The Quest of Dreams and Nightmares: My Personal OT Career and Mental Illness

I am writing in regard to the article, “The Experience of Being an Occupational Therapist With a Disability,” written by Beth P. Velde [AJOT, 54(2):183–188]. In response to Darlene M. Coffey’s letter to the editor [AJOT, 55(3):352] and as a senior occupational therapy student, I feel inspired, interested, and motivated to share my own experience attempting to function as an occupational therapist, who for years has suffered and battled with a stubborn major mental illness. My personal journey into the profession as a student, stricken with this disability, interrupted by schooling, squelched my attempts at professionalism and left me with a hopeless sense of despair and failure.

Illness came to me in 1979 like a storm, enveloping during mid-semester junior year. I was unable to concentrate on my studies; maintain important life skills; and deal emotionally, socially, and cognitively with this new life burden. My original diagnosis—chronic paranoid schizophrenia—was perhaps even more difficult to bear because I had previous education and scholastic knowledge of such a condition. As symptoms began to unravel, social stigma became overwhelmingly detrimental to my self-esteem; feelings were too extreme; and I pondered shamefully about what was truly unavoidable and out of my control. Throughout the years, the truths about myself would painfully become all too apparent.

Severe early developmental trauma, amnesiac memories, heightened states of mania and depression, temporal lobe seizures, and paranoia incorporated a new diagnosis of schizoaffective, dissociative, and post-traumatic stress disorder. Repressed or fervent feelings of grief; loss, rage, anger, sadness, shame, fear, and terror set up a continuum and baseline existence of psychosis, with its exacerbations and remissions. Suicidal expressions and decompensations and compensatory behaviors were cyclic and patterned with acute states, hospitalizations, and periods of recovery. Terrifying flashbacks; nightmares; delusions; and hallucinations of the olfactory, auditory, visual, and tactile sensory systems became a common experience in my daily life. Substance abuse, medication noncompliance, and rebelliously driven self-inflicted harm complicated and negatively affected attempts toward recovery. Medication trials and therapy programs were rigorous and extreme and often wrongfully presented and undertaken. Housing and institutional settings and situations included grouping with the mentally retarded population, and this became a further detrimental blow to my dignity and self-esteem. Opportunity and chance to thrive, survive, and grow seemed and felt like “Mission: Impossible.” At age 42, 22 years later, I can hopefully and happily express that I have matured, developed, learned some of the most important and valuable of life lessons, and survived my personal emotional explosion.

I can insightfully express that the evolution of a mental illness can be seen in a positive light. Overcoming obstacles; strong self-doubt; and many failures, embarrassments, and disappointments is a turbulent experience but one that brings wisdom, special perception about human nature, keen intuitions, and a natural capability to adapt toward self-preservation. I empathize because I truly understand, and I have learned coping strategies because I had no choice. Although the resource of my experience has been more focused as a patient with profound disability, trialed with conflict between my strengths and weaknesses, my growth and personal dignity have become paramount. I can honestly express that I possess a depth of health in values, morals, humbling opinions, my regard for others, and my respect for human nature and the process of exchange in caring interpersonal behaviors.

In regard to whether I felt appropriately supported, encouraged, and handled by teachers, peers, coworkers, and fellow occupational therapy professionals, my feelings are somewhat ambivalent yet understanding. Globally, I believe one is viewed and regarded as the way one presents oneself. Outwardly psychotic, inappropriate behavior breeds necessary concern and, at times, unavoidable negative critical reactions. If symptoms of mental illness are severe (i.e., presenting with confusion, lack of control, overwhelming dependence and dysfunction), then the reactions of others should show serious concern. What is most important in the process of helping others is to provide opportunity for objective, nonjudgmental reactions; respect for dignity; and a true chance for that person to learn and develop important goals, abilities, skills, and holistic growth. The situation may appear to the therapist and patient as somewhat hopeless, so helping one to determine and aspire toward personal ideals and dreams is very important.

Despite my many obstacles and severe symptoms, I was able to pass my curricular demands, affiliations, and licensure exam. Supervisors, teachers, and peers were helpful, although working together was stressful, and we shared problems with sense of doubt. It seems that the evolution of my health and illness had to take its course. I have actually never worked as a licensed occupational therapist mainly because of my lack of confidence and conscientious attitude about my own professionalism. Skills of observation; analysis; application of knowledge; use of creative, artistic abilities; provision of adaptive techniques; treatment planning; and documentation seemed cognitively impossible. Within the past 5 years, however, personal efforts have shown
great growth. I have worked with occupational therapy students and an occupational therapy supervisor mentor to increase my skills. I attend a clubhouse (social, avocational, vocational program) where I have had opportunity to develop. I have completed some textbook study; created my own documents of interest; started a portfolio; and volunteered in a geriopsych, activities-type capacity.

Improved medicine regimes, time in sobriety, appropriate guidance and therapy, and independent living are met goals and stabilizing aspects of my daily life. More appropriately, kinder social connections seem to be crucial in maintaining my personal health. Avocational and leisure activity is more substantial and gratifying, providing motivation and an interesting balance of activity. My activities of daily living (i.e., budgeting, dieting, exercising, apartment upkeep, cooking, basic self-care, use of community and public transportation) are better developed and maintained. I am proud to incorporate occupational therapy philosophy into my own life experience and use ideas about holistic health and functional, activity, occupation-based rehabilitation.

In conclusion, I thank those people I met throughout my journey who cared to offer sincere empathy, motivation, and hope when I could not adequately provide this support to myself. Such well-received intentions provide a true lifeline.

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Author’s Response

As author of “The Experience of Being an Occupational Therapist With a Disability [AJOT, 54(2):183–188], I am grateful that Ms. Murray has the strength and resolve to share her story. Although some participants in my original study discussed the impact of secondary health conditions, such as depression, on their lives as occupational therapists, none lived through and participated in an occupational therapy curriculum while experiencing a primary diagnosis of acute and persistent mental illness.

Few occupational therapists and occupational therapy educators doubt the rigor of our educational programs. Some of us worry about our students missing out on the typical college life. The demands on students require changes in routines, in relationships, and in roles. Often, our expectations cause students to give up outside work activities—a source of identity and self-efficacy. It is hard to imagine living the life of an occupational therapy student who experiences the signs and symptoms Ms. Murray described.

Educators face unique challenges when dealing with students who have a health condition that affects educational function. Do we approach these students as educators or as therapists? What supports are necessary to enhance occupational functioning in an educational system? Is the student responsible for attaining and maintaining her own supports? Often, we believe so and see a student’s inability to find and use resources as a reason to address professional behaviors.

Ms. Murray also calls to question the socialization process of a profession. As educators, we play a major role in this process. If we believe that part of this socialization process is to enhance independence and create self-contained individuals, then we encourage students to deal independently with their own crises when they impede educational functioning. We address academic issues and pretend that “those personal issues” are for someone else to resolve.

However, in my opinion, few educators live the life of a person with disabilities, nor do any of us truly function independently. As social beings enmeshed in our world, we have fluid boundaries between others and ourselves. As educators, this empowers us to act collaboratively with students who have disabilities to better understand their constructed worlds and together initiate supports and problem solve solutions.

Ms. Murray offers her expertise to each of us in the form of her letter describing her experience, first as a student and now as a potential peer. Are we as a profession and our society as a group of consumers ready and willing to accept her expertise? Her journey as a person and occupational therapist are far from over. As a person embedded in her professional environment, Ms. Murray has begun breaking the barriers we create within our shared profession. I thank her for her honesty and her insight.

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