# Changing the font size on recovery: a co-produced dialogue between service user and psychologist

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**Abstract**

**Purpose** – *The purpose of this paper is to co-produce the meaning of the word recovery and highlight the challenges to recovery in a secure inpatient setting.*

**Design/methodology/approach** – *A conversational narrative between a service user and psychologist focussed on the topic of recovery.*

**Findings** – *It is a reflective account, therefore no findings are required.*

**Originality/value** – *This is a co-produced paper highlighting a service user's and psychologist's perspectives on recovery.*

**Keywords** *Mental health, Coproduction, Recovery*

**Paper type** *Viewpoint*

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## Introduction

This joint venture between a service user and a psychologist comprises the following aims: to attempt to co-produce a meaning of the word "recovery" and highlight the challenges to recovery within a secure inpatient setting. This co-produced paper aims to capture the dialogue between a service user and a psychologist to allow a true reflection of the similarities and differences between their perspectives. Throughout this piece, there will be an ongoing dialogue and the names of service user and psychologist co-authoring this piece will be included at the start of each section of text for clarity purposes.

Meg: I'll start with my name I guess. Hi I'm Meg and I have embarked on a mission. I didn't want to initially write about my past because I feel there have been plenty of people with the same sort of dramas. I wanted to create something that would generate an understanding of how I feel contained in a service yet on my own personal mission to recover. The aim on my part is to do this through my own experiences and have a different way of writing than Ruth. Therefore, creating an interesting balance of explanation in each of our views. I'm the fun one! As a brief disclaimer, I will be using examples such as the act of a person self-harming to reiterate my point of what it's like to live in an environment like this.

Ruth: As a clinical psychologist, keen to co-produce and disseminate meaningful research, I have felt enthused by the idea of collaborating with Meg over a viewpoint piece. I think Meg's natural style is to be inspiring and imaginative and we hope this piece has captured her creative flair whilst also holding relevance for practitioners and service users alike.

Meg and I embarked upon this viewpoint piece following a discussion where we both felt passionate about co-producing ideas and co-authoring to capture our perspectives of recovery within inpatient settings. Our target audience is other service users and practitioners who have an interest in "what it means to recover" particularly within such a challenging environment.

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Meg's passion for expressing herself and communicating with others through creative forms has driven this piece with a combination of reflection, metaphoric and symbolic text and illustrations. The conversational nature by which we have chosen to pursue this piece has, in effect, meant that we have created many drafts and had copious e-mails and communications about how to edit and proceed with our paper. We hope the piece explores our aims adequately and encapsulates topics of interest for the reader.

## The word "recovery"

Meg: First off, when I think of recovery, I think about a person that has a resound resolution to an un-godly hangover. That would be a recovery. I don't feel I can ever truly recover from my past and current life struggles. I can't extract certain memories and never think about them again but I can learn how not to let them bombard and control my life. In brief, feeling so paranoid out in public, fears that the past is going to re-enact itself, so scared of the people around me are not who I think they are have resulted in many tricky situations involving arrests, custody suites, prison and many hospitals. How do you know when you have truly recovered? The word recover for me implies that an issue never arises again, but with mental health I find it keeps upgrading its weaponry to constantly attack me.

Ruth: The contention surrounding the use of the word "recovery" is a long-standing debate (Harper and Speed, 2012). Meg's reflective stance and expressive use of language highlights just how individualised the process of recovery needs to be for us all. The word recovery has gained prominence within mental health discourse (Rose, 2014), particularly as the use of the word has previously had a narrow focus on issues that merge with societal expectations of what recovery may look like, such as the sole focus on a medical model approach and at the exclusion of broader social factors. The more recent debate has raised issues to highlight the exclusion of marginalised groups, the need for the inclusion of a range of factors ranging from social, emotional, cultural and spiritual and has attempted to address the limited focus on the individualised experience and the need for a societal change to provide people with power and resources in order to affect change (Social Perspectives Network, 2007).

## Individualising the process

Meg: I feel individualising is key to anyone's journey of recovery. If someone sat me down once a week for an hour to look at flip charts and graphs to fill out, I'd be stuck here forever, bored and un-motivated. Because that worked for the last person doesn't mean it will for the next. I don't fit into graphs and tables. I need expansion to express those dark thoughts in a way that I feel comfortable. And yes, my journey is going to be one that no one else will do the same, but being able by Ruth to express in my own way is such a massive relief. It allows me to enjoy delving into my issues when I can put them down onto paper say in the form of "orbs" as an example. I'm creating my own unique way of explaining that I don't mind going back to because it's not just some boring graph I got told to fill in over the weekend. This is me and this is how to understand me.

Ruth: An individual formulation is key to any meaningful work, especially of course, from a psychologist's perspective. How the formulation looks, is talked about and how it evolves is hopefully guided and shaped by the individual service user with support of the practitioner. Meg's example of "orbs" (see, Figure 1 and Figure 2) is a true reflection of Meg's creativity and her drive to learn and understand through self-awareness. The "orbs" symbolise parts of Meg that become more or less dominant at certain times. Holding onto an awareness and understanding about how these "orbs" operate and have influence over other parts and Meg's internal experience, has been crucial in establishing a sense of internal influence and therefore Meg's feeling of control and independence. Strengthening influence and control over internal experiences is an important part of a recovery journey, however that may look for an individual. For Meg, "orbs" have played a key role in supporting with this sense of influence.

Meg: I find it hard to explain how I feel particularly how my mind gets absorbed by parts but then imagine "orbs" containing these coping or defense mechanisms floating around my head.

**Figure 1** A representation of three different "orbs" or parts of Meg's internal experience

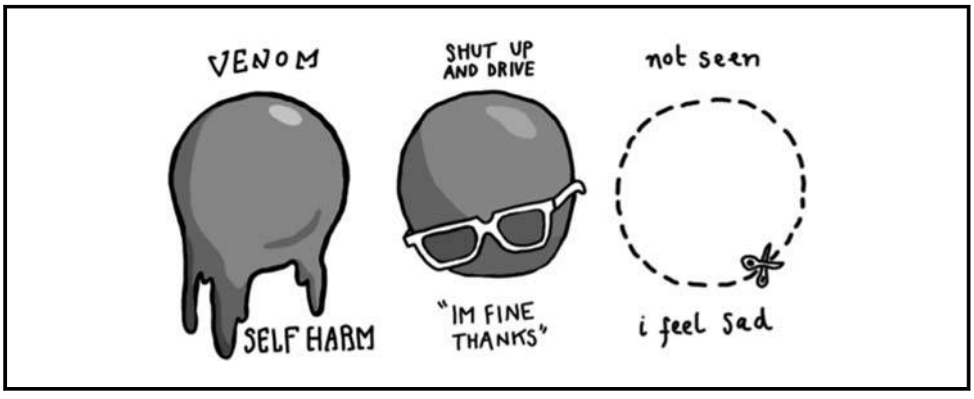
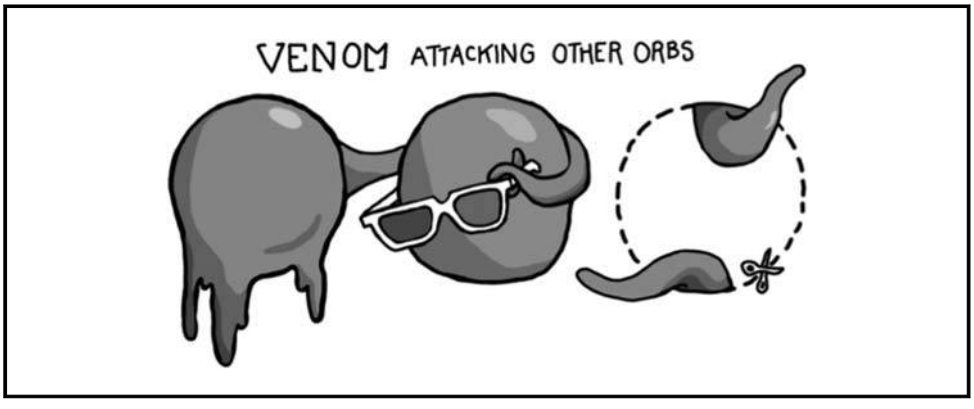



**Figure 2** A representation of one "orb" or part exercising dominance over another




Sometimes without me even knowing they get activated and when I reflect and look back I can pin point a defense mechanism that was in place and can gain a clearer understanding. They have names like "venom", "shut up and drive" and "not seen" (see Figure 1). I feel that "venom" represents my dark moments and would be a sort of gloopy sticky "orb" that can latch onto others, poisoning everything. Whereas "shut up and drive" is simply a method of me getting on with things regardless of what is happening. Everything is ok, I'm fine, no I don't need any tablets. "Not seen" represents my past and younger years. It's vulnerable and a sort of delicate side of me that can get ignored or preyed upon by others. But "venom" has this ability to engulf other "orbs" (see Figure 2). "Shut up and drive", would say, "don't say anything so you can go and hurt yourself". Of course, there are many "orbs" for all sorts of situations I can feel internally. They're developing all the time, or shall I say being discovered by Ruth and I. But by showing this sort of formulation to others, they can also gain a clearer understanding of what I'm possibly going through.

## What it means to recover

Meg: Imagine this, I haven't self-harmed or been arrested in years. I've kept myself out of hospital but my mind is still crippling me in fear. But hey, I'm not doing any risky damaging behaviors. Have I recovered? I feel that that is how people want me to be in order to be a recovered member of the community. The deemed route to recovery is to get yourself out of hospital. The belief is that once you're out of an inpatient setting, that's it, you have become a recovered member of society. But it's just not like that at all. Personally, I would rather develop than recover. You can recover from getting your first splinter, but you also learn what to do next time it happens.

It's all good and well ticking boxes and satisfying professionals so they grant you a trip to the post office and eventually discharge. But what do you learn from that? How to get out of hospital the next time it comes around. It's the realisation of this cycle that I would keep finding myself in that the light bulb went off. Maybe I need to actually put some work in and develop a way of understanding of why I find myself in these situations. I'm sure that light bulb is going to smash into pieces occasionally but I have a box of them just in case. So here I am on this static journey currently under section trying to learn ways of recovery but tailoring them into a more Meg way of thinking and practice.

Ruth: Perhaps it's more apt to use Meg's word to "develop" rather than to "recover". To what extent does recovery still have connotations of being about physical or practical rehabilitation rather than an overall development of a person's identity, sense of security and integration into society in a meaningful and inclusive way. Referring back to Meg's analogy of recovering from a splinter, perhaps the word recovery may seem categorical in nature and denote either a sense of achievement or non-achievement? Or, could this word recovery in fact encompass a broader sense of development that continues throughout one's life and is not determined by anyone else but oneself? The Social Perspectives Network (2007) refers to models of recovery that are tailored and specific to each person rather than attempting to fit groups of people who often feel marginalised by society into a previously narrowly defined definition of recovery. Some people may feel strongly about the use of this word and may be keen to deconstruct it's meaning as Meg and I have attempted to do. Whereas for others, "recovery" may just be a journey and one in which reflection and deconstruction of its meaning is not deemed necessary. Perhaps we all, service users and practitioners alike could be willing to allow for an openness in our discussion about what it means for individual people to gain a sense of "recovery" or "development" and tailor our approaches and systems to encourage a flexibility around how this looks for each person rather than assuming we all know what it means to recover.

## Recovery in a hospital setting – the challenges and rewards

Meg: Being under section is horrible. It's a soul destroying confusing time and sometimes seems like there's no way of escape. If you were locked up with another ten separate souls also feeling lost and trying to find ways to become recovered it adds to the impossible feeling of, how am I going to do this? It's easy to resort back to the self-harm and refusing to attend sessions, because that's accepted and understood. Staff can fix you up with a plaster and the psychologist can come back next week. Life can become comfortable yet in parallel to the real world.

When you have started to really work with the hospital and develop, the people harming themselves around you can make you immensely angry and jealous. Their life seems so much easier to express the pain and hurt. Seeking refuge in cuts and bruises, but it is also a constant reminder of how bad things can get. It's a life I used to live, maybe a life I will resort back to of course. I never thought I'd be in a position where I'd actually be using the service instead of ticking boxes. And I can't even begin to explain the feeling of being sat in a session trying to explain to another human how you're feeling suicidal, and the attack alarms get pulled. Suddenly staff are running past the window, a patient is determined to swallow something not meant for human consumption. Someone takes lead and directs people in what limb to grab and then the demonic screams erupt. It's near enough impossible to then carry on with the session you're now trapped in because there's a restraint out in the corridor. So, it is hard living in this environment trying to better yourself. Yet when your deemed unfit to return back to the community it's an environment you have to make the best of.

Ruth: The first point of contact with any mental health service can be a disempowering experience. People often feel a sense of desperation, disconnection and stigmatisation. Mental health systems, despite their well-meaning intentions, can often further exacerbate feelings of disconnection or disempowerment through the practices employed by the service. For example, inpatient settings by their very nature need to employ a level of control, containment and restriction in order to manage risk. However, the very process of restriction, if not executed in a thoughtful, measured way can further escalate risk and thereby strip the individual of any sense of control, influence and empowerment. So, when we come to reflect upon the challenges and

rewards of inpatient settings, it may be that there are predictably more challenges than there are rewards. However, people do leave inpatient settings never to return, people do reintegrate into the community with a renewed sense of independence and connection and so, to balance our perspective Meg and I have also highlighted the potential rewards and gains one may observe in an inpatient setting.

Meg: Even with how living in this environment has its numerous struggles, there are also benefits. So, say I wake up at 4 a.m. and can't get back to sleep. My mind becomes a race track with self-harm in the lead and my fight against it in last place, the finish line is coming up, but then a support worker jumps in. Running self-harm off the track and my mind is settled again. I mean 4 a.m. is a bit of an unsociable hour, who would you phone if anyone? The support from staff is a huge beneficial factor. It's just learning how to use them. Building the trust and feeling comfortable enough to ask for help. I can't fault the support from being in a hospital. But only when it's needed. It's also learning when to fight on your own. You could look at hospital as a sort of training ground for yourself.

Ruth: As Meg has alluded to above, any individual journey is likely to have a strong relational component. Whether a person has felt listened to or thought about, the connection with another person is often crucial to development. Returning to our earlier point about the marginalisation or stigmatisation people often feel within mental health services or have felt within their life more generally, a meaningful connection could soothe or repair this wound. Inpatient settings, particularly those that favor attachment or relational models have the power of encouraging people whose trauma may have been within a relational context to form and strengthen a new relational model, one in which people care and want to support. Meg's highly relevant point raises such important dilemmas. Meg is emphasising the benefit of having a support worker available at 4 a.m. if support is needed, however, at the same time this may generate anxiety about the future and transition to a setting where there are not staff available 24 hours a day. Inpatient services must tread a fine balance. Their remit is to offer support, safety, security and retraining. However, the risk is that they foster an over-reliance and inhibit the very aim they're trying to achieve, the strengthening of independence.

Meg: I completely agree with how as a patient you can get completely absorbed into the world of constant support. Becoming as independent as your section allows you can be a frustrating and hard battle. The easy option of staying inside just seems natural. Independence can be ripped away from a person when coming into hospital and it takes big steps to get it back, particularly the wanting to get it back.

## Motivation to recover

Meg: The motivation for this kind of recovery I find is very self-directed. It's yourself your waking up in the morning to go to a session. It's you sat in that room and it's you that decides to talk. I can't sit here and say that recovery is easy because currently I'd rather chew through a lemon. Just the other day all I wanted was to run away and forget I ever started this. But then do I really want to end up back in a place like this and never feel at peace with my mind or not have that inner understanding that will maybe allow me to prevent future relapses. This aspect is one of the reasons why I feel the need to continue with sessions. But just like the recovery process itself, everyone's motivation is also a very different journey. I have factors motivating me that others may not have. It's taken me years to compile these factors, or years to even realise these factors. Once a person comes to terms with the fact they might need some help and start making moves towards helping themselves, that for me, is the key that starts to unlock everything else.

## Co-production

Meg: Writing this paper in its self has shown me how far I've actually come. Being able to express and understand what I'm explaining that six months ago I couldn't even begin to think of how to put into words or diagrams. This process has allowed me to re-generate my love of writing and creativity in the arrangement of words. But the most inspiring aspect is that someone has given me a voice in a topic I'm passionate about. And that in itself makes me even more motivated.

A person has listened and had their own light bulb go off. It's a very empowering feeling having someone ask you to co-produce something with you. I hope that what has been written is as informative as I could make it from an inpatient setting. This has been an absolute joy and an experience I will never forget. Thanks Ruth.

Ruth: Meg's drive to co-produce the write up of her and our joint understanding of recovery has sparked energy and passion in me. It has allowed us to have a focus outside of our work, has motivated us to disseminate to others and has demonstrated the reflective capacity Meg has developed over the past year. Our therapeutic relationship has become strengthened by the many hours of writing, editing and healthy disputes about which font colour to use while making changes! Crucially though, it has reminded me how absolutely vital co-produced communication is, however that may look. Surely, co-production and the drive, energy and empowerment it brings along with it offer key qualities that help to drive forward an individual's recovery process.

## Summary

Ruth: We set out to deconstruct the commonly used concept of "recovery" through a co-produced account drawing upon existing literature and Meg's lived experience of mental health services. We considered the contentious nature of the concept and how it can be used. Meg shared her understanding of the word and how she has come to conceptualise this. Perhaps the most notable reflection is that recovery cannot truly be understood unless it is individualised and of meaning to the person engaging in the process. Meg suggested the word "develop" rather than recovery to avoid the misconception that recovery could imply that one is "better" or has been rid of something. Meg highlights that she may not be rid of past memories but aims to learn how to live with them in a way that is meaningful and helpful for her.

Meg: I hope this account demonstrates that to change the font size on recovery itself is an individual venture and can be molded in different ways. It is finding that spark separate to the fire of hatred to the system and fueling the journey across many paths to calmer waters. Also, the persistence to keep working and the drive and willing to share with someone the worries that can drag a person down. In essence, I hope this paper can open a door for someone that is looking for a key, give a new direction on how to problem solve and a clearer insight into this realm of supported living that can tie a person down, but also morph into a stage of recovery and development.

## References

Harper, D.J. and Speed, E. (2012), "Uncovering recovery: the resistible rise of recovery and resilience", *Studies in Social Justice*, Vol. 6 No. 1, pp. 9-25.

Rose, D. (2014), "The mainstreaming of recovery", *Journal of Mental Health*, Vol. 23 No. 5, pp. 217-8.

Social Perspectives Network (2007), *Whose Recovery is it Anyway?*, Social Perspectives Network, London, available at: http://spn.org.uk/fileadmin/SPN_uploads/Documents/Papers/SPN_Papers/Recovery_and_Diversity_Booklet.pdf (accessed 3 August 2018).

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