Two narratives: recovery journeys in mental health

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Abstract

Purpose – *The purpose of this study is to compare lived recovery journeys in mental health with recovery models.*

Design/methodology/approach – *Unstructured interviews with prompts were conducted with two individuals.*

Findings – *Some recovery models correspond in part with the live experience of subjects. These narratives have personal emphasis that is incongruent with the highlighted models. In particular, the subjects have a place for therapeutic interventions, i.e. talking therapies and medication.*

Research limitations/implications – *The live experience of the two people with mental health issues crosses boundaries of recovery models. Relevant models include those used in peer support; however, they too do not fit exactly with the detailed journeys.*

Practical implications – *A varied approach without preconceptions is appropriate to understand the components of these two recovery journeys.*

Social implications – *The medical model approach to mental health is not discounted rather it is integral to these two recovery journeys.*

Originality/value – *This is qualitative research using stated models of mental health recovery. In addition to the principles of hope, meaning, connectedness, identity and empowerment, the two subjects include the essential part for medication and talking therapies in their recovery.*

Keywords *Mental health Recovery, Unstructured interview*

Paper type *Opinion piece*

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Introduction

How relevant are models of recovery to recovery journeys? While there are outcome and experience measures that seek to quantify pathways, e.g. through assessment or self-rating, a qualitative approach can provide insight. So, I set out to explore how much of a fit there is between models of recovery and personal experience. I referred to models including Bill Anthony's, (Anthony, 1993), the Scottish Recovery Network's connectedness, hope, identity, meaning and empowerment (CHIME) (Scottish Recovery Network, 2016) and a model embedded in peer support practice (Watson and Meddings, 2019). I used service user experience to illuminate the aspirations of recovery practice. To gain a handle on the relationship between recovery models and personal journeys, I interviewed two individuals who live experience of the mental health system and who achieved independence with a career in peer-related employment in mental health. I conducted unstructured interviews with M and F using a recording device from which I took transcripts of the conversations. I began by asking the two interviewees to detail their recovery journeys and gave them prompts along the way after having discussed with them the recovery models I refer to. The transcripts were reviewed by the two interviewees to allow any alterations they wished to include, and I stated, at every juncture, that they were free to withdraw at any time without giving a reason. The interviews took place at neutral venues and there was no

disclosure of the purpose of meetings outside the research project. The interviewees have been anonymised because this was a condition prior to interviews.

Aspects of recovery models

As we entered 2020, a new generation of recovery paradigms is putting distance between the medical hegemony of previous times and person-centred and strengths-based approaches to mental health. The first major work on peer support, Peer Support in Mental Health (Watson and Meddings, 2019), has a three-fold underpinning to recovery of hope, identity and personal responsibility. Note that hope and identity are epithetic of the CHIME acronym in the mental health recovery of 2016. F is clear on the central place of identity to their well-being: "My identity, is probably still based on the same – I don't know what the word is – like principles or whatever [. . .] driven by (and this was how I was brought up) – achievement and work." How clear is that a sense of self comes through from F even via their severe and enduring mental health condition. M indicates that their recovery journey has with it the satisfaction of a new role, i.e. a new identity: "Seeing things from the side of somebody helping the medical team, to try to help somebody to get better, was a complete about face." Both F and M coped with aspects of their lives that most people will never have to face; yet their sense of self has been the illumination for their certainty for the future. A prompt during the interview with M: "So how do you feel about hope that your life will continue to improve and continue to remain stable [. . .] do you have that hope?" "I believe so." Helping others as a peer has enabled the recovery journey for M. What more accepted identity: as a peer, no longer as a patient. F explains the impact of the loss of hope from crisis in their illness after this prompt: "You lost meaning to your life. With these threats (to your settled life from the consequences of mental illness)." Reply: "Oh yes, massively. Yeah, massively. I couldn't really function, so there's that. Loss of function." "Would you say that was a hopeless place?" "It was horrendous, yeah. Completely hopeless." Hope and identity are intertwined in the journeys of F and M, in which crisis can be a hopeless place, and moving from the identity of ill person or patient to service user to having a satisfactory hopeful identity is key to their recovery journeys.

Connectedness

Connectedness is an element in the recovery journeys of M and of F. For F, connectedness is with family, whereas with M it is with the surrogacy of well-intentioned mental health carers. Both M and F find sustainability from their significant relationships. Moreover, in their independent roles in peer support, both have a sense of belonging from their lived experience, which they have in common with colleagues. "He was really kind, so he's the man I credit with actually starting a little bit of hope going." Thus says M of one of a number of relationships with professionals that for them went above and beyond basic duty. "And I'm very lucky she didn't (let me cancel CBT therapy) because, bizarrely, we did the sessions and the penny finally dropped. I could see the pattern." M describes the tenacity of a practitioner who made a difference and brought about a watershed moment in M's Recovery: a meaningful relationship, human contact where M was treated as a valued individual. For F, the community of those with lived experience and who are in recovery worked with a double effect: "When I first did the peer support training – with a group originally, I think it was two years ago. . .And that's when I actually realised that what I had been trying to do was come to terms and accept what had happened to me [. . .]" This element of connectedness protected F's relationship with family, and the threat on that family connection was uppermost in F's perception of consequences from mental health crisis: "I've managed to get relationships in my life back where I wanted them to be. And that was probably my biggest sort of stumbling block, was that I wasn't able for ages, I just wasn't able to really form like normal kind of relationships." Of the current connectedness in peer support, F has this to say: "I gradually worked out that I've got a lot to offer and that we

are making a difference." Connectedness, i.e. the sense of purposeful belonging that is unique in peer support or the way to make a difference, comes via as a pinnacle of M's and F's recovery journey. Although probably not many would volunteer for the life events of the two, the experience they have cannot be learned, trained for or bought is what makes their ability to participate as practitioners distinct. It is also a community for their well-being.

There is no in-depth exploration of the meaning of personal responsibility in the peer support book; however, a useful description is that, "The ability to take personal responsibility for our own life is necessary to enable Recovery to occur," which is mentioned by Recovery and Outcomes (2018), the offshoot of rethink mental illness. So for both F and M, they have gained identity and independence via their work in peer support; this gives them personal responsibility, which enables them to work as a glass full rather than half empty. They have the inner resources to give of themselves in the full confidence that they have valuable experience to offer.

The acronym CHIME includes a meaningful life, a purpose to each day and empowerment. Probably, empowerment is best seen as the opposite of having mental health "done" to an individual patient. This has systemic implications in that the service user movement undoubtedly advocates for a mental health service that promotes choice, i.e. informed choice and control for the service user in how their care comes about. Clearly, this is opposed to medical domination. The phrase is "medical services on tap, not on top." So, how do M and F see this as part of what they do? Probably, change in the system is what they aim for, and knowing them this is an essential part of their peer support practices. However, in the interviews, they have not stressed this as essential to their recovery journeys. So, meaning in the recovery of M and F has not been grounded on personal or systemic empowerment. However, they are indeed two empowered and self-aware individuals.

Personal responsibility and empowerment

With this background, M and F are providing authenticity to recovery practice in that they have a place of influence in the mental health system where they can make a difference, i.e. certainly to individuals. The reflections they make from recovery models echoes back to one of the early advocates for recovery, i.e. Bill Anthony. Bill (1993) writes thus: "(Recovery) is a way of living a satisfying, hopeful, and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness." In the interviews, M and F refer to the power for them while working in mental health peer support; their lives are indeed hopeful and contributing. Their testimony strongly provides new meaning in their lives. This was in the context I set out before the interviewing process that the recovery models I use have essential elements that include meaning, empowerment and personal responsibility. This set the ground for the conversations we had. So, while explicit references have been made in the interviews to hope, connectedness and identity, reference to personal responsibility, a meaningful life and empowerment are strongly there by implication.

These factors in the recovery practice have enabled M and F to put distance between their mental health crises and independence in the field of peer support. In the UK, the implementation of community care and change in mental health service delivery date from the early 1990s. Since the legislation of that era, the NHS has been a conduit for service user involvement, the implementation of recovery models and peer support (into the years after 2010). These aspects of care and well-being were not previously available. So, the environment has now been hospitable to the enabling of individuals to achieve independence and to report strategies to cope with the devastating effects of mental illness.

However, interviews with F and M led past the factors of recovery in the family of models I referred to, i.e. CHIME, peer support models and Bill Anthony's groundbreaking statement. Two elements to their recovery journeys need to be further considered, i.e. functional recovery and possibly the most influential element of - therapies, including talking therapies and medication.

Turning points

The two interviewees have experience that reflects the relevance of CHIME and the model of peer support, inspired by Bill Anthony.

However, both M and F have watershed moments or watershed intervals in their history. Both relate to events that are turning points where the diagnosis of their mental health issues led to essential interventions. "I think my Recovery journey started at the same place where my life hit the buffers in a big way in 2014," says M. This is a turning point; as is for F, a timeframe that kick-started the recovery process: "I think, one way that I like to look at it, you said about the absence in those models, of medication and therapy, and I think that's because those models really are just focussing on your personal recovery. And actually for me that wasn't something I really thought much about till I came into this job. So when I became unwell, I had a sort of illness, so I'm now diagnosed with bipolar disorder. But it took quite a long time to be actually diagnosed with that."

Therapeutic intervention

The paradigm is moving on with those comments from M and F. F's statement that the current generation of recovery models is about integration and inclusion; their statement around the context of non-therapeutic factors in fact leads on to the place for therapies in both their recoveries. M recounts that recovery factors entered their journey at a point of crisis. M goes on to describe the place of therapeutic interventions following on from their most vulnerable time. M credits a member of staff with giving hope and goes on to recount the essential place of medication. For M, one previous medication was not working and stability was re-established by switching prescriptions. However, M has a central place for talking therapy, particularly cognitive behavioural therapy (CBT). M describes the effect that eventually happened through this therapy: "And I'm very lucky she (the therapist) didn't (give up on engaging with M) because, bizarrely, we did the sessions and the penny finally dropped. I could see the pattern [. . .]" M reported the way to understand what drove damaging actions, including the determination to complete suicide. M has been at a turning point with the hope instilled by the staff member; it is clear that this recovery journey hinges on medication and CBT. This is how therapeutic interventions have been a necessary component to M's journey to independence in peer support. M and F have been suitable subjects for interview because their recoveries have led to positions in peer support. It is remarkable that, for both, therapeutic interventions have a permanent place in their lives. The aim of this research was not to establish this link. F too has reported life events that led to personal alienation have been coped with. Thus, symptomatic events are described: "I started doing things which were completely out of character and which were very damaging to my marriage." There was a pattern of events that F calls manic, i.e. happening regularly at intervals of three years. Medication is the intervention that gives freedom from these unhelpful times. "So I take Lithium and I also take an antidepressant."

Are these statements from M and F about medication completely out of left field? No, certainly not. Their use of therapeutic interventions, medication and talking therapies has accompanied what F describes as the personal recovery of hope, a sense of identity, connections and relationships. Surely, with this level of dysfunction, there can be no hope and no life and there can only be a life of dependency? These enlightened individuals cannot have mental health conditions and be taking medication? M and F confound this

view and indeed they are both high functioning individuals in a unique position to understand, empathise with and affect others' well-being.

The use of interventions such as medication (lithium and antidepressants for F and continuing medication for M) and talking therapies (CBT for M) may be associated with medical approaches to mental illness. However, if we search wider for recovery models and if we look back further, there are definitions that include therapeutic recovery such as that of Drennan and Alred (2012) and from peer Gordon McManus of SlaM (South London and Maudsley NHS Foundation Trust) (SlaMRecoveryCollege, 2014). For these authors of Recovery focussed practice, therapy, perhaps following from diagnosis, is an essential component to wellbeing. So, where it is therapeutic, medication is an aspect of recovery, as are talking therapies. Indeed, guidance from the era of Community Care in the 1990s associated medication and talking therapies as groundings for recovery (Department of Health, 1992). Although recovery may not be about the cure of a condition of biological origin (Mental Health Practice Essential Guide, 2008), i.e. not to exclude medication from effective care, it can be the cornerstone on which hope, identity, connectedness, a meaningful life and empowerment are built. For some, treatment plans such as open dialogue (NELFT, 2020) and early intervention (Sussex Partnership NHS Foundation Trust, 2020) can bring recovery without medication or where medication is used on demand. However, M and F can be respected for taking on board the use of medication and talking therapy, both of which have led to what F describes as personal recovery, the ability to function as independent individuals. Their histories can be an inspiration.

Summary

So, in conclusion, I revisit the opening question: how relevant are models of recovery to recovery journeys? Yes, there is relevance to two life journeys and elements of recovery models fit in with the experience of mental illness and the mental health system that M and F have had. It seems that both interviewees had watershed moments where their lives turned around. For M, this was with the hope given by a valued carer; for F this was when mental illness was recognised and there were interventions to prevent unwanted behaviours from recurrent episodes. It is also evident that both F and M follow pathways that include elements from contemporary recovery models and elements from other models; therefore, hope and identity follow on with helpful medical therapies. They could not have got to the positions they are in to help others via peer support without experiencing recovery themselves and to know what has been useful.

A final observation is that although M and F were briefed on recovery models and prompted around the stages they went through in recovery – how did they get to this place – they do not see it quite like that. Recovery for them is not so much about a linear set of occurrences that follow on one from another. It is not so much a series of destinations. Recovery for them is real and is more about where they are at. It is about the place they are in. It is a description of a set of tools for their strength. Recovery as described in the interviews has an authenticity and it is possible to understand the meaning of Recovery to both. "The meds have been fantastic. They've made such a difference [. . .] I call them my sanity sweets. I think they keep me well [. . .] I have no problem with that whatsoever." So states M about the place of medication in their Recovery. This is an element that augments the recovery factors in CHIME and the peer support models. But, is that all there is to life from someone with an illness that involves regular medication? Is that really all that is necessary? F puts their Recovery experience thus: "So it wasn't like I was really ill, had no independence, had no support etc, and then I went on a journey, and then I am here now."

The narratives of M and F through the interview process illustrate two unique individuals who have their personal recovery-related experiences. These histories are not too much of places, locations, jobs and finances rather what we have is that which was meaningful to them on their journeys.

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