

Service user perspectives on recovery: the construction of unfulfilled promises in mental health service delivery in Ireland

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Abstract

Purpose – *The concept of personal recovery is now a key pillar of service delivery. It aims to support individuals to flourish and establish a new identity following an acute episode or diagnosis. This view of recovery is unique to each person on that journey. However, there has been a significant focus on measuring these experiences. This paper aims to explore the influence of social constructionism on the concept of recovery within an Irish context, seeking to understand the influence of language, discourse and power on service users' experiences.*

Design/methodology/approach – *A qualitative, interpretivist methodology was adopted for this case study design. Semi-structured interviews were conducted with 12 service users. Thematic analysis was chosen as the method of analysis.*

Findings – *Personalising recovery did not always lead to the removal of biological symptoms, but with the appropriate supports, individual's recovery journey was greatly enhanced. On the contrary, personal recovery places overwhelmingly responsibility on the individual to succeed, largely driven by neoliberal discourse. This focus on individualism and the pressure to succeed was further experienced when people sought to re-integrate into society and participate in normalised social order. Ultimately, for many service users, they viewed personal recovery as an unfulfilled promise.*

Research limitations/implications – *It is not a representative sample of service users within an Irish context.*

Originality/value – *To the best of the authors' knowledge, this is the first study to explore influence of social constructionism on the concept of personal recovery within a mental health service context.*

Keywords *Personal recovery, Mental health services, Service user experience, Social constructionism, Discourse, Power, Neoliberalism*

Paper type *Research paper*

Introduction

The concept of recovery remains a contested idea within mental health systems (Norton and Swords, 2020; Swords and Houston, 2020). One reason for this is the range of perspectives within the mental health field competing to make sense of the notion (Swords, 2019). Yet, despite this diversity of opinion, services delivered have shifted from a paternalistic model of care to one focused on the idea of *personal* recovery (Norton and Swords, 2020; Pilgrim, 2008; Swords and Houston, 2020). The discourse (of personal recovery) views an individual's attainment of mental wellbeing as a journey to reclaiming or establishing a new identity following an acute episode or diagnosis (Swords and Houston, 2020). In this conceptualisation, the role of services is to support individuals to reach their full potential, that is, to enable human identities to flourish (Casey and Webb, 2019; Collins and Crowe, 2016; Petrakis *et al.*, 2014).

More specifically, the idea of recovery within Irish mental health services has also undergone dramatic changes. Historically, the person was considered the problem and in

need of treatment. Many people using services experienced institutionalisation, containment and a restriction of personal agency. However, following the international trend referred to above, recovery is now seen as a personalised journey where people are influential in determining their treatment plan. However, these aspirations regarding recovery have continued to face challenges in service culture. One reason is the multiple perspectives involved in Irish recovery-orientated services. This has resulted in different, competing ideas as to how recovery should be experienced and delivered in practice.

In this article, we focus on this idea of recovery as a personal journey (Pilgrim, 2008) while also acknowledging the role of social constructionism in understanding how the concept has been defined. Yet, even though recovery has been viewed as a personalised journey, there has been a tendency to treat it as something which can be measured (Kotake *et al.*, 2020; Neil *et al.*, 2009; O'Connell, 2007). Relatedly, there is an array of literature which has also sought to approach this experience from an objective stance, rather than viewing it as a subjective affair (HSE, 2017; Kotake *et al.*, 2020; Neil *et al.*, 2009; Newman-Taylor *et al.*, 2017). Furthermore, there have been frameworks, including that represented by the acronym CHIME (Leamy *et al.*, 2011), which have sought to categorise the key outcomes associated with personal recovery. CHIME refers to "connection", "hope", "positive identity formation", "meaningful role" and "empowerment". As can be seen, these are existential and psychological states of wellbeing which, it is claimed, can be measured.

If recovery is a personalised journey, are we then correct to say that it is essentially subjective in nature? Pilgrim (2008) addressed this question arguing affirmatively that it should be viewed as an individualised, meaningful and unique experience for each person: one beyond measurement, objectification and categorisation. Therefore, when seeking to make sense of it in relation to its translation from policy to practice, the emphasis should not be on objective measurement when it comes to the reality of providing and receiving recovery-orientated services. Instead, if we focus on recovery-orientated services as being socially constructed and centring on subjective experience, what can we learn about the meaning of recovery? This article attempts to examine this important phenomenological question.

It is vital to provide a brief explanation of the meta-theory of social constructionism. Many of the writers on social constructionism (Berger and Luckmann; Burr, 2015) agree that people's understanding of reality is the product of their social interactions rather than mainly the effects of discourse. In this study we concur with this position agreeing that people construct and understand their reality from the social interactions, linguistic exchanges and relationships in which they engage (O'Reilly and Lester, 2017; Swords and Houston, 2021). Taking the example of the social construction of recovery, it is impossible to understand its central tenets without acknowledging the significance of language, culture and history: how, in essence, various stakeholders have sought to define it (O'Reilly and Lester, 2017):

The central premise of social constructionism is that professional practices are not based on objective or disinterested implementation of scientific practices; rather, they are contextually, and discursively bound constructions made possible by institutional and everyday discourses and practices. (p.15)

Given the above definition, the authors sought to explore how stakeholders in mental health services constructed their subjective reality of what it meant to be mentally ill and recover, and how that reality in turn invoked subjective meanings revolving around identity formation. Importantly, as authors, we accept that there is an independent reality to illness, symptomatology and disease beyond its social construction. Hence, we position ourselves as *moderate* constructionists. Even so, this does not detract from the central supposition that the knowledge bases underpinning mental health and recovery have been created, routinised and habituated by people embedded in cultural settings (Andrews, 2012; Norton and Swords, 2020; O'Reilly and Lester, 2017).

Method

There is no research which has *specifically* focused on how recovery within mental health services is a socially constructed phenomenon (Casey and Webb, 2019; Collins and Crowe, 2016; Gaffey *et al.*, 2016; Pilgrim and McCranie, 2013; Pilgrim, 2018; Shah *et al.*, 2016; Swords, 2019). Responding to this gap, the research outlined below focused on exploring the experiences of major stakeholders involved in delivering recovery-orientated services within an Irish context. The key stakeholders involved were policymakers and policy influencers, professionals and service providers and service users and family members. In relation to this article, however, we focus specifically on the data collected solely from service users. The aim was to explore with this cohort how they understood and described recovery and how it was translated into everyday life and practice. This involved gathering detailed descriptions exploring “constructions of recovery”. Therefore, the proposed research sought to answer the following questions:

RQ1. How did this group construct the concept of recovery?

RQ2. What factors influenced the respondents’ conceptualisation of recovery?

RQ3. What were the central enabling and constraining factors that these stakeholders faced when attempting to implement a recovery-oriented approach in everyday life and practice?

In terms of the methodology, this study focused on the meaning behind individuals’ actions and the way they participated in society and cultural settings (Chowdhury, 2014). Because of this stance, interpretivism was chosen as the methodological approach to shape the research design. This position views the social world as having meaning for people living within it, and that these meanings are socially produced and reproduced (Bryman, 2012; Chowdhury, 2014; Thanh and Thanh, 2015). Moreover, given this focus on meaning, a qualitative approach to data collection and analysis was chosen (Chowdhury, 2014). In terms of research design, a single case study modality was selected because it fitted well with the nature of the discovery and research questions (Hancock and Algozzine, 2006).

Adopting socially constructionism meant acknowledging the contention that there was no essentialist truth underpinning the experience of recovery, regardless of who was reporting on the experience. Thus, the researchers sought to capture individualised accounts through semi-structured interviews tailored to each respondent’s unique narrative. In other words, this form of interviewing facilitated the gathering of participants’ views on their social reality (Bryman, 2012; Robson and McCartan, 2016), enabling them to “tell their stories” of hope, change and despondency. Furthermore, research on recovery in mental health has generally favoured semi-structured interviews (Lovell *et al.*, 2020; Meiring *et al.*, 2017; Ørjasæter *et al.*, 2017).

Data analysis

Purposive sampling was adopted to recruit participants as it provided a viable way of addressing the research questions (Bryman, 2012; Yin, 2018). Twelve service users participated in the study. Each individual was engaged with services for a period of time and at different stages of their recovery trajectory. Thematic analysis was chosen as the preferred approach to interpreting and analysing the data collected. It is a flexible form of analysis (Braun and Clarke, 2013) which supports the process of understanding how individuals make sense of a phenomenon through language and social interaction (Bryman, 2012; Willig, 2013). Additionally, it is compatible with a social constructionist position (Bryman, 2012; Willig, 2013). Critical discourse analysis was strongly considered for this study especially given its focus on understanding the role of power in shaping meaning (Braun and Clarke, 2021; Burr, 1995). However, Braun and Clarke (2021) have explained that a thematic analysis type of method can fit with a constructionist epistemology when the

researchers are not fully committed to a discourse orientation. Moreover, it was explained earlier that the researchers were adopting a moderate constructionist approach which considers the effects a reality beyond discourse.

Ethics

The study was approved by the author's university research ethics committee which was Trinity College Dublin at the time. Further approval was received from the services where participants were attending.

Findings

Three central themes emerged in the findings:

1. recovery and personal responsibility;
2. constructions of reality from those living in recovery; and
3. surveillance and normalisation.

Recovery and personal responsibility

Service users spoke about their experiences of the recovery process happening once their acute symptoms had subsided. One participant reflected on the shift beyond medication commencing once they could think clearly:

But I can think rationally and clearly. And then the rest of it is up to me. How do I make my life better? It's about taking self-ownership of yourself? (Simon, Lived Experience Service User Perspective)

The focus and expectation of the recovery process shifted to the individual taking ownership for their life. The responsibility on the service user is expressed by another participant:

I think it's a very important concept because it's about people like me taking responsibility for our own recovery. (Andrew, Lived Experience Service User Perspective)

It is an important process because it refers to recovering an individual's life following an acute episode:

What are you recovering from? I suppose you're recovering your life. (Robert, Lived Experience Service User Perspective)

These accounts pose questions about whether it is possible for service users to have complete ownership over their lives? Hypothetically, what is needed for this to become a reality?

I've been in so many areas [...] trying to find the exact help [...]. My goal was to be well, but I've gotten so far above that, I just look down and say "ha, ha [...]" I've fucking beaten you!! (Noel, Service User Perspective)

It's just unfortunate you must find out on your own [...]. You must get up, off your arse and work. (Kevin, Service User Perspective)

The focus on figuring it out for yourself and being resilient was not straightforward. There could be relapses and readmissions. This struggle was reflected in the views of one of the participants:

These are the things I had to figure out for myself. It took a bloody, Goddam long time, but I had to figure it out for myself. And until those pieces came together, then I didn't kind of really start my recovery journey. (Simon, Lived Experience Service User Perspective)

For Simon, he had to figure this process out himself. Services were available, but the capacity for change came from him constructing his own recovery journey:

It had to grow within me and it's like those ashes at the very start of my recovery, the very start of having the voices, shadows and all that, that I had, that broke me. (Simon, Lived Experience Service User Perspective)

This reflection from Simon highlighted the reality of mental illness and recovery. Taking ownership of his life stemmed from his own resilience and determination. Ultimately, recovery was a journey of learning to live again:

So, you just had to learn as you went along [...] I would have experienced recovery through my own trial and error [...] It never took place in a discussion with any of the nurses or doctors. (Bill, Lived Experience Service User Perspective)

Essentially, the recovery journey had ups and downs. Recovery was possible, but expectations needed to be managed:

[...] there are people who hear recovery and set their sights on going back in time [...] I have met people who have been able to recover from things like schizophrenia who were told they couldn't and it was possible for them to live symptom free, and it is great to have those examples [...] it's great to have something to aspire to [...] if you can't live well in the now with what you have even if that is symptoms or difficulties we will say there is no point trying to say "oh I will be happy when". and it's going to be 5-10 years down the line the recovery has to be starting in the now, I think if you can keep it in the now, you make the hope a bit more tangible. (Orla, Lived Experience Service User Perspective)

The recovery process needed to be realistic and incorporate a staged process. More importantly, once symptoms were managed, there was a greater freedom to refashion the process of recovery. Yet, how *exactly* did service user participants construct recovery?

Constructions of reality from those living in recovery

Social constructions are generated in the everyday interactions and discourses which condition how individuals interact in situations. The emphasis on service users taking ownership was an important theme explored in the previous section. A central theme underpinning the constructions of recovery for participants in this study was the focus on moving beyond the mind and medication:

Build a relationship with the occupant, not just saying like "you've this, see this, you need to take this medication; you need to go to the pharmacy now and take that for the next year; see how you feel" [...] that's the sort of thing I dread, I don't like. (Noel, Service User Perspective)

For Noel, his everyday interactions have been shaped by a focus on medication. There is a need to move beyond this reality, placing emphasis on the therapeutic relationship. Kevin, another participant supported these claims:

Sometimes it takes medicine, sometimes it just takes a nice conversation you know [...] you can't just say take the medicine, that will make you better. It's fucking ridiculous. (Kevin, Service User Perspective)

Kevin reflected on the frustrations of how services have shaped the approach to recovery. For him, the focus should be much broader than medication. Notably, these experiences were shared by other participants in this study:

It's not just about the medication and reducing symptoms [...] I used to go down to the clinic and they'd say how are you feeling and they'd say oh you're not on a maximum dose [...]. I said I don't want to be on the maximum dose [...] one time I was feeling a bit down and I told them I was fine [...] Now they kept on [...] up and up and that's, I went through a phase in the clinic. Every time you say you're a little bit down, there's another tablet. (Laura, Service User Perspective)

Laura outlined the reality of everyday interactions with service providers when someone begins to feel unwell. There is a sense, from what she said, that professional disciplines were conditioned to behave in certain situations:

[...] psychiatrists in general and some psychiatric nurses [...] I think they have a different understanding of what recovery is because there's more than just one type. There's clinical recovery, personal recovery, social recovery and they more so focus on the clinical side. So, if you have a reduction in signs and symptoms; you're recovered. (Simon Lived Experience Service User Perspective)

Simon highlighted that many professionals have become accustomed to reacting in certain ways. Expanding further, he suggested that:

[...] it's very hard to switch their mindset from medication, medication, because they've been stuck in the system so long and I'm relatively new so they just see this as "Oh this guy is the recovery guy". You know? "This guy is the guy you go to for your day's out, trips or whatever". (Simon, Lived Experience Service User Perspective)

Therefore, recovery needs to be taken seriously with interactions reinforcing that it is a journey or discovery rather than only about medical treatment:

I try to explain recovery more as a kind of discovery thing where you are sometimes recovering parts of yourself that you might have lost but you are also discovering new parts. (Orla, Lived Experience Service User Perspective)

Recovery was about discovering how to enjoy the normal things in life. Regardless of diagnosis and symptoms, an individual should be able to enjoy the prosaic events and interactions in everyday life. Orla reflected on this aspect of recovery which she adopted in her role as a peer support worker:

You can live well with even the presence of mental health challenges, that recovery is not a lofty thing where everything is going to be perfect all the time, it's quite ordinary in many ways, it's about being able to enjoy the ordinary things in life and living an ordinary fulfilling life is what recovery would mean to me. (Orla, Lived Experience Service User Perspective)

Put more simply, to live an ordinary life involves doing commonplace things. A key part of human life is to participate in interactions influenced by routine and custom. Moreover, they should be based on empathy, trust and understanding the person experiencing mental health challenges:

I have learned in my own recovery to see if I can in some ways inspire, that sounds a little bit big headed but to testify that recovery is possible. To try to relate or empathise on a level with someone who might be going through something similar and to be a listening ear in situations where I have no solutions and to actually just have those conversations and work through how a person is feeling about things. (Orla, Lived Experience Service User Perspective)

Surveillance and normalisation

Reconnecting with people and society, following a diagnosis or relapse, presented significant challenges for those on their recovery journey. The pressure to conform to the normalised behaviours of everyday interactions, as prescribed by societal standards, had

led to frustration and isolation and was often an impediment to recovery. The experience of continuous monitoring and surveillance permeated this aspect of the recovery journey:

New job, new people. It was a different experience to what I had to do [...] this job seems okay but then after seven weeks [...] they were checking me every so often [...]. Then, all of a sudden, I just snapped. Sorry, I yelled at everyone in there and they had to just let me go. (Noel, Service User Perspective)

I'd like to think that if somebody said something to me, I'd be able to say look I have mental health issues, but I don't. I've had to move places, but I hear people saying things alright, it's really bad for my mind. (Kevin, Service User Perspective)

The pressure to behave in certain ways had been overwhelming for participants:

[...] it's hard because people expect, okay you have a mental illness, but they still expect you to be totally normal and totally do a job from 9 am to 5 pm and then go out in the evenings, do you know what I mean? (Ger, Service User Perspective)

Being in employment was viewed as a normative expectation integral to recovery. However, the label of mental illness and, how an individual interacted in the expected practices of seeking and maintaining employment, could result in rejection and oppression:

My aim when I was out of work, was to get back into work [...] I accept that I have Schizophrenia [...] like in the workplace where I work, I wouldn't have been believed. When the bullying went on, my manager didn't believe me [...] part of him believed that was because I had a mental illness, you imagine things [...]. When you're in the workplace then you're not going to be believed as much as a person that's normal [...]. A person with Schizophrenia has many drawbacks that are unseen, you only realise it when you go through life and go out into the workplace. (Bill, Lived Experience Service User Perspective)

To be unemployed could invoke a sense of being judged:

What do you do in the situation? [...] you can't cover up when all the people are saying "why don't you get yourself a job?"; "Why aren't you working?"; "Why are you doing this, why can't you do that?" And then you tell them "Sorry I've an illness, I've a mental illness" and you look like you've two heads and they won't entertain you. (Anthony, Service User Perspective)

Service users believed that their mental health diagnosis had led to their employment opportunities being reduced significantly. Even if they acted "normally" in situations, their diagnosis still hindered their ability to transition into employment:

Especially with fellow service users about covert and overt discrimination that having a mental illness would, you know [...] we were afraid you know, yeah, that we wouldn't, we wouldn't get even called for an interview because we had a mental illness on our application, job application and so yeah I think for a lot of service users it's a big worry. (Robert, Lived Experience Service User Perspective)

The pressures to conform to these expected behaviours in everyday life presented as a challenge. In this connection, participants spoke about hiding their identity due to the stigma attached to living with a mental health diagnosis:

I spent most of my life in the closet in terms of my illness. (Brian, Lived Experience Service User Perspective)

People that have maybe bi-polar or Schizophrenia, they're not as likely to talk about it because I suppose [...] it's a kind of hidden group of people with more enduring mental health. (Bill, Lived Experience Service User Perspective)

Once they know you have a mental illness, they will not have anything to do with you and that's the big problem. And how can these people, how can they be a facilitated in having a life when they won't give them a chance to give them a life? (Ian, Service User Perspective)

Centrally, recovery was an approach that placed an emphasis on an individual reclaiming a positive identity following their diagnosis. However, for many service users, succeeding in this journey involved hiding this diagnosis and succumbing to the pressure to act appropriately in everyday situations.

Discussion

This study sought to explore how service users constructed the concept of recovery in mental health services. It was noted how recovery was framed as a subjective experience (Pilgrim, 2008). It took on many interpretations and meanings. Through everyday interactions between stakeholder groups, involving service users specifically, dominant discourses were co-constructed, which led to the normative perspectives shaping practices (Berger and Luckmann, 1966; Burr, 1995; Hjelm, 2014). This resulted in individuals becoming conditioned to a specific way of “being” which determined their choices, actions and mind-sets.

The findings highlighted the influence of discourse in everyday interactions. Essentially, many of these discursive influences emanated from the adoption of neoliberalism as the governing economic ideology meaning that recovery had become an almost “empty, unfulfilled concept” resting on individualism, measurement and surveillance (Jørgensen *et al.*, 2020; Madsen, 2018; McWade, 2016; Moth, 2020). Consequently, for many of the respondents, it provided false hope and limited opportunity for agency. Pertinently, within Ireland, neoliberalism has been the dominant political ideology shaping social policy on health and social care (Kitchin *et al.*, 2012; Meade, 2018; Mercille, 2018). Here, structural adjustments within political economy (following the economic crash in 2008) have fed into an austerity programme affecting health and well-being outcomes for citizens.

The cohort also expressed an overwhelmingly pressure to succeed in their recovery journeys. This burden further evidenced the role of neoliberalism shaping recovery towards some kind of performance activity predicated on individualism and responsabilisation (McWade, 2016; Ramon, 2018). In this dispensation, a perceived failure to recover from debilitating mental ill-health rested with the individual. Moth (2020) supported this claim in his study involving community mental health, multidisciplinary teams. The participants spoke about the influence of marketisation and managerialism, resulting in “work intensification”, “deskilling” and “increased administration burdens” (Moth, 2020, pp. 148-149).

These discursive influences on service culture stymied the professionals’ desire to implement a humanistic, relationship-based approach with service users on their recovery journeys (Moth, 2020). Poignantly, many providers of services held similar frustrations to those of service users. A Danish study reinforced this point when suggesting that neo-liberal policy trends impacted nurses’ practices deleteriously when they sought to support their patients’ recovery (Jørgensen *et al.*, 2020).

Identity formation is a central consideration in social constructionism (Berger and Luckmann, 1966; Burr, 1995; Hjelm, 2014). For the most avid social constructionist, there is nothing essentialist about our identities, which are differentially co-constructed by temporal and spatial determinants. It is contended that individuals inhabit multiple *processual* selves across their life-courses (Berger and Luckmann, 1966; Burr, 1995; Hjelm, 2014). Yet, within this evanescent, inner landscape, there were discursive pressures to adopt a “normal”, standardised identity (Brennan, 2014; Crepaz-Keay, 2016; Rose, 2018).

Accordingly, service users in this study wanted to recover an identity that did not stand out as aberrant from what was normatively expected. In particular, they did not want to be defined by their mental health diagnosis. Yet, having a diagnosis obdurately permeated their everyday encounters and sense of self. The attainment of “normality” became a yardstick of self-evaluation and progress. This criterion infused many domains of being including employment status and quality of social relationships. Ultimately, masking your

identity was viewed as the only exigent strategy for people on their recovery journey. What is more, for these users of services, such pressures became a form of stifling surveillance.

Surveillance can be related to the work of Foucault and his metaphor of the panopticon denoting the surveillance society (McNay, 1994). The design of the panopticon resulted in prisoners being conditioned to believe that they may be watched at any time in the prison (Roberts, 2005). Foucault applied this idea to many facets of society, including mental health institutions (Foucault, 1991), and it seemed an apt metaphor to capture the sentiments expressed in this study. Surveillance was brought into sharp focus when service users struggled to fulfil the expectations of “normalised discourse”.

Further implications for practice involve careful consideration of how to address the stigma experienced by people wanting to succeed on their recovery journeys. In this context, some studies (Horsfall *et al.*, 2010; Schulze, 2007; Stuart, 2008) have focused on highlighting and reducing the levels of stigma. Beyond this, however, there is need to explore and contest the discursive influences of neoliberalism, amongst other areas, in such debates. This could be mitigated to some degree by appropriating social constructionism in the delivery of training and education to mental health professionals and students. Such training can problematise received wisdoms and taken-for-granted shibboleths governing the recovery journey.

Limitations of research

This study did not draw on a representative sample of all service users within Ireland. Moreover, the researchers' social positions and preconceptions gave rise to the possibility of bias when it came to interpreting the data. As a mitigation, supervision and a reflective journal were used throughout the research process to enhance its trustworthiness. One further limitation was the case study design which only represented one snapshot in time regarding the sample's experiences. This was a limitation echoed by another researcher exploring the area of recovery (Sparkes, 2018). To build on this research requires a much larger sample and a more penetrative method (such as critical discourse analysis, Jørgensen *et al.*, 2020) to investigate the interplay between discourse, power, language and meaning in the construction of recovery.

Conclusion

This study explored the way recovery was socially constructed within an Irish mental health context. There was a focus on investigating how recovery was socially constructed as a personalised journey. We reported how service users articulated what recovery from mental illness actually meant to them. For some, personalising recovery did not lead to the biological symptoms disappearing. However, with the appropriate tools and supports from outside services, individuals' experiences of recovery could be greatly enhanced.

Currently, the dominant discursive influences have resulted in service users viewing recovery as a personal responsibility. The findings highlighted how this sense of responsabilisation had been influenced by neoliberal discourse impacting service cultures. In other words, a concerted focus on individual accountability is associated with the idea of individualism which is another central plank within neoliberalism. Worryingly, if someone trips up in their recovery journey, culpability rests with them, rather than the service *per se*. These experiences of “let-down” are heightened when people attempt to reintegrate within a “normalised” social order. For many service users, their identity is inextricably linked with a mental health diagnosis despite their best attempts to reframe it. Ultimately, the idea of personal recovery remained an unfulfilled promise and aspiration for many individuals on their journey to fulfilment within society.

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