



# the columns

## correspondence

### Recovery: beyond mere survival

Sir: David Whitwell (*Psychiatric Bulletin*, October 1999, **23**, 621–622) argues that 'recovery' is a myth, promulgated by over-optimistic therapists of all persuasions. If 'recovery' means getting back to exactly how you were before (as he argues), then no doubt he is right, at least for many people with significant mental health difficulties. But the mental health world needs optimism – not over-optimism, that a person can rebuild a satisfying, hopeful life and contribute to society despite the continued presence of mental health problems. Indeed, this is precisely how recovery is defined in the now extensive American literature: there is no way back to life before problems started, but there is a way forward (Deegan, 1988; Anthony, 1993; Young & Ensing, 1999).

The experience of physical disability shows just how powerful this type of 'recovery' can be, even in the face of the most extreme impairment. After Jean-Dominique Bauby's massive stroke he could only move one eyelid, his sole means of communication. There is no doubt that he would have agreed with Whitwell's interviewee who said that 'I will never be the same person again'. However, he was able to find some meaning and purpose, however, limited, in his highly restricted new life in 'writing' what the *Financial Times* described as, "one of the great books of the century" (Bauby, 1997).

As Patricia Deegan (1988) puts it:

"Recovery does not refer to an end-product or result. It does not mean that my friend (with quadriplegia) and I were 'cured'. In fact, our recovery is marked by an ever-deepening acceptance of our limitations. But now, rather than being an occasion for despair, we find that our personal limitations are the ground from which spring our own unique possibilities."

Whitwell's interviewees at times seemed to be equivocal about whether they had, in fact, 'recovered' – an ambivalence from which Whitwell concluded that they did not think they had recovered. Here there seems to be some confusion between

recovery as an ongoing process and 'being recovered' as an end-point. Deegan (1988) makes precisely this point when she argues that recovery does not mean 'cure', it is not an end-point – 'recovered' – but a continuing journey: "... an ongoing process. It is a way of life. It is an attitude and a way of approaching the day's challenges" (Deegan, 1992).

The challenge for service providers is how to reduce the barriers which impede the re-building of a person's life. How to help people to gain more opportunities: for work, income, friends and social networks. Whitwell also illustrates the importance of helping people to appreciate the "strength they have derived from the damage they have sustained and overcome".

People 'disabled' by mental health problems can do more than just 'survive'. If the Disability Rights Commission, coming into force in April 2000, succeeds in breaking down some of the barriers of discrimination faced by mental health service users; and if professionals follow the National Service Framework recommendation to support users in gaining social inclusion – then chances for recovery could increase. Not cure, but new meaning.

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Sir: I read with interest Dr Whitwell's comments about the myth of recovery from mental illness (*Psychiatric Bulletin*, October 1999, **23**, 621–622). The topic, particularly resonated with me as the institution where I work is being featured in a television series entitled 'The Talking Cure' (my italics). I would agree with Dr Whitwell's premise that we live in an age where expectations are high and there is a pressure on psychiatrists to provide 'solutions' or 'cures' through whatever treatment they offer be it psychotherapy, pharmacotherapy or some combination of the two.

It seems to me that the current emphasis on clinical governance and evidence-based medicine as well as the need for randomised-controlled trials to prove that our treatments are effective is part of this culture. While I would not argue against the value of quality assurance and evidence-based medicine, perhaps a more realistic appraisal, in broader terms, of the likely outcome of our treatment is needed.

The most up to date antipsychotics do not 'cure' schizophrenia in the same way that psychodynamic psychotherapy does not cure people with borderline personality disorders. In child psychiatry there is a pressure for clinicians to provide a cure for conditions such as Attention-Deficit Hyperactivity Disorder (ADHD), with medication such as methylphenidate. ADHD is increasingly regarded as a 'thing' that can be 'cured' whereas it is actually more of a conceptual tool which may help us to address a complicated area of child psychiatry. Of course, we often do offer valuable therapeutic interventions, otherwise what would be the point of us existing, but let us be realistic about what we can achieve. In this way too, patients may feel more empowered to find their own ways of alleviating their difficulties without relying excessively on clinicians.

Essentially, I would agree with Dr Whitwell that the desire for complete or absolute cure is a primitive one. Sometimes after a session with a particular family or child I wonder what help I have offered them. It may well be that they



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have found their contact with psychiatric services useful, but I find that I need to let go of the desire to solve all their problems or offer them a way of escaping all their difficulties. This is how it is with mental illness generally. I believe we need to be more realistic about what we can offer our patients in terms of 'recovery' while at the same time always working with them to alleviate their difficulties in the hope that things will improve.

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## Community Treatment Orders

Sir: Two recent articles (*Psychiatric Bulletin*, November 1999, **23**, 644–646 and *Psychiatric Bulletin*, November 1999, **23**, 647–648) continue the debate surrounding the proposed introduction of Community Treatment Orders (CTOs). Having experience in the use of CTOs in Victoria, Australia it is our contention that a CTO does not confer any advantage to the patient in comparison with a comprehensive community care. Indeed, we observed that their use frequently served to alienate patients from mental health services.

In reviewing CTO usage McIvor (1998) highlights the paucity of research in this area despite their widespread implementation in Australia and New Zealand and suggests the need for controlled trials in order to justify their continued use. Burns poses the question, 'is there a group of patients who are poorly served by the present legislation who are currently repeatedly subject to compulsory admission and whose welfare would be better served by a CTO?'. In our endeavour to practise evidence-based psychiatry surely the question must be, 'Can a patient be subject to a CTO in the absence of proven efficacy?'

## Reference

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Sir: I think Professor Burns (*Psychiatric Bulletin*, November 1999, **23**, 647–648) is quite right to point out that most psychiatrists can think of 'a handful' of

patients who would truly benefit from a Community Treatment Order (CTO). The criticism though that Moncrieff & Smyth are posing the wrong question (*Psychiatric Bulletin*, November 1999, **23**, 644–646) "How can psychiatry control antisocial behaviour?" is slightly unfair. The genesis of the currently proposed reforms can be traced back to Frank Dobson's widely publicised comments on the Michael Stone case, that community care had failed because psychiatrists had not been using their power to treat people in the community. Of course psychiatry possessed no such power at the time of Mr Dobson's ill-informed comments, but Mr Dobson never retracted this statement and the government has gone on to propose CTOs. College caveats aside, it is, therefore, correct to view the CTO as the Government's attempt to hold psychiatrists accountable for the behaviour of dangerous people who have had contact with psychiatric services.

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Sir: I write regarding the two articles on Community Treatment Orders by Moncrieff & Smyth and Burns (*Psychiatric Bulletin*, November 1999, **23**, 644–646 and 647–648).

My concern is that occasionally a patient who stops his or her antipsychotic medication, against advice, remains well for some years at least.

I know of no way to predict this. Thus, some people may be forced indefinitely to take medication they do not need.

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## Mobile telecommunications and agoraphobia - a modern treatment advance?

Sir: I wish to report how the advent of new technologies may be influencing the ways in which patients manage their own symptoms.

It recently came to my attention that a husband and wife had devised a method by which they had been able to extend the period of time in which a profoundly agoraphobic patient was able to be independent of their spouse, both inside and outside the home. By both parties of the marriage having a mobile telephone in their possession it allowed, in this case the husband affected with a considerable degree of agoraphobia, to spend considerable periods of time on his own without developing a severe degree of anxiety and fearfulness, with accompanying panic symptoms and an urge to either return

home or seek the company of his wife. There is, therefore, an increased degree of security knowing that help is at hand if symptoms recur. An example of this is that he is now able to spend long periods of time fishing, away from the home, an activity he found intolerably stressful previously, as he became acutely concerned if he was not able to return home immediately, or did not have access to a means of transport to do so. Therefore, his anticipatory anxiety has been alleviated by the knowledge that he can contact his wife at any time, leading to a larger social repertoire. He developed a much better sense of control over his circumstances and has broken the cycle of dread of being alone in public places. While there are obviously dangers of dependency occurring because of this, I do feel it allows the patient to have more autonomy.

I am unaware of any other reports of mobile telecommunications being used in this way and it provides a good example of how new technologies may have serendipitous spin-offs for psychiatric patients.

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## A minister for adolescence?

Sir: We were encouraged to read Parkin's (*Psychiatric Bulletin*, October 1999, **23**, 587–589) review of the difficulties surrounding the admission and treatment of 16- and 17-year-olds under the Mental Health Act 1983. As a newly formed Community Adolescent Mental Health Team we have been grappling with the current legal confusion surrounding the status of adolescents on a daily basis. The concept of Gillick competence developed from a case regarding the rights of those under 16 to seek confidential contraceptive advice and, as such, it made sense – but it is now being extended into areas where it is increasingly nonsensical and legally untested, for example, should the parents of a cannabis-using 16-year-old be told about the drug use?

The confusion over adolescents' legal status appears to hinge on one issue: are rights acquired on reaching a certain age or a certain competence? The answer at the moment is 'it depends'. It depends on whether the issue in question is consent to sex or treatment, whether the patient is male or female, homosexual or heterosexual and consenting or refusing. Adolescents' legal rights should surely be either gained at a certain age, or based on their individual competence, but not the current mixture.