STORIES OF MENTAL HEALTH, RESILIENCE AND RECOVERY

AMANDA COSTELLO
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INVESTOR IN PEOPLE

From Jerome
This book is dedicated to Professor Mary Boyle, Dr Martyn Baker and Brenda May.

From Amanda
This book is dedicated to my courageous daughters, who are able to discuss eloquently about eating disorders and trauma and the effects on the lives of others.

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FOREWORD

What does it mean to live through trauma and then to live beyond it?

Stories of Mental Health and Resilience offers no single answer to that question. Instead, it offers something deeper and more powerful: the voices of those who have lived it. At the heart of this book are seven stories personal, raw and courageous drawn from interviews conducted by Amanda. Each one reveals a different path through pain, survival and ultimately, the ongoing journey of healing. These stories are presented with care, and all identifying details have been changed to protect the privacy and dignity of the individuals who shared them.

The structure of this book mirrors the complexity of recovery.

In Chapter 1, Amanda sets the foundation with a thoughtful introduction to the concept of trauma: what it is, how it manifests and why it matters. Trauma is not just an event but a lived experience with long echoes. Understanding it is crucial to understanding the rest of this book.

In Chapter 2, Jerome shares his own story in an autoethnographic reflection on the mental health recovery movement. This personal account situates the reader in the broader context of advocacy, systemic challenges and the power of collective voices in shaping change.

Chapters 3 through 9 hold the emotional core of this work. Amanda's interviews with seven individuals illuminate not only their struggles but also their strength, insight and resilience. These are not stories of simple triumph. They are stories of persistence of people who are still here, still growing and still working through the complexity of their lives.

Finally, in Chapter 10, Jerome returns to reflect on the broader lessons we can take from these narratives: lessons for individuals, communities and systems alike.

But before diving into these accounts, it is important to ask: *What is trauma?* This question, deceptively simple, opens a door into the themes explored throughout the book. And as you turn the page, Amanda will help guide us through that door.

This book is not a clinical manual, nor is it a detached academic study. It is a human book, one that acknowledges pain, honours courage and invites us all to listen more deeply.

Let us begin.

PREFACE

Thank you for highlighting your courage and resilience in sharing your personal stories of mental health and resilience.

Beth's openness and strength in sharing her mental health journey is deeply inspiring. Her vulnerability fosters connection, and her courage paves the way for others to feel seen and supported. She leads with both heart and honesty.

Della brings bravery and authenticity to every conversation. By sharing her story with compassion and clarity, she breaks down stigma and reminds us of the power of resilience. Her voice is one that truly empowers others.

Phil's willingness to speak openly about his experiences with mental health is a powerful example of leadership through vulnerability. His strength lies in his sincerity, and his story offers hope, perspective and real connection.

Rachel's story is a testament to the quiet courage it takes to keep going and to speak truthfully about the journey. Her authenticity is deeply moving, and her advocacy helps build a culture of empathy and support.

Colleen shares with warmth, courage and generosity. Her story is one of strength through struggle, and her voice helps others feel less alone. She exemplifies the healing power of honest dialogue.

Jan brings wisdom and gentleness in sharing her mental health experiences. Her reflection and grace shine through, offering comfort and solidarity to those walking similar paths. Her story is a gift.

Fiona's resilience is matched only by her compassion. By telling her story, she not only affirms her own strength but opens a door for others to step forward. Her courage creates ripples of change.

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ACKNOWLEDGEMENTS

From Jerome

One of the advantages of aging is that you become more reflective and hopefully more appreciative of the support and guidance you have received along life's journey. As I point out in Chapter 2, I have had two main careers, the first as a clinical psychologist and the second as a professor of psychology. My entire professional career since graduating in 1979 has been in psychology. When I look back, I am now more grateful for the teaching and support I received from the three clinical academic tutors at the University of East London. These were Professor Mary Boyle, Dr Martyn Baker and Brenda May. For our first year, we also had Dr Andree Liddell. When I got my first job after graduating as a clinical psychologist, I received a card from my tutors which simply stated, 'We believe in you'. Few cards have had such an impact on me as this one. Mary, Martyn and Brenda, you may never have realised how these few words had such an inspiring impact on me. Some 41 years later after you wrote them, I am grateful for the positive boost they gave me at the start of my clinical career. Thank you from the bottom of my heart.

From Amanda

Listening to the lived experiences of others, who have had their mental health affected by the behaviour and actions of other people, including services that are employed to serve, has been humbling. The injustices that have been experienced by the participants in this book has made me reflect and realise how much suffering has been created by individuals, who have lacked compassion and empathy, during times when the participants have been vulnerable and alone.

Inclusion and diversity is an important aspect of our everyday lives and requires us all to practice inclusion, care and compassion at times when others are suffering and need our support.

Throughout my career as a nurse and a teacher, I have witnessed how dangerous behaviours and action can affect the everyday lives of individuals and their families.

The impact of the participants' stories and reflections is an essential guide to ensure that we all whistle blow poor practice and the dangerous behaviours towards vulnerable people that always deserve the very best support to make sense of the trauma that is a cause of their mental health.

The strong and courageous participants in this book are acknowledged for their high levels of inner strength and resilience.

Thank you all for sharing your stories to support the lives of others who may be struggling to make sense of themselves.

1

WHAT IS TRAUMA?

The central part of this book of *Stories of Mental Health and Resilience* is the seven stories that form the backbone of the book. The stories are from interviews conducted by Amanda. All identifying details have been altered, including names, to protect confidentiality and to preserve anonymity. In Chapter 1, Amanda provides the background to an understanding of trauma. In Chapter 2, Jerome provides an autoethnographic account of his involvement in the mental health recovery movement. Chapters 3–9 are the interviews Amanda conducted with the seven contributors. In Chapter 10, Jerome summarises lessons arising from the book. Let's start though by trying to define trauma.

Trauma, a complex and multifaceted concept, is often understood as an emotional response to a deeply distressing or disturbing event that overwhelms an individual's ability to cope, causing feelings of helplessness, diminishing their sense of self and creating emotional turmoil. According to Judith Herman, a psychiatrist and author of *Trauma and Recovery*, trauma can result from a variety of experiences, including but not limited to, violence, abuse, accidents or natural disasters (Herman, 1992).

Bessel van der Kolk, a prominent psychiatrist and author of *The Body Keeps the Score*, emphasises that trauma is not just a psychological condition but also has significant physiological implications. Van der Kolk explains that traumatic experiences can alter brain function, affecting areas responsible for emotion regulation and memory processing (van der Kolk, 2014).

Peter Levine, another expert in the field and author of *Waking the Tiger: Healing Trauma*, describes trauma as an event that overwhelms the nervous system and disrupts the normal coping mechanisms of the body and mind. Levine's work highlights the importance of addressing trauma not just through talk therapy but also through body-oriented therapies that help

individuals process and release the trauma stored in their bodies (Levine, 1997).

These scholars collectively highlight that trauma is not merely an event but the body's response to an event. The impact of trauma can be pervasive, affecting one's mental, emotional and physical health. Effective treatment often requires a comprehensive approach that addresses the mind and body, emphasising the importance of restoring a sense of safety and empowerment to the individual.

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2

WHAT IS RECOVERY? AN AUTOETHNOGRAPHIC ACCOUNT

INTRODUCTION

This chapter is written from a personal perspective. It uses an approach called autoethnography, which may be new to many readers. The basis of the chapter will be to talk about my own journey of recovery, from being a clinical psychologist and working to develop the approach now known as recovery to my current post as a professor of psychology, still with a great interest in and involvement with the concept of recovery.

FROM REHABILITATION TO RECOVERY

After I finished my clinical psychology training at the University of East London, I was unable to get a job in London. I had to move to Kidderminster, just South of Birmingham to work in a district general hospital psychiatric unit as a basic grade psychologist. We never managed to sell our house in London, and after a burst water pipe that flooded the house, we were forced to return to London after only 14 months in the job. I managed to get a job locally at Claybury Hospital in Essex. This was one of two large psychiatric hospitals scheduled for closure. The North-East Thames Regional Health Authority decided that Friern Barnett Hospital and Claybury Hospital would be the first mental hospitals to close. Other mental hospitals like Runwell, Goodmayes, Severalls and Warley would be allowed to stay open, but the direction of travel was clear: they were all going to close in the future. The government had decided that community care was the way forward.

The new job I had secured at Claybury was as a senior clinical psychologist. The main part of the job was to work in the hospital's rehabilitation unit, which comprised two wards and an assessment unit. I was also involved in the plans to move patients from the hospital to new community residential services. One of the first things I was asked to do was to conduct a survey of the inpatient wards using the Hall and Baker Rehab Scale. This was a nurse rating scale that two nurses completed on every inpatient, almost 650 patients (Carson et al., 1989). The main guiding principles of our work were psychiatric rehabilitation as articulated in the main textbook of the time (Watts & Bennett, 1983). The process of rehabilitation could however take several years, so it was clear that a different approach was needed to move all the patients from hospital to community. New approaches such as normalisation or social role valorisation were called for. I was involved in helping to design some of these new community residential services. After almost 7 years, I was encouraged to apply for the position of lecturer in psychiatric rehabilitation at the Institute of Psychiatry, where I moved in 1992. Part of the reason I wanted to move was to work with one of Britain's leading rehabilitation psychiatrists Dr Frank Holloway.

I was originally based in the St. Giles' Day Hospital in Camberwell. Frank had been involved in the reprovision of Cane Hill Hospital in Surrey and moving patients from there back to Lambeth. This was still quite a traditional rehabilitation service with day hospitals, day centres, a sheltered employment service called SRA and a range of supported living services. Some of these services had 24-hour staffing, others with much less support and some people living independently. However, in 1995, the local mental health service decided to move to sector-based generic community teams, based in community mental health centres. My role then changed to becoming more of a generic clinical psychologist with my own caseload and less of a rehabilitation specialist.

In 1996, I attended the World Association of Psychiatric Rehabilitation conference in Rotterdam, Holland. I got to hear Dr Patricia Deegan and Professor John Strauss. Both were amazing clinical academics, but it was Deegan who was to have the more lasting influence on me (Deegan, 1996). After the lecture, I bought a copy of the video of both their talks and started using her video in training with mental health professionals and in my work with patients. Frank left to work in Croydon and asked me to join him, but I decided to stay on in West Norwood, where I had built up a caseload of 60–100 patients. When we merged with the West Lambeth services, we had to change our clinical model to two teams. One was to be called the Assessment and Treatment Team and the other the Recovery and Support Team. In 2006,

I moved to work in Streatham. It was then that I started to embrace the recovery model that I had first heard about from Patricia Deegan in 1996.

WHAT IS RECOVERY?

There are many definitions of mental health recovery. Probably the most famous was that developed by the late Professor Bill Anthony. He stated,

> *Recovery is a deeply personal unique process of changing one's attitudes, values, feelings, skills, and roles. It is a way of living a satisfying, hopeful and contributing life, even with the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness. (Anthony, 1993)*

I decided to focus my attention more on the Recovery and Support Team and provided monthly education sessions when I addressed various issues linked to recovery. This led to one of the most productive phases of my clinical career. The recovery approach meant recognising two types of expertise. There was that of the mental health professional who had studied mental illness for years and developed clinical expertise in working with people who had psychiatric illness. More significantly the people with lived experience were now to be regarded as partners in the process of recovery. This meant a complete transformation in the way we worked with patients. We were now partners, though never equal partners, as we were paid, and they were not. However, together we embarked on a number of joint projects.

The Recovery Group was one of the first things we established (Morgan & Carson, 2008). This was a monthly meeting for any patients who wanted to attend. It involved bringing in outside speakers to talk about their stories of recovery to inspire our patients. Hence we had talks from people like Peter Bullimore (Bullimore & Carson, 2012), Andrew Voyce (Voyce & Carson, 2013), Stuart Baker-Brown (Baker-Brown & Carson, 2013) and the amazing Rachel Perkins (Perkins, 1999). We also had presentations from many of our own patients who had a wide range of talents that they shared with the group. We had presentations on poetry, art, music as well as hearing remarkable life stories. This led me to develop a series of papers called Recovery Heroes, which featured some of our own patients Dolly Sen (Sen et al., 2009), Margaret Muir (Muir et al., 2010) Gordon McManus (McManus et al., 2009) and Matthew Ward (Ward et al., 2010b). It was Dr Peter Chadwick who

attracted the biggest audience of 50 to our community team base, and he also featured in the recovery heroes' series (Chadwick et al., 2009). Additionally, we ran recovery workshops, a Recovery Oscars event and exhibitions for World Mental Health Day. Two of our most memorable activities were making a recovery film and Matt Ward's plays.

The recovery film was made by Michelle McNary. My clinical psychology students had been working with Michelle for almost 2 years. They would arrive on 6-month placements with me, and I would always ask them to work with Michelle, as she clearly benefitted from having bright clinical psychology trainees seeing her on a regular basis. After she had just finished seeing the third trainee, Michelle asked why could not she work with me? I agreed to take her on personally. We established a goal that she would make a film about her own recovery from a very serious psychotic episode that had led to her spending a year in hospital. It proved too challenging for Michelle to script her own story. I suggested *'Why don't you make a film about recovery?'* Frank Holloway suggested enlisting the help of Dr Paul Wolfson, who, before becoming a psychiatrist, had been a scriptwriter. Michelle and I presented the idea for a film to two senior managers from the South London and Maudsley NHS Trust. To my surprise, they agreed to give us £15,000 to make the film (https://www.youtube.com/watch?v=vGHQHQIDRLI&t=33s). The film has had over 10,000 views. The four patients who took part sounded like recovery philosophers (Carson et al., 2012). I actually edited a book with one of the people in the film, Gordon McManus (McManus & Carson, 2012). Gordon developed his own definition of recovery,

> *Recovery is coping with your illness and having a meaningful life. (McManus, 2012, p. 53)*

I was approached one day by a man called Matthew Ward. He had been asked to speak to me by his occupational therapist Davina Blunt. He told me he was an actor. I asked him what he felt he might be able to contribute to our recovery group. He said he had a one-man play called St. Nicholas, which lasted 90 minutes. I arranged for him to give a performance of the play at the team base. Part of the way through this, he forgot his lines. My heart stopped beating for a second. Luckily, he remembered his lines and on he went to finish the play to great applause. I had invited one of the heads of fundraising from the Guy's and St. Thomas' charitable trusts to hear him. On the strength of this performance, she commissioned us to put on the play at five locations in Lambeth, with the last night being in the Great Hall at St. Thomas' Hospital. Each performance was followed by me interviewing Matt about his

mental illness. So, we made the entertainment into an educational exercise with handouts and a questionnaire (Ward et al., 2010a). Equally importantly, Matt agreed to stand in when Dolly Sen was unable to present at a one-day recovery conference. Matt developed a presentation, *'My recovery a work in progress'*. In this, he told his own story of recovery, in between short periods of mesmerising Shakespearian acting, with excerpts from King Lear and Hamlet. An amazingly talented man. I had not seen his presentation in advance, so I was as astounded by his theatrical performance as was everyone else. Reality intruded in what was one of my proudest days working in the health service, when I called the team base for an update on one of my patients who had gone missing, only to be told that he had hung himself. I had to go back into the workshop and pretend that nothing had happened, though I informed some of the managers who were attending. What a day!

FROM RECOVERY TO BURNOUT

My main character strength on the Via Strengths Test is 'Zest, energy and enthusiasm' (see www.viastrengths.org). This led me to initiate a number of innovative developments in recovery in South-West Lambeth. Matt's 1-week tour meant going to five different venues, setting up the refreshments, giving out and collecting the questionnaire surveys at the end. There was so much copying to be collated that I had my children help me with the stapling and so on, placing handouts into folders and other admin tasks. I was still doing my day job as a clinical psychologist seeing patients. In addition to coping with the aftermath of two patients' suicides, I had another patient throw herself off a cliff. Another patient tried to hire a hitman to kill a man living in his mother's house, his inheritance and was sent to prison. Eventually, this was beginning to eat away at my own morale, and I decided to take early retirement from the NHS at the age of 54. I wanted to go out with a bang and hosted a large 'retirement do' in the atrium at Guy's Hospital, attended by over 100 people. It was worth every single penny of the £5,000 it cost me.

FROM BURNOUT TO BOLTON

After about 6 months of retirement, I realised I was going to need to find another job to boost the family income. I decided I would try and become a university lecturer. Conversations with my friend Professor Woody Caan

suggested I might apply for a Visiting Professorial role. It seemed there was little difference between the role of a Visiting Professorship and a full-time Professorship. I decided, therefore, to apply for three professorial positions. I was only interviewed at Bolton. By the time I reached back home to London, I had a call from the University to offer me the post of Professor of Psychology, which I accepted on the spot. A new chapter was about to start.

STUDENTS AS PATIENTS

When I announced that I was retiring, my previous line manager challenged me saying, *'You'll never survive without working with patients!'* He knew how much patient contact meant to me. I had hoped when I arrived at Bolton to be able to give the students examples of clinical cases that I had worked with as a way of bringing the subject of mental illness to life. I soon realised that a large number of our students had mental health problems themselves. Having recently started a new series of patient narratives, 'Remarkable Lives', a follow-on from the earlier 'Recovery Heroes'. I was soon able to recruit new storytellers from some of my students. Having accumulated a number of these narratives, one of my students, Robert Hurst, and I decided to try and analyse these student narratives using the CHIME model of recovery (Hurst & Carson, 2021a).

THE CHIME OF THE BELL

While analysing these stories, Robert intuited that there was probably a sixth factor at work. The term CHIME was established by Professor Mike Slade and his team (Leamy et al., 2011). Their work built on that of some Australian researchers (Andresen et al., 2003). Retta Andresen and her colleagues had looked at the patient recovery literature and noted there seemed to be four key elements in recovery. These were **H**ope and Optimism, **I**dentity, **M**eaning and **E**mpowerment. Mike Slade and his colleagues felt that the Australian researchers had missed human connection or relationships, which are vital for all of us. They suggested adding **C**onnection to the original work by Retta Andresen and her colleagues, hence **CHIME** was born. Along with other colleagues, Robert and I were able to validate the CHIME model using both student and lived experience narratives (Hurst et al., 2022). Robert suggested we add C for creativity, to make the model C-CHIME, as he could