



STAYING CONNECTED: SERVICE-USER EXPERIENCE OF THE RECOVERY JOURNEY AND LONG-TERM ENGAGEMENT WITH A MENTAL HEALTH CLINIC

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[See table of contents](#)

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Article abstract

While there has been much interest in recent years about the potential impact that short-term therapy can have on those needing mental health support, relatively little attention has been paid to the needs of those who require long-term support. In this phenomenological study exploring long-term service-users' experiences of the recovery journey and the role of mental health support in facilitating that journey, a sample ($n = 6$) of service-users who had a minimum of five years of continuous involvement with a community-based mental health clinic participated in a pair of focus groups designed to help them share their experience of the recovery journey. Our analysis revealed themes of contending not just with extreme violence and other adversities, but also with an often unhelpful helping system, as service-users expended effort in locating the consistent, accessible support they needed in order to find a reason to go on in the wake of devastating personal experiences. The study also emphasized how prioritizing the top-down need for efficiency over the bottom-up need for consistent, flexible support can have the inadvertent effect of extending rather than shortening treatment. Implications of these findings for the delivery of mental health services are discussed.

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Abstract: While there has been much interest in recent years about the potential impact that short-term therapy can have on those needing mental health support, relatively little attention has been paid to the needs of those who require long-term support. In this phenomenological study exploring long-term service-users' experiences of the recovery journey and the role of mental health support in facilitating that journey, a sample ($n = 6$) of service-users who had a minimum of five years of continuous involvement with a community-based mental health clinic participated in a pair of focus groups designed to help them share their experience of the recovery journey. Our analysis revealed themes of contending not just with extreme violence and other adversities, but also with an often unhelpful helping system, as service-users expended effort in locating the consistent, accessible support they needed in order to find a reason to go on in the wake of devastating personal experiences. The study also emphasized how prioritizing the top-down need for efficiency over the bottom-up need for consistent, flexible support can have the inadvertent effect of extending rather than shortening treatment. Implications of these findings for the delivery of mental health services are discussed.

Keywords: mental health, long-term recovery, continuity of care, service-user perspective, phenomenology, resistance to negative social responses

Lyuda Krupin and Nick Todd are psychologists, and Eric Howey and Tara Perry are social workers (MSWs), with Alberta Health Services.

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Abrégé : Si l'impact potentiel des thérapies brèves sur les personnes ayant besoin d'un soutien en matière de santé mentale a suscité beaucoup d'intérêt ces dernières années, les besoins des personnes ayant besoin d'un soutien à long terme n'ont pas fait l'objet de beaucoup d'attention. Cette étude phénoménologique explore les expériences des usagers et usagères ayant utilisé des services de santé mentale à long terme, et le rôle de ces services sur leur parcours de rétablissement. Dans le cadre de cette étude, un échantillon ($n = 6$) d'usagers et usagères ayant un minimum de cinq ans de suivi continu dans une clinique de santé mentale communautaire a participé à deux groupes de discussion (*focus groups*) conçus pour les aider à partager sur leur expérience de rétablissement. Notre analyse a révélé des thèmes liés à la lutte non seulement contre la violence extrême et d'autres adversités, mais aussi contre un système d'aide souvent inefficace, les usagers et usagères ayant dû déployer des efforts pour trouver le soutien cohérent et accessible dont ils avaient besoin pour se rétablir. L'étude a également soulevé que la priorité accordée à la sécurité des personnes et à l'amélioration de la qualité de vie est un facteur important de la réussite de la lutte contre la violence. L'étude a également mis en évidence que de prioriser l'efficacité plutôt que le besoin des usagers et usagères d'avoir un soutien cohérent et flexible peut avoir comme conséquence involontaire de prolonger le traitement au lieu de le raccourcir. Les implications de ces résultats pour la prestation de services en santé mentale sont discutées.

Mots-clés : santé mentale, rétablissement à long terme, continuité des soins, perspective des usagers, phénoménologie, résistance aux réactions sociales négatives

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IN CURRENT PUBLIC HEALTH CARE management, there is an abiding pressure to do more with less (Brown et al., 2022; Davies, 2007; Falkenström et al., 2016). This emphasis on efficiency means that treatment regimens become increasingly homogenized and focused on maximizing the so-called “dose – response” ratio (Hansen et al., 2002; Robinson et al., 2020; Sundet, 2021). In this climate, interest in brief psychotherapy approaches has proliferated, and expectations for the length of successful therapy have tightened (Hoyt & Talmon, 2014). These new expectations have led programs to focus on system-imposed session limits, discharge criteria and decentralized service-user preferences for how their treatment should be provided. At our mental health clinic in rural Alberta, we noticed a number of service-users who appeared to need and to appreciate a much longer involvement in the recovery process than is conventional, and we were interested in hearing about their experiences.

Our research team, consisting of two psychologists and two clinical social workers, works in a clinic that serves an urban town with a population of approximately 30,000 people, which is located a short distance outside one of Canada’s largest cities. The town has one provincially funded addiction and mental health program; this clinic serves individuals of all ages with a wide range of concerns, from family conflict to enduring mental illness. The length of service ranges from one session to several years’ duration. It was the unique needs of our long-term service-users (those who have attended therapy for over five years), who constitute approximately 1.5% of the clinic’s total caseload, that drew our attention in the present study. We undertook a phenomenological study to explore the views of our longest-served service-users in the hopes that their perspective could provide increased understanding of their recovery journey. The role of prolonged engagement in counselling was one area the participants highlighted as both necessary and beneficial to them. The following pages describe the study and our resultant findings, and offer a rationale for the need for service-user-directed therapeutic support that does not preclude long-term engagement in the mental health system.

Reassessing the Value of Long-Term Therapy

While there are many studies that explore the efficacy of therapy in general and what service-users value in mental health services, the specific needs of those with “enduring mental ill health” (Kai & Crosland, 2001, p. 732) are generally understudied. This dearth of research is a significant gap, given that current research is beginning to question the long-held

view that most therapeutic change occurs over the first four to eight sessions (e.g., Bone et al., 2021; Falkenström et al., 2016; Nordmo et al., 2021; Robinson et al., 2020). Nordmo et al. (2021) point out that such estimates often derive from research cohorts that consist of relatively high-functioning individuals in naturally time-limited settings. As such, they cite Robinson et al. (2020) in estimating that 95% of service-users in outcome studies come from university clinics or similar settings. This narrow research population provides a skewed view of how much therapy is necessary or beneficial, which in turn increases the already substantial pressure within mental health services to impose limits on the services they provide. However, when the needs of the moderately to severely afflicted are considered — including the individuals we, mental health therapists, are mandated to serve — Nordmo et al. (2021) conclude that “patients continually improve throughout therapy with appropriate dosage estimates far exceeding what is generally found” (p. 866).

Outcome research also emphasises that a prominent theme in surveys of service-user satisfaction with mental health services is the ongoing relational aspect of continuity of care, which is not a pillar in developing time-limited programs. In a seven-year study of satisfaction rates for service-users of mental health services in rural Norway, Ruud et al. (2016) found that “patients were generally satisfied with the services” (p. 6), proposing that “the continuity of a personal relationship between the patients and the GP [general practitioner] may be one aspect contributing to this, as this has been shown to be one of the key factors in satisfaction of severe mental illness patients with the GP” (p. 7). These findings echo those of Lester et al. (2003) in their study of satisfaction with primary care amongst patients with severe mental illness in an urban British setting. These authors emphasize that “relative ease of access was a key component of patient satisfaction” and that “the potential for a long-term relationship that helped ensure continuity of care, where trust could be gradually earned and where the patient was known as an individual, was particularly highly prized” (p. 510). They also note that, without this continuity of care, service-users are often obliged to retell their story over a series of outpatient interviews, which might help create or at least reinforce the chronicity of a mental illness (Lester et al., 2003).

Kai and Crosland (2001) likewise cautioned that “requiring [service-users] to repeatedly rehearse their medical histories [. . .] could have an adverse effect on their health by underlining their previous distress and the chronic nature of their problems” (p. 732). Other researchers note that, in cases where patients had difficulty in accessing care, they would often use a strategy of “exaggerating their symptoms in order to get an appointment” even when “uncomfortably aware that exaggeration might feed existing negative stereotypes of malingering” (Lester et al., 2005, p. 10). Apart from their overt attempts to manage an unyielding system, service-users who experience such inner discord — as cognitive

dissonance theory (Festinger, 1957) suggests — may seek to resolve it by convincing themselves that they are in fact in serious decline. To the extent they are successful in doing so, we can expect an efflorescence of psychological and physical symptomatology; hence, Cummings' (2001) observation that “one of the most frequent behaviours of patients fearing termination is the return of the original symptoms that brought the patient into treatment” (p. 4). This research suggests that mental health service-users who face obstacles in accessing care can be expected to present as more severely and chronically ill than they would were services more readily available. Such an understanding moves us toward appreciating mental distress as consisting at least as much of problematic interactions between the service-user and helping systems as it does in a medical illness situated strictly within the individual patient.

One model of therapy service provision that approximates the continuous, accessible care valued by service-users is found in the “intermittent therapy” model developed by Cummings (1990, 2001) and others, which is a “series of time-limited psychotherapies over an extended period of time” (Drisko, 2005, p. 7). Cummings (2001) notes that one of service-users' biggest concerns about termination is “What if my symptoms return?” (p. 3). This anticipatory anxiety, Cummings (2001) suggests, may play a part in any relapse they experience. To counter the effects of anticipatory anxiety, Cummings (2001) proposes a concept of “interruption, not termination” (p. 3). Drisko (2005) suggests that such a model would “follow the metaphor of the family physician” in “offering service as needed and requested by the client” (p. 9) rather than as imposed by the service provider. This “new conceptualization of termination” would see it as “ending a piece of therapeutic work rather than ending a relationship” (Drisko, 2005, p. 19; see also Sanville, 1982). In touting the economic benefits of intermittent therapy, Cummings (2001) raises the interesting point that, during gaps in the therapy, the service-user often “continues the therapy, talking to the therapist and finding answers ‘in his or her head’” (p. 4). Cummings (2001) also maintains that focussed intermittent psychotherapy — at times preceding absolute necessity — prevents later serious episodes that would require more extensive treatment. Thus, early intervention is not only therapeutically desirable, sparing the patient prolonged and even increased distress, but it is also cost effective, in that it prevents the need for more costly interventions at a future time. Models such as the intermittent therapy model provide a way in which discreet chapters of therapeutic work can be closed without the disruptive need to close the book on the therapy as a whole. As practitioner-researchers, our key interest was in learning from our clinic's service-users how we can develop a model of service delivery that is responsive to their need for continuity of care while also acknowledging our need to make our services available to as wide a range of service-users as possible.

Method

After a review of various qualitative research methodologies (Creswell, 2013; Lavrakas, 2008), the research team chose phenomenological research as the best fit for our goal of understanding long-term service-users' experiences. Phenomenology also offers guidance in addressing researcher bias: "Phenomenology is a project of sober reflection on the lived experience of human existence — sober, in the sense that reflecting on experience must be thoughtful, and as much as possible, free from theoretical, prejudicial and oppositional intoxication" (van Manen, 2007, p. 11). To add to the richness of our information and with the intention of hearing the voices of our participants, we chose to collect information using two focus groups: the first to gather information, and the second to share the findings and provide the participants an opportunity for clarification and feedback (Morgan, 1997).

Phenomenological research asks researchers to acknowledge and "bracket" their pre-existing positions and experiences in order to set aside the researchers' beliefs, feelings, and perceptions and be more open to the participants' first-hand knowledge of the experience being investigated (Creswell, 2013). As therapists in the clinic, we acknowledged that we would have biases, and thus no therapists who had had a direct therapeutic relationship with participants were involved in either focus group.

Prospective participants were all long-term (i.e. beyond five years of first receiving service) adult mental health service-users between 18 and 65 years of age who were able to give consent and had the cognitive ability, as judged by their primary therapist, to reflect on their personal experience. An administrative assistant initially contacted the 25 prospective participants by telephone. Those indicating an interest in participating were then provided with a letter outlining the research proposal, ethics approval process, and intended participant questions. Six chose to participate. Each participant provided written informed consent before the first focus group. Consents were reviewed with the researcher during the first focus group, and participants had the chance to ask any questions before the first focus group started. Participants were also informed that confidentiality could not be guaranteed due to the attendance of multiple service-users in each group.

Participants consisted of three men and three women; five identified as white and one as Indigenous. Diagnoses accumulated during their involvement with the mental health system included post-traumatic stress disorder, schizoaffective disorder, psychosis not otherwise specified, and major depressive disorder. Participants experienced moderate to severe impairment in functioning; due to the debilitating effects of their severe mental illness, most were supported by pension or disability incomes. The ages of participants ranged between 40 and 60 years. To protect our research participants' anonymity, we have not distinguished between

speakers or attributed to separate individuals any of the quotations provided below, not even through the use of pseudonyms.

Data Collection

To clarify the unique needs of long-term service-users for ongoing support, the research team developed two questions that we asked in the first focus group:

- i. What is the recovery journey experience of a long-term mental health service-user at our clinic?
- ii. What is the role of a community outpatient mental health clinic in this journey?

The research team felt that these questions best provided structure for service-users contributions while also keeping the focus as broad as possible.

Focus groups were conducted by two clinicians. The lead interviewer, Eric Howey, MSW, was a member of the research team; he had not worked directly with any of the participants. The support therapist, Melissa Devine, MSW, was not otherwise involved in the research program and likewise had not worked with any of the study participants to assure no conflict of interest or influence from previous knowledge. The first focus group was 2.5 hours long, while the second was 1.5 hours long, in accordance with Kreuger's (1997) recommendations for allowing sufficient time for data gathering.

The focus groups were audio recorded and transcribed for data analysis. All four researchers were involved in coding data. To minimize biases, a minimum of two researchers were present during the written phase of coding. The process of developing themes began with horizontalizing the data — that is, initially assuming that every statement is important, and from there deriving meaning units that best summarized the descriptions of service-user experience (Braun & Clarke, 2008; Moustakas, 1994). Themes were derived from the data and checked for accuracy with participants when they returned for the second focus group.

Findings

We derived four main themes from our analysis: (1) the significance of experiences of trauma and violence as a source of both struggle and strength, (2) the role of professionals as both helpful and unhelpful in the recovery journey, (3) the positive effects of community, connection, and isolation, and (4) dislike of the term 'recovery,' with preference for the term 'journey.' Quotations from the participants are included to illustrate the themes derived from the data; however, for privacy considerations

related to living in a small community, participant identification was not assigned.

Violence and Trauma

Participants afforded traumatic experiences a prominent place in their accounts of their recovery journeys, most relating a history of traumatic experiences that included both intentional harm by others and accidental loss and bereavement. For example, one participant spoke of the violence he experienced in his childhood:

I'm the oldest of ahh, 10 children [. . .] and growing up, ahh, was always a struggle in our family. We were a poor family and, ummm, alcoholic dad and mom and, you know, I, growing up I got beaten, as did a lot of my siblings. To be like, to be knocked out unconscious and a couple of times saved my mom from being killed by my dad, three times maybe. So went through life with that. I've always been in charge of or been physically a parent to all my siblings.

Participants also testified that unhelpful comments or judgments from others were emotionally damaging:

You tell people [what happened] and they just think, no, no, this kind of thing doesn't happen that only happens on TV, that doesn't happen in real life.

This participant did not have an extensive history of traumatic injury, but nevertheless noted the disproportionate impact of negative social comments on their well-being.

Another participant emphasized how the pain they experienced was compounded by the unhelpful actions of the helping system, beginning with being billed for parts of their dying daughter's care:

My daughter lived for five days [after the fire]. She was airlifted to [a community hospital in Edmonton] and I had to take her off life support. And after I took her off life support, I donated all of her organs because there was a young lady who needed a heart and lungs, and so I donated all of her organs to save basically this one young woman [. . .] [W]hen we went through the court system, the federal government actually billed me for part of my daughter's care, after she saved five lives [. . .] Um, to bill me \$18,000 for part of my daughter's medical care when she saved five lives.

Other participants suggested that further hardship and trauma was caused by an adversarial court system that begins from a position of skepticism and doubt, and by professionals that participants consulted not believing them:

[A government agency] wanted me to go to a psychiatrist when I had already been seeing a psychologist for eight years, but they wouldn't accept what [my psychologist] said. And they sent me to the psychiatrist, and I told him what happened, and

within five minutes his whole demeanor changed, and I realized he didn't believe a single word I had said. And it was just way obvious with his body language and the questions he was asking.

Researchers such as Bonnan-White et al. (2018) confirm that such responses are common, noting that “between 25% and 75% of trauma survivors experience negative reactions from social support system members” (p. 1264). Bonnan-White et al. (2018) assert that such responses “have the potential for re-victimization and adverse outcomes,” while “positive reactions from others have consistently been found to buffer the negative effects of trauma” (p. 1264). We conclude that the need for continuing validation in the face of ongoing negative social responses is one argument for extended involvement in therapy throughout the recovery journey.

Professionals

All participants in the research study had experience with different helping professionals (such as doctors, psychiatrists, and mental health therapists) over the course of their lives, with uneven results. On the one hand, they expressed the value of professionals and the importance of relationship and fit. Helpful professionals were trustworthy, safe, and consistent; they could provide useful direction. One participant reflected that they needed

A safe place where you can trust your surroundings. It just came to me that when I am driving, and when people that I know are driving, they come across unexpected situations. So, when you are driving you have to be on high alert. You can't exactly trust your surroundings. For a million different reasons. But when we're in a room with a counsellor that we trust, or I am in my sanctuary, it is unlikely that I am going to get ambushed. You know, anything is possible, but it is unlikely, so I can take a deep breath and relax as best I can.

On the other hand, participants observed that trusting, consistent relationships with professionals were often lacking. As one participant succinctly noted, “I've also met a lot of crack-pot therapists along the way; just so you know, you're not all sane and lovely.” Such professionals were experienced as judgmental, prescriptive, and inconsistent. Another participant observed, “We are looking for a safe place. Some place where we can actually relax our — what do you call it when you are tense because you are expecting another attack?” Participant feedback emphasized that, when therapists offered direction and guidance without first establishing therapeutic alliance, their words were often experienced as judgmental and unhelpful:

Some people out there want to fix you. They're fixers. But they haven't been, they don't have enough depth [of understanding] of your situation, or whatever issue

you are dealing with, they just try to be exuberantly helpful. Sometimes that can be unhelpful. There's a lack of understanding that some things can't be fixed in five counselling sessions.

The frequency with which participants reported unhelpful experiences with mental health services is concerning, given the many studies extolling the importance of the connection between clinical efficacy and therapeutic alliance (e.g., Brown et al., 2022; Jordan, 2002; Shotts, 2019).

Consistency thus emerges as central to developing trust and safety, and — for participants with extensive histories of loss — consistency was crucial for the therapist to build a depth of understanding of these experiences.

Seeing the same therapist for a long period of time was a pillar in my support because to start with someone new is really, really, really, really difficult. I had this assurance in my heart and mind that he had seen me enough that he would know, he would see changes in me, I could bounce things off him because he had seen me on good days and bad days; this year and that year; this season and that season. So somebody knowing you for a long period is huge, versus like say a walk-in where they don't know you from Adam.

Brown et al. (2022) note that, since research has repeatedly confirmed that “relationality is the primary determinant of therapeutic success [. . .] it is arguable that a short number of sessions may be a barrier to the development of a strong therapeutic alliance and successful outcomes, particularly in complex and co-occurring issues that include trauma” (p. 2). Participants’ comments further echo the findings of researchers such as Ratcliffe et al. (2014), who emphasize the importance of therapy for creating “a localized sense of safety” (p. 10) from which larger recovery efforts can be launched for those who have been subjected to severe violence.

Connection

Another theme that emerged was participants’ emphasis on the fundamental importance to the recovery journey of healing connections with family, friends, and community: “I think [. . .] if you don't have a connection, you can't go down the road; the road just stops.” Family support was seen as important, but also as a connection that could cause further pain, particularly if there was rejection or lack of understanding on the part of family members. Participants noted that it was helpful to feel connected to community through altruistic acts such as standing up for their children and protecting endangered siblings as a child. Even endorsing their own suffering often made the journey easier: “*maybe with all that I'm taking onto me, maybe somebody else is getting a pass.*”

While much healing occurred in relationship with others, some also found it in times of solitude or connection with nature: *“because I’m interacting with nature, I’m seeing things that interest me and I’m connecting, ummm, in a massive way.”* The participants’ reflections helped us recognize our own initial assumption that isolation was a negative factor in the recovery journey. In fact, being alone was often helpful for participants in reducing stress levels, feeling safe, and developing strong connections with self and nature.

Given the ambivalent sense of connection they often had with their own families of origin, it is interesting that participants emphasized the importance of a sense of connection with the clinic over time, describing that connection as similar to the enduring bonds that might ideally develop between family members:

This has become my family, [the clinic]. This has become the place where I [. . .] come to just release what I’ve gone through, you know, and since my last session, because there’s always something.

Our research participants’ language challenges a tension in our field between acknowledging the critical importance of therapeutic relationship and a caution against ‘developing dependency.’ It could also be argued that this building of a sense of surrogate family can be understood as a way of taking control over the randomness of being assigned to a family of origin that might have been more hurtful than helpful. By likening their involvement with the service to participation in a family, service-users might be resisting commodification as an object of treatment by new public management. It is thus potentially a response to system-focused services, or what one commentator has called “the dominating relationships in health care between the medical model, the randomized controlled trial and new public management” (Sundet, 2021, p. 1), through which the uniqueness of the individual is lost in favour of the “generalized individual.” Fox (1999) also details how “institutions produce the types they need to do their work” (p. 436). Nonetheless, participants suggested that connection over time was important to their healing.

Journey

Another challenge to our initial assumptions came from participants’ discussion of the term “recovery.” Recovery has become a popular term in mental health literature and academic discourse over the past few decades since being championed by Anthony (1993). However, participants did not feel this term described their efforts to improve their lives, even if in the academic literature or mental health promotional materials, “recovery” is constructed differently.

I don't think recovery is necessarily the right word. I guess it is a good question. I feel like recovery — does that mean that everything is healed? Is that how we look at recovery? Is that what it is?

The notion of recovery was too rarefied a concept to seem attainable:

A picture came to my mind of the word 'recovery' being winning Olympic gold and all I want is some fresh air and a little bit of exercise [. . .] I mean that is what I call recovery. Something that rips your heart and soul out of you — how do you recover from that?

Participants shared their understandings that, as the victims of events and experiences they did not choose and cannot change, their lives may never be the same. Rather, their experience is of a journey — one in which they are living with rather than overcoming or recovering from the mental health concern. The journey remains an ongoing process of change in their lives. A core element of this journey was persistence in the face of overwhelming adversity. A second feature of this journey was its unidirectional nature. Over time, participants came to see that the destination was no longer a return to a former state considered “normal,” but rather a new equilibrium that often blended insight and lessons learned with the need for acceptance and compromise with a new reality:

For most of us, we are never going to get there [back to where we were], at least for me. Now, that doesn't stop me from trying, and it doesn't stop me from trying the things people tell me to do, but, with the damage that had been done, there is no way back. I have to find a new way.

The notion of a journey supports the idea of ongoing connection and relationship, precisely because there is no end-point.

Discussion

Our participants' insights about helpful and unhelpful aspects of their journey and the role of continuity and connection with a trusted professional provides a much-needed counterpoint to the tendency of mental health services to become consumed by the question of efficiency. Participants' comments support, from a number of perspectives, the need for access to long-term continuity of care that is service-user-directed rather than session-limited.

First, there is their assertion that long-term support is necessary for long-term afflictions. While brief therapy strategies can be useful to help those with severe mental illness deal with specific, discrete problems of living (Hoyt & Talmon, 2014), our study suggests that such help is best delivered in the context of open-ended support that matches the chronic nature of the service-user's struggle. Open-ended support reduces the

need for those facing immanent termination of their service provision to manifest increased symptomatology in order to assert their need for consistent support.

Our research also revealed the importance of a consistent relationship in therapy as a way to allow service-users the time to make the critical shift from recovery — in the sense of “re-covering” or returning to a previous normal state — to a journey toward a new normal that acknowledges that things have permanently changed. This implicit critique of the recovery concept echoes recent work that has sought to complicate our understanding of this popular term (e.g., Braslow, 2013; Rose, 2014; Woods et al., 2022). An important dimension of the recovery journey for participants was the development and recognition of a history of resistance — not just to the original experiences of violence imposed on the service-user, but also to the pervasive experiences of invalidating negative social responses that all participants experienced (Coates et al., 2003).

The insights of our service-users also revealed the multiple failures of the dysfunction or disease model — borrowed from the medical treatment of discrete injuries and pathologies — to capture the dynamic and evolving nature of the kind of concerns people bring to psychotherapy. Thus, a struggle that started as in incident of childhood mistreatment may evolve over time to involve a crisis of self-identity, struggles with mental and physical health, and a need to deal with a lifetime of negative social responses imploring the service-user to ‘get over it’ or ‘stop living in the past.’ Open-ended, service-user-directed therapy acknowledges the reality that psychological treatment is not a ‘dose specific’ treatment of a unitary psychological disorder, but an ongoing response to an evolving and dynamic complex of physical, mental, and social dimensions. Recent research by Nordmo et al. (2021) details how the pathology or dose metaphor borrowed from the biomedical model fails to capture the emergent quality of the psychotherapeutic process and results in severely underestimating how much service-users continue to benefit from open-ended therapy.

Hearing the voices of our service-users helps us prioritize their need for accessible, consistent and flexible support over the need of the system for efficiency or the need of the therapist for a ‘cure’ or a lighter caseload. Our analyses of their comments highlight the paradoxical effect that a helping system overly concerned with efficiency can ultimately produce more mental illness, not less. We join with others who have pointed out that, as active tax payers, service-users can be viewed as “part-owners” of the service and therefore as having a right to be “actively involved in any publicly funded research that may impact on their health status” (Boote et al., 2010, p. 12; see also Beresford, 2005; Crits-Cristophe et al., 2017; Davies, 2007; Grim et al., 2016; Ross et al., 2014). Service-user-feedback can therefore be considered both morally and practically beneficial to both providers and service-users of mental health services.

Limitations

This study was conducted in a small community with limited opportunity to create enough data for full saturation or for comparison across groups in other small mental health clinics. Also, those accessing private services may be a uniquely different population with varied experience, in that the reality of our location in an affluent community may also present a certain perspective and experiences that may not be easily translated into other communities. Therefore, further research with more varied community experiences would be beneficial to make broad generalizations on the needs and demands of this population at large.

Conclusion

This study explored the needs of long-term service-users at a rural mental health clinic, an area not sufficiently considered in the literature. Our findings both confirmed our intuitive feeling that obliging service-users to complete treatment in a set number of sessions may not be helpful and may be in fact counterproductive for some, and gave us surprising insights into how aloneness may be part of a helping process that participants preferred to describe as a journey rather than in terms of recovery. Our findings also revealed ways in which service-users resist commodification as objects of treatment who can be expected to conform to the efficiency demands of what has been described as a neoliberal and biomedical assemblage that “has pressured practitioners to adopt medicalized, short-term strategies, under efficiency-based models legitimized by claims of “evidence-based” practice” (Brown et al., 2022, pp. 1–2; see also Davies, 2003; Holmes et al., 2006). Insisting on long-term connection is one way service-users defend their humanity in a system increasingly concerned with moving them along a conveyor belt of time-limited, goal-focused therapy. In replacing metaphors of production and efficiency with metaphors of connection and continuity, service-users not only resist the increasing digitization and medicalization of the treatment process, but simultaneously remind us that connection is not something that can simply be turned on at the beginning of a session and turned off at its end. Their voices remind us that sacrificing connection on the altar of efficiency is an assault on the beating heart of therapy.

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