

# Using Image-Change Methodologies to Create Mental Health Recovery Curriculum

as told by Ike Powell, 2019

I spent 25 years (1964-1989) with the Institute of Cultural Affairs (ICA). During those years I was immersed in what we called Imaginal Education methodology. The ICA worked on the westside of Chicago in an impoverished neighborhood called '5th City'. ICA's research in community development revealed that the major block to people in 5th City improving the quality of their lives and the conditions of their community was not necessarily poverty, but their sense of powerlessness over-against powers they felt created their situation. The ICA called this sense of powerlessness the 'victim' image. They saw themselves as 'victims' to external forces. They had no power to create changes in their community or in their lives. The power to change lay in external forces. As long as they saw themselves as 'victims', they would not be able to grasp their power to be change-agents – no power, no possibility. Changing their image of themselves had to be the beginning point of the change process. Imaginal Education was a methodology developed by the ICA that was also known as image-change.

I have spent the last 29 years working in the field of public mental health. During this time, any success I have had has been the result of my ability to transfer what I learned about image-change from the ICA into my work as a curriculum developer and trainer in the public mental health field. I stress 'public' mental health services because the recipients of those services are poor and the services are often very underfunded.

In order to understand how I have used Imaginal Education or image-change methodology in my work, it is important to understand how living with a mental illness diagnosis impacts one's self-image. When I first began working as a consultant in the mental health field, I knew very little about mental illness. In 1989, I was initially hired as a community organizer by the Mental Health Empowerment Project in Albany, New York to help organize people who were receiving services from the New York public mental health system.

I soon became aware that the people I was trying to organize were very similar to the people I had worked with in '3rd world' villages, urban ghettos and rural pockets of poverty with the ICA. They were marginalized by society and saw themselves as broken, worthless individuals with no power to make changes in their lives, their situations or in the system that was providing them services. What was going on? Many of these people were well educated. Many were on medications that were controlling the symptoms of their illness. Thus, they were not experiencing the debilitating symptoms of their illness. If it was not the illness that was making it difficult for them to believe they had the power to make changes, what was it? I soon began to realize two things –

1. What you believe about yourself because you have a mental illness can often be more disabling than the illness itself.
2. Often the greatest impact of a mental illness is a sense of loss and disconnection from everything that once gave you a sense of meaning and purpose. Often the most debilitating loss is the loss of the belief in one's ability to make changes in one's life.

My experience soon reconfirmed what I had learned in the ICA: Beliefs determine behavior. Change beliefs and behavior changes. This raised three questions - What were the beliefs that were holding people back? How/why were these beliefs created? How could these beliefs be challenged and possibly changed?

When I first got involved in this work in the late 80's, initial introductory conversations with people I encountered in training programs often went something like this:

“Hi, my name is Mary. I'm bi-polar.”  
“Mary, can you tell me something else about yourself?”  
“I take XXX medication.”  
“Anything else you would want us to know?”  
“I go to the New Horizon day-treatment program.”  
“Anything else?”  
“I haven't been in the hospital for eight months.”

People often saw themselves as their diagnosis and had no life outside of that diagnosis and the services being offered to them. Their world was the world of mental illness and mental illness treatment services. They had no life outside of that world. In doing this, they tended to take on all of the negative images associated with mental illness. They often saw themselves as broken, inadequate human beings who would never be able to hold a job, have good relationships and/or meaningful roles in the community. Because of their mental illness, they had lost jobs, friends, family, possessions; they had their education interrupted, embarrassed themselves and others, and so on. They would always be ‘mentally ill’, so their current situation would always be their situation. For them, mentally ill people did not have the power to make significant changes in their lives. This was often supported by the system that was providing them services.

Where does all of this negativity come from? Mental illness is one of the most stigmatizing illnesses there is. That is evidenced in some of the words/phrases often associated with that illness – crazy, looney, mental patient, dangerous, etc.

The public mental health system can often be as stigmatizing as the general society. When I got into the field in 1989, the focus of most agencies providing services was on the disability and controlling the disruptive behavior. The goal was to stabilize people with medications that reduced the symptoms and controlled the behavior. Then maintain them at the level at which they were stabilized. There was little focus on helping people recover any of the things they had lost, especially their belief that they could take control of their life and move it in the direction they wanted it to go. The following is a paragraph from one of the sessions in our basic core recovery training curriculum.

*Up until around 1980, the belief that dominated the public mental health system was that people diagnosed with a mental illness would not recover. More than likely the illness would get progressively worse. The best you could expect was to get people stabilized and then maintain them as best you could in supervised environments in which they would not be able to harm themselves or others and would not be causing too many problems. This usually involved high doses of medication, long stays in secure institutions and/or years in ‘day treatment programs’ designed to entertain with TV, table games, recreation, trips, outings and other ‘low stress’ activities. It is important that we understand the mindset and beliefs of what is called, “the old system,” because many of these beliefs have been hard to let go of and can still be found in many agencies and organizations today.*

People were often told that they were incompetent, incapable and incurable – **and they believed it.** They only had to look at how messed-up their life was - **and it was all their fault.**

We had to find a way to change the story. We had to... *“Shift the focus of their thinking from what was wrong with them to what was strong with them”* – to use the words of Dr. William Anthony, a pioneer in the field of mental health recovery. We had to find and highlight other voices that were promoting the possibility of recovery. It turned out that most of them were people who had been diagnosed with a mental illness and were now living a full and meaningful life. How had they done it? In New York, we began to use the insights of these folk as the basis for what we called ‘our core recovery curriculum.’ I gathered together a group of ‘mentally ill’ people whom I had met through a variety of training programs – people who were beginning to see possibility for their recovery. We spent hours discussing what had helped them move on with their lives. We tested new curriculum modules.

In 1992, I moved to Georgia to take care of my aging parents. I continued some consulting work in New York and began to engage in Georgia. A major break-thru happened in Georgia in the late 1990’s. Georgia was able to work with the state office of mental health and the office of Medicare-Medicaid Services (CMS) to create an employment position within the system that would be funded by CMS called “certified peer specialist’. This is a person who is living with a mental illness and is doing well who could be trained to use their lived experience to help people living with a diagnosis and not doing as well. I was asked to create the curriculum for this training program.

Another insight emerged that helped form the curriculum. Building off of the wisdom in the statement, “What you focus your energies on, you give power to”, we saw that *“When the focus is only on the disability, people began to see themselves as disabled”*. The curriculum needed to focus on strengths rather than weaknesses. We had to change the focus of people’s stories. The development of this new training curriculum and the possibility of a Medicaid-funded position within the mental health system gave us a great opportunity to do this.

“Change beliefs – change behavior” became “change the story - change the life.” I had to look at how people talked about their past, present and future. I began to try to articulate the foundational beliefs upon which this new curriculum would be built. The following foundational beliefs began to emerge and had to permeate all of the curriculum:

- 1) **Recovery is possible.** (*We defined recovery as the “...the process of gaining control of one’s life – and the direction one wants that life to go – on the other side of a psychiatric diagnosis and all of the losses associated with that diagnosis.”*)
- 2) **What you believe about yourself because you have a mental illness diagnosis is often more disabling than the illness itself.** (*The curriculum had to focus on changing the story people were telling themselves about who they were and what they were able to do.*)
- 3) **Often the greatest impact of a mental illness is a sense of loss and disconnection from everything that once gave you a sense of meaning and purpose. Often the most debilitating loss is the loss of the belief in one’s ability to make changes in one’s life.** (*The curriculum had to define the peer specialist’s job description in non-clinical terms – not focusing on the illness, but on the impact of the illness.*)
- 4) **Everyone is doing the best they can – given their past experiences, present situation and current level of awareness.** (*Everything in your past was your attempt to survive. This closes the judgmental door and opens the door of non-judgmental acceptance.*)
- 5) **What you focus on, you give power to.** (*The curriculum had to shift the focus from the illness to what they had learned about surviving.*)
- 6) **At any moment you are free to make any decision. But once you decide, it is the only decision you could have made.** (*Again, this takes away the judgment attitude toward the person.*)

- 7) **People change their thinking and acting when they become aware that their current thinking and acting is working against them having the life they want.** *(This insight/belief is crucial. The curriculum had to help people see the possibility of acting on their own behalf to create the life that they wanted. Then and only then could they see the benefits of change. Motivation to change is based on awareness of the personal benefits of making that change.)*
- 8) **Because of your past experience of living with a mental illness, you have developed a variety of skills and knowledge that have helped you survive and possibly even thrive in creating a life of meaning and purpose.** *(The curriculum would need to help them rearticulate their story about their past by focusing on what they had learned that helped them survive - and possibility thrive.)*
- 9) **You are now in position to use this ‘lived experience’ to help others.** *(The curriculum would need to reframe the past from “how the illness has destroyed my life’ to “how the illness has prepared me to help others”.)*
- 10) **There is now a salaried position in the MHS that has been designed to give you the opportunity to do this. This position has the possibility of accelerating the shift of the system to a more recovery focused system.** *(The curriculum needs to continually remind people - “You are now in a training for which your past experience is a pre-requisite, not something you need to hide or be ashamed of – and this training is recognized by the largest insurance company in the world – Medicaid/Medicare Services.)*