus on assisting the person to engage in meaningful activities—often by participating in those activities themselves. Yes, actually doing the activities that are meaningful and important to the client is the primary strategy of occupational therapy.

The underlying purpose of the meaningful activities varies widely. For example, an activity can offer the opportunity to practise daily-living skills (such as banking, grocery shopping and laundry), establish social relationships, build self-confidence, or develop positive thoughts and hope. Activities can be completed alone or within groups. Even in a restricted inpatient setting, occupational therapists can provide a range of opportunities for activity participation. For example, they can use the activity

The ultimate goal of occupational therapy in the inpatient setting is to foster a positive cycle of hope, empowerment, life meaning and personal growth—and to make that process as seamless as possible in the transition from inpatient setting to community.

of cooking to focus on a person's past role as a cook, they can use exercise to promote physical well-being, they can use tabletop games to have fun and to encourage social interaction, or they can help plan and host a bake sale to incorporate the skills of event planning, baking, selling and money management.

Families' assistance in meaningful activity participation can promote the progress of a personal recovery journey. Occupational therapists always work closely with families to facilitate the families' participation in supporting their loved ones' recovery. Occupational therapists help families learn how to provide appropriate supports and build on family strengths to encourage positive joint activities, such as eating meals together, going for walks, or even just sitting and talking about things in a supportive family context.

There are four core elements of occupational therapy in an inpatient setting:²

1. **Assessment.** The occupational therapist carefully assesses what the person used to do in the past, what the person wants to do currently and what the person hopes to do in the future. This

includes assessing the person's ability and strength to perform those activities and the barriers that the person faces in doing so. To make their assessment, the OT uses a range of assessment tools (such as the "Personal Recovery Outcome Measure"³) as well as close observation.

2. **Individual therapy.** When individual therapy begins, the OT can help a person to set recovery goals and then to work towards these goals. If a person is involuntarily admitted to the hospital or admitted in a crisis state, the occupational therapist recognizes and addresses the person's unique barriers and needs in this state, such as lack of motivation, anxiety or disturbed cognitive and behavioural function.

Solution-focused, brief therapy is one of the interventions used to affirm a person's feeling of anxiety and encourage them to refocus on the self and on possible solutions. The OT helps people clarify what they want to happen in their lives (e.g., "I want my own place"), design strategies to bring them about (e.g., finding resources for independent housing), and

co-construct solutions (e.g., practising independent living skills). The OT encourages the person to stop doing what doesn't work and do more of what does, and helps them change their thinking and actions to be more positive and solution-oriented. On a practical level, the OT will identify all the things that could potentially go wrong, discuss the possible positive and negative consequences of each risk, and then work together with the person to identify actions that reduce negative consequences.

3. **Group therapy.** Occupational therapists also use a wide range of therapeutic groups, depending on the facilities and resources available. These groups can be activity-based or support-based. Inpatient group settings provide opportunities for social interaction, sharing of experiences, learning from each other and practising skills. A typical group might focus on education to understand the illness, stress and anxiety management, lifestyle management, arts and crafts, leisure, gardening or activities of daily living (e.g., doing laundry or grocery shopping).

4. **Discharge planning.** Part of the recovery process in an inpatient setting is putting in place plans to help the person solve problems they may encounter once they leave the hospital. These problems can include issues involving finances, housing, relationships, employment, education and finding resources such as community rehabilitation programs. People and their families and support

networks need ongoing support after the client has left the hospital. The occupational therapist ensures that the transition process from hospital to community is smooth and that the client receives the mental health services they need without interruption. Occupational therapists integrate community resources (for example, the community agencies that provide employment services) and connect them to people and their families.

The ultimate goal of occupational therapy in the inpatient setting is to foster a positive cycle of hope, empowerment, life meaning and personal growth—and to make that process as seamless as possible in the transition from inpatient setting to community. Occupational therapists actively convey their belief in people to be an agent in their recovery, envisioning a future life for the client even when they are hospitalized. Occupational therapy encourages people to make decisions to empower themselves and increase their sense of self-worth and helps people to find and use their strengths to achieve their goals.

By encouraging and ensuring a client's activity participation, occupational therapists show the acutely ill individual how to take the first steps in the recovery process on the way towards returning to health and re-entering the community. As one patient summarized, occupational therapy "[makes] you feel good. I thought, Oh boy, I can do this ... then maybe I can do the banking or make myself a decent meal ... it grows from there."¹

For more information on finding an OT in BC and using occupational

therapy as a tool in the recovery process, try the following:⁴

- contact a local hospital or community health care centre to determine if occupational therapy services can be accessed as an outpatient or in your home
- ask your family doctor or other health care professional (e.g., a psychiatrist or nurse) for a referral to occupational therapy
- if you have extended health coverage (e.g., Blue Cross, The Cooperators, SunLife), contact your coverage provider and find out if occupational therapy is covered under your plan
- use the "Find an Occupational Therapist in BC" tool (www.caot.ca/site/findotbc) to access OTs in your area. ▼

No Improvement Needed

HOW PRACTISING MINDFULNESS TAKES US BEYOND SELF-IMPROVEMENT TO A DEEPER SENSE OF WELL-BEING

Brandi Matheson

In a world where we are bombarded with *bigger, faster, better*, it's not surprising that many of us have become fixated on the idea of self-improvement. Let's face it: most of us are familiar with the notion that we need to improve ourselves in order to be happier, healthier, more successful and loved. Perhaps we have tried countless ways to change ourselves through diet, exercise, therapies and achievements, or by engaging in practices like yoga, mindfulness and meditation.



Brandi is a mindfulness-based stress reduction teacher (through the University of Massachusetts' Center for Mindfulness) and a certified trauma-informed yoga teacher. She formerly worked at Communitas Supportive Care Society, including time as the manager of Centennial Place, a mental health clubhouse in Mission, BC. She lives in the Fraser Valley

Brandi Matheson

As a recovering self-improvement seeker, I too have been fooled by the notion that if I just bettered myself in some way, my suffering would vanish, never to return. In fact, my work in the mental health field, as a support worker and as the clubhouse manager of Centennial Place, a mental health clubhouse in Mission, BC, was rooted in the understanding that we need to "get better." This idea that something is wrong and that it needs to be fixed

or cured underlies our current medical and mental health systems; it is what fuels our society's "need to improve" mindset. Like many other people, I spent much of my time looking for ways to save people (including myself) from experiencing the blips and dips of life.

This explains my initial excitement when I first stumbled across the practices of mindfulness and meditation. I immediately saw

Mindfulness is not just about paying attention, but about how we pay attention. If our attention is rooted in judgement and expectation, it will be more difficult to feel at ease with how things are. And accepting how things are is the key ingredient for reducing stress and supporting healing.

mindfulness as this amazing New Age technique that would finally satisfy my need to improve myself by eliminating all that was wrong. But the more I studied the practice of mindfulness, the more I understood that mindfulness, in its essence, is the practice of paying attention to how things are, beyond the fixed ideas of what is wrong or right.

An ancient practice that fulfills contemporary needs

Mindfulness as a practice is actually a very ancient art—its origins go back 25 centuries. But contemporary meditation and mindfulness practitioners and researchers have pointed out that the skills of mindfulness practice are timeless, just as beneficial in our modern society as they were in the ancient world.¹

I was enthused to share what I was learning about this powerful practice with the members at Centennial Place. It didn't take long for mindfulness to become the most popular program we offered: the majority of our referrals expressed interest in it, and often, their participation in the program led to remarkable results.

That said, mindfulness meditation may not be possible for an individual

in acute distress. Someone in a state of crisis does not feel enough safety in their internal system to be able to fully engage in the practice. In these cases, other "lighter" mindfulness techniques can be of great value. Even simply directing an individual's attention to what is happening externally rather than internally—helping them focus on the outside world—can be helpful.

Jon Kabat-Zinn, a scientist, medical researcher and meditation teacher known for bringing mindfulness to mainstream medicine and society, talks about the Seven Attitudinal Qualities of Mindfulness in his book *Full Catastrophe Living*.² These qualities can support you to cultivate feelings of betterment by accepting yourself just as you are—right now. I've paraphrased these qualities below, with suggestions for practising each of them in our everyday life.

The Seven Attitudinal Qualities of Mindfulness

Mindfulness is not just about paying attention, but about how we pay attention. If our attention is rooted in judgement and expectation, it will be more difficult to feel at ease with how things are. And accepting how things are is the key ingredient for reducing

stress and supporting healing. It is no wonder that Kabat-Zinn emphasizes how we pay attention in his Seven Attitudinal Qualities.

1. A beginner's mind

As adults, we become conditioned to see ourselves through our past experiences and habits. We tend to judge ourselves based on how much better we think we should be doing. Such conditioning stifles creativity and limits self-potential. By cultivating the quality of a beginner's mind—seeing things with fresh new eyes—we can learn to see ourselves beyond such limiting self-beliefs that keep us stuck in the same place.

In our daily lives, we can practise a beginner's mind by regularly stepping outside our comfort zone and trying new things. For example, if we see ourselves as an introvert, we can try making small talk with a stranger in a grocery line-up. If we see ourselves as an extrovert, we can try setting aside a time for solitude. Challenging our limited beliefs about who we are by trying things we don't normally do opens us up to new worlds of possibility.

2. Non-judgement

Disapproval and judgement are often interwoven with our belief in the need for self-improvement. This makes it very difficult to feel at peace within oneself. By cultivating the quality of non-judgement—an open-minded awareness of self—we can learn to recognize the judging mind without getting caught up in the judgements it makes.

To practise non-judgement in our daily lives, we can learn to be aware of our continuous judgements about our inner

experience. Once we recognize those judgements, we can re-frame them, with kinder words and thoughts.

3. Patience

We live in a world of immediate gratification, and we often suffer if we feel things aren't progressing fast enough. When we cultivate the quality of patience—allowing life to unfold in its own time—we experience the peace that arises from not hurrying the natural processes of life.

To cultivate more patience in our daily lives, we can learn to let go of any rigid timelines we may have set to achieve our goals without giving up the earnest effort we are making towards achieving those goals.

4. Non-striving

In contemporary Western culture, we tend to be driven by our goals and the outcomes of our attempts to achieve those goals. We expend effort trying to get what we want or get more than what we have. By cultivating the quality of non-striving—by doing less, and by accepting where we are and what we have—we find, ironically, that we move ahead precisely because we are not trying so hard to move ahead.

In our daily lives, we can practise non-striving by taking time each day “to be” rather than “to do.” Meditation is an excellent way to practise being with yourself without any agenda or expected outcome.

5. Acceptance

When it comes to self-transformation, we must learn to accept ourselves first. When we cultivate the quality of acceptance—seeing and accepting

things as they really are—we can learn to appreciate ourselves as we are right now, without needing to change a thing. That, in itself, is self-transformation.

We can practise acceptance in our daily life by cultivating a sense of humour about our experiences, learning how to see our own personality quirks, worries and fears—seeing ourselves as a unique element of the human experience.

6. Letting go

It's impossible to grow when we don't have enough space. By cultivating the quality of letting go (of things we do not need as well as negative emotions or thoughts that take up space in our awareness), we can create space for new opportunities.

When we practise letting go, the breath becomes our greatest teacher. With each exhale, our bodies experience a sense of release. So, whenever we notice we are holding onto something too tightly, we can turn towards our breath, allowing each exhale to teach us how to naturally let go, both physically and emotionally.

7. Trust

We are all born with an intrinsic wisdom, one that is eroded over time by our self-doubt and insecurities. By cultivating the quality of trust in our instincts—an inner confidence—we can develop faith in our intuition and our ability to make skilful decisions and choices.

In our daily lives, we can learn to practise trust by listening to the voice of our own basic wisdom and goodness, and by allowing that to be our

guide rather than following the voice of another.

Mindfulness and the Seven Attitudinal Qualities are not a quick fix; they are an invitation to take part in a lifelong practice. The goal is not to achieve a particular result, but to take part in the ongoing process. Practising mindfulness will not rid you of all your insecurities overnight. But by cultivating the qualities of mindfulness, you can step off that hamster wheel of self-improvement and step into your life, just as you are.

If you would like to learn more about mindfulness and the Seven Attitudinal Qualities, taking a mindfulness-based stress reduction (MBSR) program is a great way to do so. Find one near you at www.mbsrbc.ca. Or pick up a copy of Jon Kabat-Zinn's *Full Catastrophe Living* at the bookstore or a library. ▽

WRAP and Roll

EMBRACING THE WELLNESS RECOVERY ACTION PLAN, HARNESSING PEER SUPPORT AND LIVING YOUR BEST LIFE

Hazel Meredith, MA

Many of us have experienced mental health challenges and worry that we might experience them again. How can we better prepare ourselves for living our best life, despite these challenges?

Hazel is a WRAP facilitator dedicated to leadership and innovation in mental health care and substance use. In 2010, she helped spearhead the program's development on Vancouver Island. Hazel has a bachelor's degree in psychology and conflict resolution. Her master's thesis (2017) focuses on early psychosis, peer support and health care transformation



Photo credit: SDI Productions at ©iStockphoto.com

The Wellness Recovery Action Plan® (or WRAP®) is a structured approach designed to help each of us develop our own personalized wellness toolbox. WRAP's founder, Dr. Mary Ellen Copeland, developed the program as she helped her mother cope with serious mental health challenges in the late 1990s.¹ Since its creation, WRAP has been hailed as an effective relapse prevention tool.²

The WRAP program helps participants to create a document that lists the

goals they would like to achieve for their wellness, and then to develop six wellness action plans. I think of this as "earthquake preparedness" for mental health. When we find ourselves facing a mental health challenge and sense that our foundations are starting to shake, we can pull out one of our action plans. WRAP helps us develop these plans when we are well so that we have something to hang onto when we are struggling. As our health ebbs and flows, we can update our WRAP to reflect our changing needs. The

WRAP document is a living document, intended to be useful to us as we grow and change over time.

Although you can create your own WRAP with or without a WRAP-trained guide, participating in the program in a group setting can lead to shared wisdom and help build a supportive community. WRAP encourages us to identify five people as our key supports, including professional helpers, family and friends. Facilitated WRAP workshops are a great opportunity to expand your personal network.

How WRAP works

The first step in the WRAP program is to make a list of the activities that make you feel good—things that you, personally, need to do in order to feel healthy mentally, physically and emotionally. Some things on your list may be the same as the things on another person's list, but ultimately, your list will be unique to you. Everyone needs different things to feel content, happy and well.

Once you have made this list, the next steps of WRAP will help you overcome a challenge and improve your well-being.

Meet Jessica.* Jessica is a 24-year-old single mother of two toddlers. She is finding it difficult to adjust to her role as a responsible, single mother. She frequently drinks a lot of alcohol at parties with her friends and occasionally smokes marijuana. But as a mother, Jessica is motivated to change. She wants to return to school to become a dental hygienist so she can support her young family and move out of her parents' basement suite. She began writing a WRAP for herself

and is working on implementing her preparedness kit to improve her life, achieve her goals and keep her well.

1. Develop a daily maintenance plan.

Using the list of activities that make you feel content and happy and well, come up with a daily plan that maximizes the health benefits of these activities. The plan should include dedicated time and space to do at least one of these activities every day.

Jessica knows that every day she needs to get her kids up, feed them breakfast and get them dressed. She needs to do the same for herself. Jessica likes to go to the park most mornings so she can socialize with other parents and let the kids play with other children. If she doesn't do this, she feels isolated. When the kids nap in the afternoons, Jessica likes to read, relax or do some light chores. Using these activities as a guide, Jessica develops a daily maintenance plan for a typical day—a list of all the things she needs to do to maintain a sense of balance in her life.

2. Acknowledge your stressors.

The next step in the WRAP program is to write a list of your personal stressors. Take the time to think about the things in your life that can trigger unhealthy coping behaviours. Be as detailed as possible so that you can anticipate as many potential triggers as you can.

One of Jessica's key stressors is loneliness. She gets frustrated when she is lonely, especially in the evenings after the kids have gone to sleep. Another stressor is financial instability. She knows that night classes at her local college would help with loneliness, but she doesn't have enough savings

to enrol. This makes her feel both frustrated and angry. She often has the urge to drink alcohol when she feels this way.

3. Learn your early warning signs and generate ideas to address them.

Next in the WRAP program, write down a list of your "early warning signs"—what you feel when you haven't successfully calmed your stressors. Think about the physical and emotional cues that tell you when you are about to engage in unhealthy behaviours.

For Jessica, the primary early warning sign is a strong urge to drink alcohol. By thinking about how this urge manifests itself in her body, Jessica had the opportunity to get to know herself a bit better. She also came up with ideas for addressing those early warning signs. She realized that if feelings of loneliness, frustration and isolation triggered her urge to drink, then it was important to minimize opportunities for those feelings to build. She decided that if she felt

related resource

To learn more about WRAP, recovery, peer support and our services at Mental Health Recovery Partners (MHRP) South Island, visit www.mhrp.ca and click on the South Island link, or like us on Facebook at [facebook.com/MHRPSouthIsland/](https://www.facebook.com/MHRPSouthIsland/). You can also view information videos at youtu.be/ti6GU2il4hg and youtu.be/QLAqNO5lm3w.

lonely, she would invite a friend over or ask her parents to babysit so she could go out for coffee. She decided that getting a part-time job in the evenings would keep her busy and help her earn money for school. She also decided to attend a support group for people facing alcohol challenges. She shared this wellness plan with her parents, two close friends and, eventually, the manager at her new part-time job at a coffee shop. These people are now Jessica's support team.

4. Learn how to recognize when things break down, and have a plan.

Having a wellness plan does not mean we are always successful in following it. It's important to accept that there will be setbacks and to be forgiving of ourselves when they occur. Equally important is being able to recognize a setback and knowing what tools we have to deal with it.

Sometimes, despite her hard work, Jessica gives in to her addiction, goes out at night and drinks too much. The next day, she feels sick and she often misses work. She finds it very difficult to cope with her children when she is suffering the effects of a party night with friends. This situation can very quickly escalate. WRAP encourages us to delve into our toolkit when things are breaking down to help us get our wellness plan back on track. When this kind of situation happens, Jessica attends several support meetings over the next few days and then picks up a few extra shifts at the coffee shop. She limits her evening interactions with friends so as to not be enticed to drink, and focuses on making connections with other parents in the neighbourhood park.



Photo credit: SDI Productions at ©Stockphoto.com

People of all ages can use the WRAP program for recovery or management of a range of issues — from mental health challenges to trauma, weight loss, health management and building self-confidence and meaningful relationships

5. Make a crisis plan.

The WRAP program encourages us to put a plan in place in the event of a mental health crisis. The thought of making such a plan makes Jessica feel weary but she knows that relapse is part of the recovery process and that a crisis event could happen.

Jessica has asked her parents to take over the primary care of her children if a crisis happens. She has also asked them to take over her finances and to inform her employer that she will be away for a period of time. Jessica has decided that if such a crisis were to occur, she would check herself

into rehab, where she would receive specialized care and services to help her remain sober and well enough to be responsible for her children.

6. Make a post-crisis plan.

After our mental health is no longer in immediate danger, we still need to have in place a detailed plan for continued recovery — one that minimizes the chances for another crisis. Jessica's post-crisis plan includes having her parents keep a close eye on her to encourage her to remain sober and be present for her kids. When they all feel she is ready, Jessica will resume control of her finances and return to



MHRP and peer support networks

Mental Health Recovery Partners (MHRP, previously the BC Schizophrenia Society (BCSS) Victoria, BCSS Nanaimo and BCSS Campbell River) recognizes the value of peer support within the framework of the WRAP program and mental health advocacy generally. A strong peer support relationship complements clinical care and can strengthen the positive outcomes of WRAP participation. At MHRP, we have made peer support a guiding principle of our work and service environment. Peer support includes support from family members and peers with lived experience of their own mental health challenges.

Since 2010, all MHRP employees have been able to opt in and develop their own WRAP. My colleagues and I

share a common WRAP language and ethical outlook. Not only do we provide a support network for each other but we also exercise this deeper understanding in our work with clients.

In addition to having hosted over 35 WRAP programs since 2010, with over 420 participants, MHRP South Island has unveiled a comprehensive 40-hour peer support training module, authored by WRAP consultant and facilitator Jenn Cusick. The module has been successfully piloted locally and in Alberta. Over the next year, we hope to train more peer supporters locally and beyond.

work. Jessica will attend her support group as much as possible and try to socialize with people who support her sobriety.

People of all ages can use the WRAP program for recovery or management of a range of issues—from mental health challenges to trauma, weight loss, health management and building self-confidence and meaningful relationships. WRAP facilitators are not there as experts but rather to share, shoulder-to-shoulder, the experience of living in the WRAP recovery-oriented way. Many family members find it helpful to participate in the program

themselves. We cannot create a WRAP for someone else, but we can benefit from our own WRAP program and then share the language and concepts with our loved ones. ▾

HeretoHelp: Preventing Relapse of Mental Illnesses

www.heretohelp.bc.ca/infosheet/preventing-relapse-of-mental-illnesses

Find tips, strategies, and activities to help you understand your own early warning signs, identify important supports in your recovery, build healthy coping skills, and seek help when it's needed.

Anxiety Canada

My Anxiety Plan

maps.anxietycanada.com

My Anxiety Plan is a free resource for adults and youth who experience an anxiety disorder. Learn skills based on cognitive-behavioural therapy to manage symptoms and prevent a relapse.

Canadian Institute for Substance Use Research

You and Substance Use: Stuff to think about...and ways to make changes

www.heretohelp.bc.ca/workbook/you-and-substance-use-stuff-to-think-about-and-ways-to-make-changes

A workbook for people thinking about changing their substance use. The information and tools help you think about your own unique relationship with substances so you can make changes that better meet your goals.

Alcohol & Drug Information and Referral Service

1-800-663-1441 or 604-660-9382 in the Lower Mainland

Find substance use recovery supports on your area, such as SMART Recovery and Alcoholics Anonymous. It's free, confidential, and available 24/7.

Wellness Recovery Action Plan (WRAP)

www.mentalhealthrecovery.com

Find information and resources from WRAP, an approach that helps people manage their mental health and live well. To find a WRAP course near you, talk to your local mental health team or community mental health organization.

Early Psychosis Intervention

www.earlypsychosis.ca

In addition to connecting people with help during their first episode of psychosis, Early Psychosis Intervention offers information and resources for people who have already been diagnosed and are working on recovery. You can also download the *Dealing With Psychosis* workbook for managing psychosis and preventing relapse at www.earlypsychosis.ca/resources-and-downloads.

BC Psychosocial Rehabilitation Advanced Practice

www.psyrehab.ca

Psychosocial rehabilitation (PSR) includes effective recovery-oriented approaches (including in areas like employment, education, leisure and wellness) for people with more persistent mental and substance use disorders. PSR Advanced Practice is a space and resource supporting service providers through knowledge sharing. Find tools, webinars, events and learn from other providers.

 This list is not comprehensive and does not necessarily imply endorsement of all the content available in these resources.



Suite 905, 1130 West Pender Street
Vancouver BC V6E 4V4 Canada

