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Nina Petersen Reed

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Thesis for the Degree of
Philosophiae Doctor
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Personal Recovery - Unique and Collective

Exploring Enacted Narratives of Mental Health Recovery in Everyday Life

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Trondheim, October 2020

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Tittel på avhandlingen:

Personlig recovery – unik og kollektiv

En studie av recovery i psykisk helse som utfoldende narrativer i hverdagslivet

Tema:

Recovery i psykisk helse og mening i hverdagen.

Sammendrag:

Formålet med dette forskningsprosjektet har vært å utforske hvordan personlig recovery foregår og kan støttes. Jeg har fokusert på personlig recovery som en prosess hvor mennesker skaper en meningsfull hverdag på tross av de psykiske helseproblemene de opplever. Studien tar utgangspunkt i at vi mennesker skaper mening, eller sammenheng, gjennom de hverdagsaktivitetene vi deltar i.

Det viktigste funnet i denne studien er at personlig recovery er en unik og kollektiv prosess som involverer å skape mening sammen med andre. Dette foregår gjennom hverdagsaktiviteter og fremstår som komplekse samspill. Funnene våre viser hvordan innsats fra flere mennesker er nødvendig, samt hvordan kontekstuelle muligheter og begrensninger som økonomi og møteplasser også er avgjørende.

Prosjektet bestod av to delstudier. I den første delstudien intervjuet jeg ansatte i kommunalt psykisk helsearbeid, i den andre delstudien gjorde jeg deltakende observasjoner i hverdagslivet til fire mennesker som har opplevd utfordringer knyttet til sin psykiske helse. Dataene fra begge delstudiene ble analysert og tolket i lys av eksisterende kunnskap om recovery, mening, hverdagsliv og aktiviteter. Narrativ teori om hvordan mening skapes gjennom hverdagsaktiviteter som knytter fortid, nåtid og fremtid sammen har også vært sentralt i prosjektet.

Navn kandidat: Nina Petersen Reed
Institutt: Institutt for Psykisk Helse
Veileder(e): Sissel Alsaker og Staffan Josephsson
Finansieringskilde: HiST/NTNU

Ovennevnte avhandling er funnet verdig til å forsvares offentlig
for graden *PhD i helsevitenskap, Doctor Philosophiae.*
Disputas gjennomføres digitalt
fredag 30. oktober 2020.

PREFACE

In spring of 2015 I had just finished my master's degree in social work. Although finding my work within community mental health services both interesting and rewarding, I was now looking for new ways of contributing to the field of mental health. I had not really thought much about getting a PhD, but then this heading showed up among the job advertisements: Mental health – influence and participation in everyday life. After reading the project plan and talking with the project manager, Sissel Alsaker, I knew that this project was something I wanted to be part of!

And so it went. I got the opportunity to make this PhD-project mine. The past five years have been such an interesting, challenging, eventful and educational journey, and I am sad its now at its end. However, I hope to continue my work within the mental health field and academia, building further on what I have learnt and experienced these past years.

ACKNOWLEDGEMENTS

Just like the processes I have studied; this PhD-journey was a collective one. I could not have completed this project and thesis on my own, and there are several persons I would like to thank.

First of all, thank you to my supervisors Sissel Alsaker and Staffan Josephsson for initiating this project, for trusting me to conduct it, and for giving me the best supervision I could have hoped for. Sissel, you have been such a patient and caring presence in my life during these years, always offering your guidance, support and encouragement along the way. I have enjoyed our travels together, as well as our coffee breaks. I cannot thank you enough… Staffan, thank you for your skillful guidance and support. I have greatly appreciated our meetings and talks, particularly when visiting you and your colleagues in the beautiful city of Stockholm.

Further, I would like to express my deep gratitude to those persons who participated in the project, both individuals with firsthand experiences of mental health problems and being in recovery, as well as community mental health workers. Thank you so much for the experiences, knowledge and thoughts you have shared with me. I also want to thank management and staff who supported this project and helped recruit participants.

Furthermore, I would like to thank all my wonderful colleagues at the Department of Mental Health, NTNU, and in particular my group at Mental Health Work. Thank you for your interest and valuable input in my project, but most of all for your emotional support and uplifting presence in my everyday life. A special thanks to my fellow PhD-students and Ferske Forskere: Kristin Espeland (a.k.a. 'job-wife'), Julia Hagen, Mariell Høgås, Kathrine Nilsen, Hilde Markussen, Olga Lehmann, Tonje Indrøy and Irene Wormdahl. You are all such a wonderful support and inspiration! Thank you also to my former PhD-fellow Johnny Andoh-Arthur for inspiration and encouragement, and thank you Espen Sagsveen, for your contribution to this study as well as our good times lunching at both Øya and Dragvoll. Finally, thank you to Sør-Trøndelag University College/NTNU for financial support.

Lastly, I would like to thank my family and friends for your support, optimism and patience with me during this period. Mom Kirsten Petersen and dad Harald Reed, thank you for listening to my moaning and groaning at times, and for your involvement and advice. To all my friends and extended family: thank you for providing opportunities to laugh, chat, work out, wine & dine, and travel. All this has been greatly appreciated and very much needed during these years. And finally, to my husband Tomas and my sons Even, Sigurd and Gustav: what would I have done without you? You give me so much joy, as well as a lovely chaos to come home to every day which puts everything else in perspective. I love you. Thank you.

SAMMENDRAG (Norwegian summary)

Denne avhandlingen presenterer et kvalitativt, fortolkende og narrativt forskningsprosjekt med det formål å utforske hvordan personlig recovery i psykisk helse forløper og kan støttes som meningsskapende prosesser. Gjennom narrative intervju og etnografi skapte jeg data om hvordan mennesker med psykiske helseproblemer utøver sin innflytelse på og utfører hverdagsaktiviteter, samt om hvordan profesjonelle og brukere samhandler. Disse dataene ble analysert og fortolket med fokus på å skape prosessuell og kontekstuell kunnskap knyttet til mitt formål.

Prosjektet bestod av to studier. Studie I var en intervjustudie med det formål å utforske hvordan psykisk helsearbeidere i kommunen og brukere samhandler. Artikkel 1 "*Community mental health work: Negotiating support of users' recovery*" (Reed, Josephsson, & Alsaker, 2017) presenterer våre funn av hvordan profesjonelle, brukere og andre samhandler gjennom forhandlinger når de deltar sammen i recoveryprosesser. I studie II utførte jeg deltakende observasjoner med fire personer mens vi gjorde hverdagsaktiviteter sammen, og utførte en narrativ analyse og fortolkning av dataene. I artikkel 2, "*Exploring Narrative Meaning Making through Everyday Activities – A Case of Collective Mental Health Recovery?*" (Reed, Josephsson, & Alsaker, 2018), var formålet vårt å utforske hvordan personer med psykiske helseproblemer skaper mening gjennom å gjøre hverdagsaktiviteter sammen med andre. Vi fant at deltakelse i aktiviteter sammen med andre innebærer muligheter for å skape felles forståelser og sammenheng i kollektive meningsskapende prosesser. I artikkel 3, "*A narrative study of mental health recovery: Exploring unique, open-ended and collective processes*" (Reed, Josephsson, & Alsaker, 2020), var formålet vårt å utforske hvordan recovery forløper gjennom menneskers engasjement i hverdagsaktiviteter. Funnene våre viser hvordan recovery innebærer unike, flertydige og åpne meningsskapende prosesser, hvor flere personer, aktiviteter og steder er involvert.

Hovedfunnet i denne avhandlingen er at recoveryprosesser involverer mange bidragsytere som sammen engasjerer seg i å skape narrativ mening. Jeg fremholder at personer i recovery er avhengige av slike kollektive innsatser for å skape bevegelse i prosessen med å skape en meningsfull hverdag, og at personlige recoveryprosesser i psykisk helse derfor er både unike og kollektive.

SUMMARY

This thesis presents a qualitative, interpretive and narrative research project aiming to explore how personal recovery in mental health unfolds and may be supported as processes of meaning making. Through narrative interviews and participant observations, I created data about how individuals with mental health problems influence and do everyday activities, as well as how professionals and users collaborate. These data were analyzed and interpreted with a focus on creating processual and contextual knowledge related to my aim.

The project consisted of two studies. Study I was an interview study with the aim of exploring how community mental health workers and users collaborate. Article 1, "*Community mental health work: Negotiating support of users' recovery*" (Reed et al., 2017), presents our findings of how professionals, users and others collaborate through negotiations when working together in recovery processes. In study II I did participant observations with four individuals while doing everyday activities, and carried out a narrative analysis and interpretation of the data. In article 2, "*Exploring Narrative Meaning Making through Everyday Activities – A Case of Collective Mental Health Recovery?*" (Reed et al., 2018), our aim was to gain a deeper understanding of how individuals with mental health problems create meaning through doing everyday activities with others. We found that engaging in activities together provides possibilities for negotiating shared understandings and coherence in collective meaning-making processes. In article 3, "*A narrative study of mental health recovery: Exploring unique, open-ended and collective processes*" (Reed et al., 2020), our aim was to explore how mental health recovery unfolds through individuals' engagement in everyday activities. Our findings show how recovery unfolds as unique, ambiguous and open-ended processes of meaning making, in which several persons, activities and places are involved.

The main finding of this thesis is that processes of mental health recovery involve many contributors who together engage in narrative meaning making. I argue that individuals in recovery are dependent on such collective efforts to create a meaningful everyday life, and therefore personal recovery in mental health is both unique and collective.

LIST OF ARTICLES

Article 1:

Reed, N. P., Josephsson, S., & Alsaker, S. (2017). Community mental health work: Negotiating support of users' recovery. *International Journal of Mental Health Nursing, 27*(2), 814-822. doi:10.1111/inm.12368

Article 2:

Reed, N. P., Josephsson, S., & Alsaker, S. (2018). Exploring Narrative Meaning Making through Everyday Activities - A Case of Collective Mental Health Recovery? *Journal of Recovery in Mental Health, 2*(1), 94-104.

Article 3:

Reed, N. P., Josephsson, S., & Alsaker, S. (2020). A narrative study of mental health recovery: Exploring unique, open-ended and collective processes. *International Journal of Qualitative Studies on Health and Well-being, 15*(1). doi:https://doi.org/10.1080/17482631.2020.1747252

Contents

1. INTRODUCTION

Mental health problems affect us all as a society, and mental health recovery is a process which many of us will undergo at some point in our lives. The Norwegian Institute of Public Health (2015) estimate that between 30 and 50 percent of the Norwegian public will experience mental illness at some point in their lives, with anxiety and depression as the most common groups of diagnosis. Further, mental illness is the second largest category of illnesses which lead to deteriorated health in the Norwegian population (Norwegian Institute of Public Health, 2017), and is also associated with reduced ability to work, higher risk of physical illness, and shorter life expectancy (Norwegian Institute of Public Health, 2018). Additionally, international research shows how mental health problems may have detrimental effects in individuals' lives, as persons with severe mental illness describe experiences of suffering, shame and alienation. They also describe challenges regarding integration in their community, interpersonal relationships and involvement in meaningful activities, as well as a wish for being treated with respect and being involved in their care and treatment (Zolnierek, 2011). Therefore, I argue that understanding how mental health recovery unfolds, and how we can facilitate and support such processes, is a crucial task for research and practice.

Personal recovery in mental health is defined in literature as a process of re-creating a meaningful everyday life despite the challenges brought about by mental health problems (Borg, 2007; Davidson & Roe, 2007; Onken, Craig, Ridgway, Ralph, & Cook, 2007). This understanding of recovery highlights the complex and ongoing nature of recovery as processes, rather than focusing on end results (Davidson, Tondora, & Ridgway, 2010). Further, this definition suggests that processes of meaning making are central to mental health recovery. But how do such meaning-making processes of recovery unfold?

Knowledge from occupational science argues that we make meaning in life through doing everyday activities (Eklund, Hermansson, & Håkansson, 2012; 2004; Wilcock, 1999), and narrative research has shown how meaning making unfolds through complex processes of tying together our past, present and future through what we do in everyday life (Alsaker, 2009; Alsaker & Josephsson, 2010; Josephsson, Asaba,

Jonsson, & Alsaker, 2006; Mattingly, 1998; Ricoeur, 1984). Further, through its potential for contributing meaning doing everyday activities holds potential for recovery and change (Mattingly, 1998; Townsend, 1997). Being able to influence and control what we do, doing activities that create meaning for us, and finding the right balance between activities with different meaning, has been found to have positive impact on our mental health, and may therefore contribute to mental health recovery (Argentzell, Håkansson, & Eklund, 2012; Bejerholm & Eklund, 2007; Borg, 2009; Doroud, Fossey, & Fortune, 2015; Ulfseth, Josephsson, & Alsaker, 2016). However individuals with mental health problems may experience major changes in their lives, disrupting their possibilities of doing everyday activities (Alsaker & Ulfseth, 2017; Baker & Procter, 2014; Ivarsson, Carlsson, & Sidenvall, 2004; Nagle, Cook, & Polatajko, 2002; Prusti, 2000; Zolnierek, 2011), and complicating their opportunities to make choices and to making meaning (Ponce, Clayton, Gambino, & Rowe, 2016; Steger, Frazier, Oishi, & Kaler, 2006). Following this I understand that making meaning through everyday activities may represent challenging and complicated processes for individuals with mental health problems, which may require support from professionals or others (Kelly, Lamont, & Brunero, 2010; Yilmaz, Josephsson, Danermark, & Ivarsson, 2009).

My aim in this PhD-project has been to explore how personal recovery in mental health unfolds and may be supported as processes of meaning making. Based on the arguments presented above, the processes of meaning making involved in recovery seem to unfold through a continuous and complex stream of seeking to create coherence in life through influencing and doing everyday activities, as well as sometimes needing support from others. I suggest that through studying what individuals do, we can capture and explore temporary glimpses of how recovery unfolds as processes of meaning making. Therefore, I chose to seek knowledge related to my aim by studying how individuals with mental health problems influence and do everyday activities, as well as how professionals and users collaborate when support is needed. Existing literature mainly describes general characteristics of recovery, and identifies ‘stages’ of recovery through everyday activities, and to complement these studies I have sought to create processual and contextual knowledge about recovery, such as other authors also have called for (Doroud et al., 2015; Sutton, Hocking, & Smythe, 2012). The knowledge

gained in this study can contribute important insights into how processes of recovery can be supported and facilitated.

In this section of the thesis I will present my aims of research next, before I go on to present everyday life and community mental health services in Norway as my contexts of research. Then I will define the most central concepts in this thesis: mental health recovery, meaning and everyday activity, as well as narrative as a key theoretical perspective, in section 2. In section 3 I will describe some relevant research and literature, before I present my methods and philosophical foundations in section 4. This is then followed by a presentation of the findings from all three published articles, as well as my interpretation of main findings, in section 5. Section 6 contains both a discussion of findings, implications for practice and a methodological discussion, before I present my conclusion in section 7.

1.1 Aims

My aim in this PhD-project has been to explore how personal recovery in mental health unfolds and may be supported as processes of meaning making. I have sought to do so through studying how individuals with mental health problems influence and do everyday activities, as well as how professionals and users collaborate. How do persons with mental health problems influence and steer what activities to do, and how do they do these activities? How do they create meaning through the activities they do? How can professionals support users' influence and engagement in everyday activities? How can professionals support mental health recovery? These are some of the questions I have sought answer to in this project.

The project consists of two studies. In Study I my focus was on how community mental health professionals collaborate with individuals in recovery to enhance and sustain their influence and activities when working together in the contexts of everyday life, resulting in article 1. In Study II, I explored how individuals with mental health problems influence and do everyday activities to create a meaningful everyday life. Article 2 and 3 were written based on this study.

The specific aims for each of the three articles were:

Article 1: To explore how community mental health workers provide support to users by investigating professionals' own narratives of how they work.

Article 2: To gain a deeper understanding of how individuals with mental health problems create meaning through doing everyday activities with others.

Article 3: To explore how mental health recovery unfolds through individuals' engagement in everyday activities.

1.2 Contexts of research

I will now present my contexts of research, everyday life and community mental health services.

Everyday life

As presented in my introduction, I argue that processes of mental health recovery unfold in everyday life. Therefore, when studying these processes everyday life has been a highly relevant context of research.

Literature does not offer a clear definition of the concept of everyday life, however Gullestad (1989) understands everyday life as consisting of two dimensions which individuals strive to integrate; one is the daily organization of activities and events, the other is the experience of meaning and community. Also highlighting activity and meaning as central dimensions in everyday life, Højholt and Schraube (2015) understand everyday life as a field of activity through which we conduct, or lead, our lives. They suggest that the conduct of everyday life involves three dimensions: firstly, ordinary activities that are repeated regularly, are habitual, and organizes important tasks of living. Secondly, extraordinary activities that meet the demands of unexpected or challenging experiences and situations. Lastly, both ordinary and extraordinary activities are involved in the third dimension; that of making sense of it all. In this dimension, daily experiences, both ordinary and extraordinary, are integrated with our history, as well as our images for the future. Dreier (2008) emphasizes the open-ended and changing nature of everyday life, and how this requires us to continuously learn, change or re-affirm the way we conduct our lives and what we pursue. Thus, everyday life is not only structured and habitual, but also flexible and changing.

Further, Højholt and Schraube (2015) underline that everyday life must be understood as social processes: our routines, dealing with challenges, and sense-making are created, maintained, negotiated and changed in communication with others. Højholt and Schraube describe the activities of everyday life as a mediating structure between individual subjects and societal structures and culture.

What I understand from these writings is that everyday life is a continuous, complex and social process, a ‘movement through life’, made up of everyday activities

and concerned with meaning making. Everyday life is both about structure and creating coherence, dealing with challenge and instability, as well as possibilities for change and recovery. Further, everyday life unfolds in, through and in negotiation with, the different physical, social and cultural contexts and encounters of people lives.

The data material in study II of this PhD-project was created in such everyday life contexts: in the specific situations, interactions and activities through which the participants sought to make meaning and recovery, and in locations such as a church, a local coffee shop, or as was the case in many of our meetings: a community mental health center. This takes us to another relevant context of research in this project: community mental health services.

Community mental health services in Norway

Community mental health services in Norway offer both support, treatment, rehabilitation, education and activities in a wide range of settings such as supportive housing facilities, home visits, ambulatory treatment teams, vocational rehabilitation services, as well as community mental health centers (Ose, Kaspersen, Ådnanes, Lassemo, & Kalseth, 2018). I created the data for study I of this project through interviewing community mental health professionals at a service offering a large variety of individual and group support and treatment options. Their services were offered in a variety of locations depending on the users' wishes: they could meet either at the office, in people's homes, or out and about in the community. Data for study II was created through participant observations together with four users of community mental health centers, and some of our meetings took place at these centers. These centers function as meeting places where individuals can come and go as they please, sit down and have a coffee or a meal together with other visitors and the employees, play a game of cards or pool, or join one of the activity groups such as knitting, painting or photography. The centers also offer support through individual conversations with the professionals, as well as group conversations and courses.

Thus, community mental health services served as contexts of data creation in this project. However, community mental health services also served as a context from which this project took form, in my understanding making this thesis highly relevant for

these services as it answers to their need for knowledge, as well as their current strategies.

Part of the aim of this project has been to create knowledge about how personal recovery in mental health is supported, answering to a call for more knowledge about how to support individuals in their local communities and everyday lives (Ekeland, 2011; Keet et al., 2019; Longden, Read, & Dillon, 2016; Rosen, O'Halloran, & Mezzina, 2012). This need for new knowledge was brought about by extensive changes in how we understand and treat mental health problems in Norway, as has been the case in many western countries since the 1970s. Emphasizing deinstitutionalization and normalization, both individuals and services have moved out of the hospitals, to live and provide support in the local communities (Curtis & Hodge, 1994; Pedersen & Kolstad, 2009). Reducing the impact of traditional medical perspectives on community mental health services has been part of this change (Ekeland, 2011; Minsitry of Health and Care Services, 1998), and in recent years the perspective of recovery has gained increased attention as an alternative perspective (Anthony, 1993; Borg, Karlsson, & Stenhammer, 2013; Rosen et al., 2012). Recovery has also been implemented in Norwegian professional guidelines (Norwegian Directory of Health, 2012, 2014).

Further, this PhD-project may contribute knowledge relevant for ongoing governmental strategies through its focus on how meaning is made through everyday activities, as well as how professionals may facilitate such processes. In their strategy for good mental health (2017-2022), *Mastering life* (Norwegian Ministries, 2017), the Norwegian ministries state that they wish to create a society which promotes mastery, belonging, inclusion, participation and experiences of meaning for all. As a fruitful resource they mention the Australian program ABC (act-belong-commit). This program focuses on engaging people in physical, spiritual, social and mental activities that both increase their belonging to the communities in which they conduct their everyday lives and recover, and that involve commitment to causes that provide meaning and purpose (Koushede, Nielsen, Meilstrup, & Donovan, 2015).

2. CONCEPTS AND THEORY

I will now present the most central concepts and theory of this thesis. First, I will present my understanding of mental health recovery both as a process of change and as a professional perspective for services. Next I will describe my understanding of the concept of meaning, before I present relevant theory about narratives and narrative meaning making. Last, I will present my understanding of everyday activities.

2.1 Mental health recovery

Mental health recovery was first introduced and discussed by former patients or users, the so-called 'psychiatric survivor movements', in the U.S.A. These groups sought to change how professionals and others understand mental health problems, as well as mental health services. They advocated moving away from traditional medical perspectives and paternalistic approaches to give way for multidimensional understandings of mental health problems, a holistic perspective of individuals, and more humane and individually adjusted services. Initially, recovery was presented as a unique and deeply personal process of gaining hope and willingness to act and establishing new meaning in life, inspired and supported by love and faith from other persons (Anthony, 1993; Patricia Deegan, 1988; Patricia Deegan, 1996; Patricia Deegan, 1997). Professionals and researchers later adopted the concept and created recovery models and approaches (Anthony, 1993; Stuart, Tansey, & Quayle, 2017). Thus, recovery is discussed in literature both as a process of healing and change, and as a perspective for mental health services, and both these uses of the concept are relevant in this thesis.

Recovery as a process of healing and change

The recovery perspective gained force as both ex-patient/survivor/user-voices and research documented how mental illness is less chronic than previously thought, as well as how having a mental illness does not mean that one cannot lead a productive and meaningful life. Highlighting how mental illness is not chronic and a defining dimension of a person, some focus on *recovery from* the symptoms and difficulties of mental illness, resuming a life as one had before (Davidson & Roe, 2007; Davidson & Schmutte, 2020). This view of recovery is often framed in literature as '*clinical*

recovery' – highlighting the decline of symptoms of illness as a goal and objective measure for recovery (Topor, Denhov, Bülow, & Andersson, 2018).

However, Davidson, Tondora and Ridgway (2010) problematize the notion of recovering from mental illness, as this renders recovery as an outcome that many will never succeed achieving. They argue that recovery should perhaps be understood as an ongoing process rather than an outcome, and that it is possible to *recover in* life although one still experiences mental health problems. This is often referred to as *personal recovery* and is the understanding of recovery I build on in this thesis. Making this distinction between *recovery from* mental illness and *recovery in* life, I choose to use the term 'mental health problems' rather than 'mental illness' or other terms related to a clinical understanding of these issues. I understand personal recovery as a subjective experience, not available for objective evaluation (Topor et al., 2018), and therefore also choose not to focus on medical diagnoses, but rather individuals' subjective experiences of symptoms and the challenges they cause in their everyday lives.

Focusing on personal recovery, I embrace that individuals may find new ways of being productive and creating meaning even though they still experience symptoms and other consequences of mental health problems, such as poverty, unemployment, loss of valued roles, stigma and so forth (Anthony, 1993; Borg, 2007; Davidson & Roe, 2007; Patricia Deegan, 1988; Patricia Deegan, 1996; Onken et al., 2007). Further, everyday life environments emerge as crucial arenas for recovery in favor of mental health service settings, as persons in recovery describe it as a process of achieving normality, finding a balance between activity and rest, and overcoming challenges in everyday life posed by illness (Borg, 2007; Borg & Davidson, 2008).

Additionally, personal recovery appears ambiguous and complex, involving several dimensions, or processes. Leamy et al. (2011) present a framework for personal recovery consisting of five categories: Connectedness, Hope, Identity, Meaning in life, and Empowerment (CHIME). This framework aims to offer a holistic, social and contextual understanding of personal recovery, showing how these are not solely individual processes, and this has also been supported by subsequent studies (Bird et al., 2014; Slade et al., 2012; Stuart et al., 2017; Tew et al., 2012). However, there exists some tension regarding how personal recovery is described and understood. Although

several authors acknowledge the social and multidimensional nature of personal recovery, several authors critique existing literature on personal recovery for overemphasizing the individual's effort to recover and downplaying the role of context (Davidson & Schmutte, 2020; De Ruysscher, Tomlinson, Vanheule, & Vandevelde, 2019; Duff, 2016; Price-Robertson, Obradovic, & Morgan, 2017). I support this critique and argue that we should seek contextual and processual knowledge about mental health recovery. Therefore, the complexity of personal recovery, as well as its social and contextual dimensions, have been central in this PhD-project.

Recovery as a professional perspective

William Anthony (1993) was one of the first to write about recovery as a new perspective for mental health services. He argued that the era of deinstitutionalization changed the service system dramatically and created a demand for new knowledge and practices for providing services in community contexts. These changes, as well as clear demands from the 'survivor movements' gave way for the emergence of the recovery perspective. As I described earlier, this has also characterized the evolvement of Norwegian community mental health services.

According to Anthony (1993), a recovery-oriented system deals with all the negative effects of mental illness and seeks to establish new meaning and purpose in individuals' lives. Facilitating community integration, supporting participation in meaningful activities and inspiring hope are described as central tasks for recovery-oriented services (Le Boutillier et al., 2011). Further, recovery-oriented support is advised to be open and flexible, adapted to individuals' complex needs and everyday lives. Moving beyond diagnostic labels and assuming a holistic view of users, as well as partnership and shared decision making are described as central aspects in the collaboration between recovery-oriented professionals and users (Chester et al., 2016; Davidson, Tondora, Pavlo, & Stanhope, 2017).

However, in line with the critique of the perspective of personal recovery, some also critique recovery-oriented services for placing too much focus and responsibility for change on the individual, leaving change of social and structural conditions and inequality in the background (Harper & Speed, 2014). Slade (2010) suggests that mental health professionals should view their job as not only working with individuals but also

becoming ‘social activists’ who challenge stigma and discrimination and work to promote societal well-being. Supporting this extended view of what mental health services should be, Keet et al. (2019) suggest six key elements in good community-based, recovery-oriented mental health care: 1) protecting human rights; 2) focusing on public health; 3) supporting service users in their recovery journey; 4) make use of effective interventions based on evidence and client goals; 5) promoting a wide network of support in the community; and 6) making use of peer expertise in service design and provision. These elements reflect a holistic approach to mental health, where both health promotion, illness prevention and care are part of the services, involving not only mental health professionals and users, but also other public sectors as well as peers, family and extended social networks.

In this research project I have explored both how recovery-oriented mental health professionals collaborate with and support users. In section 6 I will discuss implications for recovery-oriented services based on my findings.

2.2 Meaning

Exploring how personal recovery in mental health unfolds and may be supported as processes of meaning making has been my aim in this project, and I have used the concept of *meaning* extensively throughout the thesis and articles. In psychology and human sciences, the concept of meaning is widely used, but there does not exist a common theoretical understanding or definition of what the concept refers to. However, the different definitions often share two basic assumptions: meaning is about coherence, and meaning is connected to context (Leontiev, 2013).

These two basic assumptions are also evident in my narrative understanding of meaning in this thesis, which mainly builds on the work of Paul Ricoeur (1984), Jerome Bruner (1990) and Cheryl Mattingly (1998), and focuses on meaning as a process unfolding in everyday life, and through actions, rather than understanding meaning as a result or as something that is inherent in certain activities. I was also inspired by the work of Victor Frankl (1963), an existential psychologist who in correspondence with the narrative perspective has focused on meaning making as a process. In accordance with Frankl (1963), I claim that experiencing meaning is essential for all of us, and that we have a drive towards creating meaning in life which directs our actions.

In the narrative theory I build on in this thesis, meaning is understood as coherence, or causality, between events and experiences over time, and making meaning is closely related to action. Mattingly (1998) writes that the meaning of any activity resides in its contribution as an episode in a larger story, a narrative. A narrative is an assembly of actions and events which together make meaning by contributing to a plot, issues or values, that are important to the person acting, but still unfulfilled (Polkinghorne, 1995). Following this, I understand that individuals make meaning through doing everyday activities that may contribute coherence with their previous activities and experiences, as well as their images, desires and direction for the future. However, coherence is not described in literature as a stable entity, but rather something that is tried out, communicated and negotiated through everyday activities and interactions (Bruner, 1990; Mattingly, 1998; Ricoeur, 1984). Thus, I consider meaning to be a fresh product which needs to be continuously pursued through the activities and interactions of everyday life, and which is shaped by the particular contexts it is developed in.

My understanding of meaning as contextual implies viewing it as temporary and changing, but also concrete in each particular context. Ricoeur (1984) writes about the hidden or symbolic meaning of actions, referring to social or cultural rules, norms and ethics that guide our actions. In line with this, Bruner argues that meaning is always created in the context of culture, as humans are tuned to social meaning and living in groups. However, he underlines that cultural contexts are always concrete contexts of practice and that "*Meaning grows out of use*" (1990, p. 118). Similarly, Frankl (1963) suggests that life continuously asks something from us, directing our activities and providing concrete meaning at a specific time. Following this, I argue that exploring meaning implies focusing on what people are doing in a particular context at a particular point of time, such as I have sought to do in this study.

In conclusion, I understand meaning as coherence between past and present events and activities, as well as future images and dreams, mediated by a plot. Further, meaning is fleeting and contextual, and needs to be continuously made and negotiated through everyday activities, interactions, and in each specific everyday context of practice. This narrative understanding of meaning adheres with my choice of everyday life as context and everyday activities as focus of data creation in study II. Further,

theory about narrative meaning making was a central theoretical resource in study II, which I will elaborate on in the following section.

2.3 Narrative

Both studies in this project build on a narrative perspective on meaning making and knowledge production. I understand making narratives from and through our activities and experiences as an inherent, human capacity (Bruner, 1990). Narratives are about human actions, and preserve the meaning and complexity of these actions as they unfolded in temporal, geographical, interpersonal and environmental contexts (Polkinghorne, 1995). Therefore, narrative theory and methods inspire and promote processual and contextual knowledge about experiences, such as I have wished to contribute through this project. However, there are different ways to build on narrative theory and use narrative methods in research, necessitating that I position myself in 'the narrative landscape'.

Narratives and action

This project is particularly grounded in the French philosopher Paul Ricoeur's (1913-2005) extensive work on narrative. Ricoeur related narratives to the interpretation and understanding of human actions and meaning making. Building on ideas of Aristotle, Ricoeur argued that in real life, narratives are closely connected to actions, and that narratives not only exist as told or written stories. Ricoeur proposed that in addition to creating stories *from* our previous actions, we also create stories *in* or *through* our actions over time (Ricoeur, 1991). Ricoeur viewed unfolding actions and events as 'not yet told stories' or 'potential stories' (Ricoeur, 1984).

Ricoeur's work on such enacted narratives, or meaning making through actions, does not relate specifically to issues of health and recovery. However, building on Ricoeur's work, Cheryl Mattingly (1998) developed further Ricoeur's understanding of meaning making by studying enacted narratives in a clinical, occupational therapy setting. She showed how professionals build on their knowledge and experiences, imagine future possibilities and act to create narratives of healing and change together with their patients to help them make meaning of and through their experiences. Mattingly's work inspired both my wish to explore the role of meaning making in mental health recovery, as well as my use of narrative methods and theory in this project.

Narrative meaning making – the threefold mimesis

To show how narratives play out through actions, and as a method for interpretation of human actions, Ricoeur further developed Aristotle's work on *mimesis* (the imitation of human action and experience) into '*the threefold mimesis*' (Ricoeur, 1984). This model of narrative meaning making suggests that meaning is embedded in an individual's actions over time, tying together past, present and future (Alsaker, 2009). In study II I explored processes of meaning making through everyday activities and used the threefold mimesis as a central theoretical resource to analyze and interpret the data from my participant observations. Therefore, I choose to explain it in more detail here.

Mimesis is the process through which we seek to connect action to meaning, and Ricoeur described it as involving three *folds*. It is important to underline that processes of mimesis are un-linear, moving back and forth between the different folds (Alsaker, 2009; Ricoeur, 1984). *Mimesis I* holds the continuous stream of everyday activities and experiences in real time, ongoing and without a beginning, middle or end. What we do and experience in mimesis I provides us with images and ideas of possibilities for coherence which we may try out in mimesis II. *Mimesis II* is how we seek to make meaning within this continuous stream of experiences, by tying together past and present experiences and activities as well as images for the future. This involves trying out how possible explanations, values or issues (plots) may contribute meaning, and is a complex process of moving back and forth between possibilities, trying and failing, and making choices. Further, possibilities of how events and activities can be tied together and understood in relation to each other can be tried out through thought experiments or internal dialogues, as well as engaging in activities and communication with others. The third fold of meaning making, *mimesis III*, is where meanings and explanations are 'set', at least for now, and shared and communicated as understood. Now a coherent explanatory story can be presented to ourselves and to others, with a sequence of actions and events; a beginning, middle and an end, and with a plot, a common value or issue, tying these experiences together. However, the stories and meanings made in mimesis III are not fixed, but may undergo changes as a result of communication and negotiation with others, as well as new experiences and altered contexts which set in motion new processes of mimesis (Alsaker, 2009; Ricoeur, 1984).

The model of the threefold mimesis shows how narrative meaning making is not just something that happens in retrospect, when communicating experiences as coherent and understood in mimesis III, but rather a continuous process of creating meaning which involves both our thoughts and activities, as well as ongoing communication with others. In our daily lives these processes of making meaning are often fast, implicit, subtle and unconscious. We act based on routines, communication with others, previous experiences and thoughts about where we are heading without really thinking that much about it (Alsaker, 2009; Ricoeur, 1984; Ulfseth, 2016). However, mental health problems may bring about several changes and challenges in individuals' everyday lives, in my understanding potentially disrupting ongoing processes of narrative meaning making and requiring comprehensive efforts of re-establishing meaning in everyday life. This recognized the narrative meaning-making processes I explored in this study, and in our findings these processes appear as both complex and challenging, involving having to re-think what is important in life, discovering what possibilities and limitations are currently present, engaging in new activities, as well as continuously having to endure disrupting experiences such as symptoms, treatment, dependence on support, stigma and hospitalizations.

2.4 Everyday activity

My focus on personal recovery in mental health, as well as my narrative understanding of meaning and meaning making, lead me to explore individuals' everyday activities and experiences in this project. I argue that everyday activities entail possibilities of producing meaning and thus narratives of change and recovery (Mattingly, 1998; Ricoeur, 1984).

Staying close to Ricoeur's work on narratives, I build on his conceptualization of meaningful actions in my understanding of the concept of everyday activity. Ricoeur (1991, p. 189) defines 'meaningful action' as an action which the person doing it can account for, or tell about, in a way that makes it sensible for himself and/or others. Such actions do not just happen, it's not just 'one thing after another', rather they are initiated and performed by responsible agents with goals and motives (Ricoeur, 1984). Conversely, an activity appears meaningless when disconnected from other experiences, when one's participation is unexplainable and cannot be understood in relation to

previous experiences and future images (Mattingly, 1998). Following this, I use the concept of everyday activity in reference to actions that people do in their efforts of conducting their everyday, and to produce coherence mediated by important issues in their lives. Further, I argue that everyday activities must be understood through their connections with previous activities and events, as well as the actor's images for the future. Additionally, actions are always done in interaction with others, either in cooperation, competition or struggle (Ricoeur, 1984), thus everyday activities must also be understood contextually as they are conducted in the physical, social and cultural contexts of people's everyday lives.

3. RELEVANT RESEARCH AND LITERATURE

This far I have introduced and presented my understanding of mental health recovery, meaning and narrative, as well as everyday life and activities, as central perspectives, concepts and theory, and contexts, for this research project. In this section I wish to elaborate on what we know, and what we perhaps should learn more about, concerning how processes of personal recovery relate to meaning, narrative and everyday activities.

3.1 Personal recovery and meaning

As I have already asserted, meaning is suggested to be an important dimension of recovery. In their much referred to review of what personal recovery is, Leamy et al. (2011) argue that meaning in life is one of five core dimensions of recovery. In this study they connect 'meaning in life' to spirituality, making meaning of mental illness experiences, quality of life, social roles, social goals and rebuilding life. Other studies also support meaning as a core dimension of recovery (Onken et al., 2007; Stuart et al., 2017), and several authors describe recovery as a process of recreating a meaningful everyday life (Anthony, 1993; Borg, 2007). In their review of literature about the elements of recovery, Onken et al. (2007) describe meaning making as an individual drive, as well as a social process, and connect meaning making in recovery to purpose, productivity and spritiuality. However, this literature does not make clear or elaborate on what the concept of meaning refers to in relation to mental health recovery.

Only a few studies target meaning in relation to recovery specifically, and even fewer explore how meaning is made. In a study exploring what creates meaning in the lives of individuals with mental health problems, Eklund et al. (2012) found that individuals describe social contacts, engagement in occupations[1], experiencing health, precious memories, and positive feelings as important sources of meaning. Ulfseth, Josephsson, and Alsaker (2015) explored how processes of meaning making take place in everyday occupations among people with mental illness at a psychiatric center, and

[1] Occupation is a concept commonly used in occupational therapy and occupational science. The concept refers to what individuals do when they act upon their own intentions or goals in communication with their contexts at a specific point of time (Yerxa, 2000). This term is not commonly used in everyday speech or in other professional disciplines, which is why I have rather chosen to use the term activity in this thesis. However, I write occupation when referring to literature which uses the term.

show how meaning making unfolds as shared narrative processes linked to the little things that happen in everyday life, everyday activities and to small-talking with others. Huguelet et al. (2016) suggest that meaning in life is connected to realizing important values through actions. However persons with mental illness may experience problems related to mentalizing how to do this, as well as experience that values feel less important to them than before. The authors suggest that professionals supporting recovery should help individuals mentalize what their current actions and projects might mean to them as part of their lifetime trajectory, as well as consider values to be an important issue to focus on in therapy.

All these studies above mention activities, or actions, as central to meaning making. Additionally, several studies specifically connect meaning making in mental health recovery with participation in everyday activities. Some studies highlight how doing activities provides possibilities for making meaning through feelings of belonging and mutual recognition (Lund, Argentzell, Leufstadius, Tjörnstrand, & Eklund, 2019), others focus on how activities such as painting can help create meaning connected to spirituality (Van Lith, 2014), or how the pleasure of giving to or helping others gives meaning and purpose in life (Davidson, Shahar, Lawless, Sells, & Tondora, 2006). Additionally, several studies find that work, or work-like activities provide meaning for persons with mental health problems by providing purpose, structure and connectedness (Blank, Harries, & Reynolds, 2015; Leufstadius, 2018). Further, several studies find that meaning is particularly created through activities which provide opportunities for social connection and inter-dependence. Through such activities individuals describe experiencing meaning in the form of feelings of wellness, positive changes in self-perception and improved quality of life (Hancock, Honey, & Bundy, 2015; Nordaunet & Sælør, 2018).

To sum up, literature suggests that meaning making are central processes in mental health recovery, and points to everyday activities as a source of meaning. However, there seems to exist little research which clarifies what the concept of meaning refers to, or how meaning is made through activities. As I have presented in earlier sections, I suggest that narrative theory may offer one way of understanding this. In the following I will therefore explore research and literature focusing on mental health recovery in relation to narratives.

3.2 Personal recovery and narrative

There exists a large body of literature collecting and analyzing told or written narratives of recovery, acknowledging personal narratives as important sources of knowledge, and narrative methods as valuable in studies about recovery (Llewellyn-Beardsley et al., 2019; Spector-Mersel & Knaifel, 2018). Narrative studies have contributed knowledge about the complex and subjective experiences of recovery, exploring topics such as the social determinants of recovery (Georgaca & Zissi, 2017), moral agency in recovery (Myers, 2016), dimensions of recovery (Jacobson, 2001), the return to home after hospital stays (Ulfseth et al., 2016), as well as how recovery and occupation is connected (Kelly et al., 2010), including the relationship between participation in music and theatre and mental health recovery (Torrissen & Stickley, 2018; Ørjasæter, Stickley, Hedlund, & Ness, 2017). Further, narratives of recovery are frequently shared in media, mental health settings and other places to educate others about recovery. Sharing such narratives have been found to create connectedness, promote understanding of recovery, reduce stigma, enhance validation of personal experience, and inspire empathy and action (Rennick-Egglestone et al., 2019).

Only a limited range of literature delves into the narrative nature of recovery, and how recovery unfolds as ongoing narrative meaning making such as I have done in this PhD-project. The existing literature about the narrative nature of recovery predominantly focuses on narrative meaning making as personal change and adaptive strategies unfolding through cognitive processes and internal dialogue. Patricia Deegan (2002) describes recovery as a self-directed process of discovering one's limits and possibilities, and creating narratives of change. Roe and Davidson (2005) explain how mental illness may bring about major disruptions in individuals' lives, challenging coherence and continuity. They suggest that narrative processes of re-authoring one's life story, picking up the pieces from one's former life and weaving them together with the changes and disruptions caused by illness, as well as one's thoughts about the future, are key dimensions in mental health recovery. Also Onken et al. (2007) write about re-authoring one's life story – making sense of one's experiences of illness as an important part of recovery. Similarly, both Grant, Leigh-Phippard, and Short (2015) and Kerr, Deane, and Crowe (2019) understand narrative identity construction to be a key

process of mental health recovery, involving adaption to the current situation, and describe this as a process of evolving one's internal life story, integrating the past, present and future to provide unity. Further, studies about the narrative nature of recovery underline how these processes of narrative meaning making are not linear, but rather diverse, multidimensional, un-linear, open-ended and changing (Llewellyn-Beardsley et al., 2019).

Some authors also mention how narrative meaning making in recovery involves actions, however the literature on this is very limited. Roe and Davidson (2005) write that narrative meaning making requires individuals to be active agents who assemble, rearrange, improvise, try again and negotiate to create coherence. Lysaker, Lysaker, and Lysaker (2001) underline that coherent life narratives supportive of recovery are created both through internal dialogue as well as dialogue with others and through integrating one's evolving actions within the narrative. The role of activities in narrative meaning making and mental health recovery has also been found to be evident in a narrative study about the role of exercise in mental health recovery (Carless, 2008), and was the focus of exploration in a study about meaning making at a psychiatric center (Ulfseth et al., 2015, 2016). These studies show how meaning making is inspired and unfolds through everyday occupations and small talk in social situations at the ward.

Following my review of existing literature about mental health recovery and narrative it seems that there exists limited research and knowledge about how recovery can be understood as narrative meaning-making processes. The literature that does point to the narrative nature of recovery focuses on these processes as mainly cognitive and individual. Thus, there seems to be a lack of research exploring enacted narratives as I do in this project. However, the literature reviewed in section 3.1 does point out the crucial role of everyday activities in the meaning-making processes of recovery. Therefore, I present my review of literature concerning recovery and everyday activities in the following.

3.3 Personal recovery and everyday activities

"Those of us who have been diagnosed are not objects to be acted upon. We are fully human subjects who can act, and in acting change our situation."

Patricia Deegan (1996, p. 92) here underlines the importance of *doing* to elicit change and recovery. The role of doing everyday activities in mental health recovery has been a focus of exploration in several studies. These studies report findings of how doing activities can facilitate recovery in several ways. Activities provide pleasure, something to look forward to, possibilities of discovering competencies, improve self-concept and quality of life, help build hope, meaning and purpose, and may be a source of commitment and contribution to others (Davidson et al., 2006; Kelly et al., 2010; Nordaunet & Sælør, 2018; Torrissen & Stickley, 2018). Everyday activities may also provide opportunities of change and trying out new possibilities in everyday life (Borg & Davidson, 2008; Torrissen & Stickley, 2018; Ørjasæter et al., 2017).

Persons in recovery describe being in a practical and ongoing process of dealing with tasks and challenges in a variety of everyday arenas, successfully doing trivial activities of the everyday (Borg, 2007; Davidson & Roe, 2007; Tanaka & Davidson, 2015). Similarly, several studies exploring the relationship between recovery and activities suggest that activities not only facilitate recovery, but that recovery should be understood as an occupational journey. Kelly, Lamont and Brunero (2010) found that the recovery journey involves going back and forth between being passive, taking initiative and responsibility, becoming active, meeting barriers and getting support. Similarly, Sutton, Hocking and Smythe (2012) explored recovery narratives and found four 'occupational modes' which they termed 'disengagement', 'partial engagement', 'everyday engagement' and 'full engagement' (2012, p. 144). In line with, and partly based on, Sutton et al. (2012), Doroud, Fossey and Fortune (2015) did a literature review on the subject, and they also found that recovery may be seen as an occupational journey. They describe how recovery proceeds *through* occupational engagement, starting with re-engagement, followed by participation in everyday life occupations, and finally re-gaining full community participation and citizenship. Everyday activities provide possibilities of rebuilding hope and meaning, provides structure and 'normalcy' to life, as well as connections with others and productivity. Based on their findings,

Doroud et al. (2015) suggest that occupational re-engagement and recovery not only relate, but are in fact much of the same.

However, as stated in my introduction, research shows that persons in recovery may meet challenges and need support when doing activities. Such challenges may be lack of skills and education, inadequate funding and support, stigma and discrimination, and lack of opportunities and choice. Accommodating environments that feel safe and promote initiative and mutual support are found to facilitate participation (Kelly et al., 2010). Further, being appreciated, respected and not standing out; trusting, supportive and mutual relationships; as well as predictability and control are factors found to support persons with mental health problems when doing activities (Yilmaz et al., 2009). Thus, I suggest that knowledge about how persons with mental health problems influence and do everyday activities, and how they may be supported while doing activities, is a valuable contribution to mental health services that seek to provide recovery oriented services.

Based on my review of research shedding light on the relation between recovery and everyday activities, personal recovery appears to me as processes of dealing with the practical matters of conducting an everyday life, providing joy and purpose in life, making change, re-connecting with persons and communities, and making meaning through doing everyday activities. It seems that recovery is done, or enacted, not something that just happens.

3.4 Summary

My review of literature on personal recovery, meaning, narrative and everyday activities indicates that meaning-making processes are central in personal recovery, and points to everyday activities as crucial in recovery, partly because they may offer possibilities of meaning making. Further, several authors point to narrative as a possible way of understanding meaning-making processes in recovery. However, the literature exploring the narrative nature of recovery in relation to doing everyday activities is very limited. Thus, we seem to know little about how processes of narrative meaning making in recovery may unfold through everyday activities, including how such processes can be supported by others. In all, there seems to be a lack of research literature focusing on meaning and meaning making in personal recovery. This project seeks to provide

knowledge about these issues, as my aim has been to explore how personal recovery in mental health unfolds and may be supported as processes of narrative meaning making, through studying how individuals with mental health problems influence and do everyday activities, as well as how professionals and users collaborate.

4. METHODS

My aim in this PhD-project has been to shed light on how personal recovery in mental health unfolds and may be supported as processes of meaning making. This aim asks for processual knowledge about personal experiences, and points to qualitative, interpretive methods (Malterud, 2015). Narratives tie together individuals, activities and contexts and offer as I see it a way of understanding recovery not by breaking it up in different dimensions, but by understanding how the multiple aspects of recovery come together in processes and make meaning as a whole. I therefore chose to use narrative methods in this project. Further, this aim directs my attention towards ongoing and open-ended processes of recovery, rather than resolved stories of either success or failure. How can such ongoing processes be 'captured' and studied? How can data be created in ways that conserve the complexities, unresolved issues, contexts and actions of such ongoing processes? I imagine that through observations of concrete situations and activities we can capture and explore temporary glimpses of these processes, therefore I chose to create data for study II through ethnography, or participant observations.

Polkinghorne (1995) divides narrative inquiry into two main categories: studies who gather stories as their data, and uses paradigmatic analysis to produce categories out of common elements in the data, and studies who gather data about events, actions and experiences, and uses narrative analysis to understand the data elements in relation to each other and produce explanatory stories. In this project, both studies draw on the last tradition of narrative inquiry, analyzing data by searching for connections and processual understandings.

In Study I, I created data through narrative interviews and conducted an interpretive analysis focusing on processual findings and understandings. In study II, I did participant observations inspired by ethnography and performed a narrative analysis of the data. I will describe the methods for each of these two studies separately in the following, but first I will present the philosophical foundations of the study.

4.1 Philosophical foundations

The methods I chose in this project reflect philosophical influences from both constructivism, phenomenology and hermeneutics.

Exploring the hows - constructivism and narratives

In this thesis I explore processes of narrative meaning making in personal recovery as they are enacted and experienced by individuals, professionals and others in a variety of everyday life contexts. I suggest that narratives of recovery are made by both human and non-human contributors, such as law, service management, places, events and activities. This reflects a constructivist ontological viewpoint such as presented by Latour (2005), in which both human and non-human entities are viewed as actors in the actor-networks constructing realities.

By creating data through interviews and ethnography, and through a joint process of analysis and interpretation, I argue that I have been part of a data-creation and understanding-developing process together with the participants and my co-researchers. Further, I argue that enacted narratives of recovery are not fixed – contrarily they fluctuate depending on the participants who tell and enact their story, me as a researcher trying to understand, as well as our physical, historical and social contexts (Bruner, 1990). Hence, I do not believe there is a 'truth' out there for me to find. This entails that I also build on a constructivist epistemology, maintaining that knowledge is constructed in an interplay between researchers, research participants, as well as the contexts of research (Malterud, 2015).

Moving between parts and whole – hermeneutics and phenomenology

Further I have explored both how activities, persons and contexts contribute in processes of meaning making and recovery (the parts), as well as how they work together (the whole). To create such knowledge, I combined a constructivist epistemology of data creation with a narrative method of analysis which is philosophically grounded in Ricoeur's phenomenological hermeneutics.

Ricoeur argued that to reach a deeper understanding of human experiences we should both describe them phenomenologically and try to discover their meanings and possible explanations hermeneutically. Further, he proposed that we should be both subjective (understanding, empathic) and objective (explorative, distanced) in our

interpretations (Ricoeur, 1973; Ricoeur, Rendtorff, & Hermansen, 2002). My method of interpretation in this project reflects such a philosophical stance. I explored mental health recovery and meaning making in particular situations of doing everyday activities, using my empathy, as well as personal and professional experiences to try to describe and understand the participants actions, thoughts, feelings and needs for support in each situation. This entailed exploring the particular situations in connection with other events and activities in the persons' lives, as well as their everyday contexts. However, I also explored these situations in a larger context of the participants social and cultural contexts, using narrative theory and empirical knowledge when searching for possible understandings. This movement between closeness and distance, parts and whole, expanding my understanding in concentric circles, or a spiral, is what characterizes the double hermeneutic of interpretation (Gadamer, 1988; Giddens, 1993).

4.2 Method, study I

One empirical article is published from study I:

Reed, N. P., Josephsson, S., & Alsaker, S. (2017). Community mental health work: Negotiating support of users' recovery. *International Journal of Mental Health Nursing, 27*(2), 814-822. doi:10.1111/inm.12368

Research design

This study made use of an explorative, qualitative approach involving narrative interviews.

Recruitment and participants

The aim for this study was to explore how community mental health workers provide support to users, by investigating professionals' own narratives of how they work. Given our interest in how recovery unfolds in everyday life we sought to interview community mental health workers who meet and work with users in a variety of places, offering support directed towards challenges in everyday life. The participants in this study were therefore recruited from two community mental health service departments in an urban municipality in Norway.

Study I was started before I entered this PhD-position. My main supervisor had contacted the leader of one of the community mental health service department, seeking approval and participants for the study. The leader supported the study, and she

was put in touch with three community mental health workers who agreed to participate and were interviewed by a research assistant during the winter of 2014. When I continued on this study as part of my PhD-project in fall 2015, I made contact with the leader of the other community mental health service department in the city and interviewed four professionals at this department. These interviews were conducted by December 2015.

In total seven community mental health workers participated in this study, two men and five women. They represented several professions: three nurses, one practical nurse, one occupational therapist, one social worker and one sociologist. They all had further education in areas such as mental health, therapy, violence and/or drug abuse. They had worked in community mental health services from 2 to 17 years, with an average of 11 years.

Data creation

To obtain processual knowledge about how these professionals work with users, I chose to do narrative interviews (for interview guide, see appendix 1). Our main question was: *Can you tell me about what you do in your work, and how you collaborate with users?* We encouraged the professionals to tell stories from their work to obtain detailed information about the actions and contexts that constitute their meetings with users. We asked follow-up questions to urge the participants to elaborate further on their narratives, to tell us about how they work to support service users' influence in their everyday life, as well as their participation in everyday activities in their local communities. We also asked how they manage challenges, dilemmas, opportunities and limitations in their work. Each interview lasted about 1 hour and took place in the offices of the services. The interviews were audiotaped and transcribed verbatim by either me or a research assistant.

Data analysis

The data were analyzed through an interpretive, hermeneutical approach, reflecting an 'editing analysis style' (Crabtree & Miller, 1999; Malterud, 2015), involving the following steps. First, the third author and I read through the transcripts several times to acquire an overview of the data. Second, all three authors took part in a preliminary analysis of the data through discussions. Our analytical interests and interpretations

were guided by knowledge about recovery as a perspective on mental health and services (Anthony, 1993; Borg, 2007; Davidson et al., 2005; Le Boutillier et al., 2015), as well as our focus on everyday life as a context of recovery and provision of support (Borg, 2007; Scott, 2009). Through this preliminary analysis we found that the professionals told about several situations of supporting users which involved dilemmas or challenges for them, and we chose to explore these parts of the data in our further analysis.

In the third step of analysis, I read the transcripts again, marking parts of the transcripts in which the professionals discussed such dilemmas and challenges. In the fourth step of analysis, the third author and I worked through these marked passages and divided them into six groups according to the particular situations described. These were: 1) independence vs. supportive relationships, a question of time; 2) being a parent and being a service user; 3) integration, segregation, exclusion; 4) service users' self-determination; 5) powerlessness, evasiveness, hope and collaboration; and 6) new public management and recovery. The data concerning these six different situations involving dilemmas or challenges were explored and interpreted further, seeking to understand the process of collaboration between service users and professionals in these situations. Knowledge about processes of negotiations served as an analytical resource in this stage of the analysis (Alsaker & Josephsson, 2003; Lewicki & Wang, 2006), helping us understand these processes of collaboration. In negotiations two or more opposing parties seek agreement through sharing knowledge, perspectives and wishes, and then discussing, balancing and compromising between these considerations to establish a shared understanding and decision. Negotiation processes can be open and ongoing, moving between possibilities and choices in particular situations over time. Through the professionals' narratives of how they work in these challenging situations, we found that they engage in what we recognize as negotiations with users, service management and/or others. In the published article we present our analysis of how these negotiations unfold in the first four of the six situations we explored.

Ethical considerations

The PhD-project was approved by the regional committee for medical and health research ethics (approval number: 2013/2410/REKmidt). Study I was also supported by

the director of health in the municipality, as well as the leader of the community mental health services. Prior to the interviews, the researchers gave both oral and written information to the participants about our study aims, how we would ensure their anonymity, as well as what participating in this project would entail for them. All participants signed written consent forms prior to the interviews (for written information and consent forms, see appendix 2). We changed participant's names and details in the published article to ensure participant anonymity.

4.3 Method, study II

Published articles from study II:

Reed, N. P., Josephsson, S., & Alsaker, S. (2018). Exploring Narrative Meaning Making through Everyday Activities - A Case of Collective Mental Health Recovery? *Journal of Recovery in Mental Health, 2*(1), 94-104.

Reed, N. P., Josephsson, S., & Alsaker, S. (2020). A narrative study of mental health recovery: Exploring unique, open-ended and collective processes. *International Journal of Qualitative Studies on Health and Well-being, 15*(1).

Research design

In study II we applied a phenomenological-hermeneutic narrative-in-action design (Alsaker, 2009; Alsaker, Bongaardt, & Josephsson, 2009; Josephsson & Alsaker, 2014), involving participant observations.

Recruitment and participants.

For this study I sought participants who experience mental health problems and are living at home in their community. To recruit participants for this study I contacted the leader of the community mental health centers in the municipality of research. She supported the project and helped me connect with the employees at three centers. They all invited me to their weekly house meeting to inform service users and professionals about the study. At these meetings I presented what the study was about; what it would mean to participate, and how I would ensure participant confidentiality. After the meetings I also put up posters at the centers with information about the study, as well as contact information (for poster, see appendix 3). Persons interested in participating were encouraged to contact me either directly, or through the professionals working at the

centers. Four persons, two men and two women in their 40s and 50s, showed their interest in participating in the study by contacting me directly.

Data creation

I created the data material through participant observations while I was doing everyday activities of their choice together with the participants. I followed recommended guidelines for participant observations provided in literature on ethnography (Fangen, 2004; Hammersley & Atkinson, 2007). I met with each of the participants 7-8 times, during a period of 6-8 months. Each meeting lasted from 2-4 hours. We did a variety of everyday activities together, such as joining the art-group at the day center, going for walks in the forest, going to the gym, baking and cooking at home or at the community mental health center, joining meetings and meals at the center and more. During the meetings I did the activities together with the participants and joined in the conversations with them as well as others present. Before and after each meeting I wrote field notes in four parts including: my preparations, preunderstandings and reflections before the meeting; the place, time and main activity of the meeting; my detailed recollections of the events and conversations taking place during the meeting; as well as my reflections and preliminary analysis after each meeting. These field notes, in total about 49500 words, formed the data material in study II.

Data analysis

Me and my co-researchers analyzed the data through a phenomenological-hermeneutic, narrative approach (Alsaker, 2009; Alsaker et al., 2009; Josephsson & Alsaker, 2014; Polkinghorne, 1995). In narrative analysis the researchers seek to discover plots, or central issues in the data, which may help understand the data material through connecting several elements (Polkinghorne, 1995). The analysis of this data material started with the third author and me reading the field notes to get an overview of the material. I read the field notes several times, searching for significant events (Mattingly, 1998), raising curiosity and questions related to the aims of the study. I presented such parts of the data material to the others in the research group, and all three researchers joined in discussions about possible understandings of the material.

In hermeneutic analysis, the researcher moves in spiralling circles between parts and whole in the data material, seeking to expand her understanding (Gadamer, 1988).

During the preliminary analysis, we engaged in such a hermeneutical process of exploring both parts and whole in the data material, focusing both on the concrete activities and events described in the material, as well as on developing holistic overviews of the material created with each person. Additionally we developed further our interpretations by drawing on an analytical framework of narrative theory as well as relevant research literature on recovery and narrative meaning making, fulfilling a 'double hermeneutic' spiral of interpretation (Giddens, 1993).

Our analysis in study II was further developed in two different directions, yielding two empirical articles: one being a case-study presenting our analysis of an activity done with one of the participants (article 2), the other presenting our overall findings from the data-material created with all four participants (article 3). I will continue by presenting the further analysis of these two articles separately.

Further analysis, article 2

Reed, N. P., Josephsson, S., & Alsaker, S. (2018). Exploring Narrative Meaning Making through Everyday Activities - A Case of Collective Mental Health Recovery? *Journal of Recovery in Mental Health, 2*(1), 94-104.

The aim for this part of study II was to gain a deeper understanding of how individuals with mental health problems create meaning through doing everyday activities with others. To explore this aim I searched the data material for unfolding activities and events. Theory about narrative meaning making and mimesis (Alsaker, 2009; Ricoeur, 1984) guided my analytical focus. I therefore took particular interest in parts of the data material where I had to stop and ask: What happened here? How did this come about? Why did he/she do that? Such puzzling events are open for exploration and interpretation and may be particularly valuable to uncover individuals' underlying intentions and meanings (Josephsson & Alsaker, 2014). After having identified such events, I searched the data material for other parts of the data that seemed relevant and perhaps contributed to these events in some way. As a next step of analysis, I assembled these parts of data material into a chain of events, moving from parts to whole, hoping to shed light on the puzzling events first identified.

For this article the research team chose to analyze further only one such chain of events; that of George baking gingerbread together with others at the community mental

health center. We chose these parts of the data material because of their detail and depth, and thereby potential of answering to our study aim. What raised questions and curiosity in these events was how George suddenly seemed hesitant to go to bake gingerbread, after having been the one who initiated and participated in planning the activity.

After having identified parts of the data-material we viewed as contributing to this activity we expanded our interpretation through making use of our analytical resources of narrative theory about the process of mimesis, as well as empirical and experiential knowledge about mental health problems and recovery. Through exploring these different parts of the data material in relation to each other, and through making use of our analytical resources, we developed an emplotment, an interpretation of how these events together make meaning (Josephsson & Alsaker, 2014). We then assembled these events in a narrative which portrays a possible plot, as well as how the process of mimesis unfolded through these events. This narrative is presented in our article together with our theoretical and scholarly arguments to support our findings and interpretations.

Prior to publication I presented our writings to George, who recognised and approved our findings and interpretations, and acknowledged that they are relevant and important to him.

Further analysis, article 3

Reed, N. P., Josephsson, S., & Alsaker, S. (2020), A narrative study of mental health recovery: Exploring unique, open-ended and collective processes, *International Journal of Qualitative Studies on Health and Well-being, 15*(1).

The aim for this part of study II was to explore how mental health recovery unfolds through individuals' engagement in everyday activities. In this analysis we shifted our attention from an in-depth focus on particular activities towards exploring how the participants engage in several everyday activities and how these may be understood in connection to each other.

In the next stage of analysis, I read the fieldnotes again asking questions such as: What activities do the participants engage in, and how does this come about? What are the driving forces for what they do? How do they make meaning through their everyday activities? What may be possible storylines related to living an everyday life with

mental health problems? What unfolding narratives do the participants act in? As in our analysis for article 2, I took particular interest in parts of the data material that were puzzling to me, and which I understood as relevant to our aim, such as: Why was Sandra all of a sudden able to defy her anxiety, get up from that sofa, and start doing activities at the community mental health center? How was Carl able to initiate starting his own enterprise, while often seeming dependent on others when doing everyday activities? Such questions were used as starting points for further analysis.

Further, we worked hermeneutically with the data, applying narrative theory of how meaning is created through connecting past, present and future events by a plot as an analytical resource (Alsaker et al., 2009; Josephsson & Alsaker, 2014; Mattingly, 1998). Starting with the puzzling events first identified, we searched the data for other relevant events – both actions and spoken data were included in this search. By connecting different parts of the data material and drawing on knowledge about narrative theory and personal recovery, the research group imagined and discussed possible plots which could help understand how these events came about. We then assembled several events into the written narratives or explanatory stories presented in article 3, together with our interpretations of how meaning was established through activities and which possible plots connect these events.

Ethical considerations

This PhD-project was approved by the regional committee for medical and health research ethics (approval number: 2013/2410/REKmidt). Study II was also approved and supported by the leader and staff of the community mental health centers. Prior to data creation, I repeated information about the study, what it would mean to participate, as well as how confidentiality is secured to the participants, both orally and in writing. The participants also signed written consent forms (for written information and consent forms, see appendix 4). Names and personal details in the articles are fictional to secure participant confidentiality.

When creating data in close collaboration with the participants, within their everyday life contexts, and over time, I had to be extra sensitive and reflexive regarding the researcher-participant relationships (Josephsson & Alsaker, 2014; Lawlor & Mattingly, 2001). During data-creation we shared personal experiences of doing

activities together and talking, and developed relationships of mutual trust and care. To keep relationships professional, I spoke with the participants regularly about the nature and temporality of our relationship, planning our future meetings as well as when to end our shared data creation process. My experiences from being a community mental health worker helped me create and sustain these professional and trusting relationships, but at the same time I had to be careful not to engage in the previously known role of being a professional helper. When ending the data creation process, I told the participants that they could contact me at any time with any questions they might have, and I made sure to keep in touch with them throughout the project period to update them on the research progress and communicate my care and thankfulness for their participation.

Further, doing an interpretive analysis of the data involves a possibility of understanding events from the data in ways that the participants themselves have not thought of and might not recognize, especially as my personal and professional background is substantially different from that of the participants. I am younger than them and have no personal experiences of mental health problems. My everyday life is quite stable, consisting of many different activities which contribute meaning, such as caring for my husband and three children, keeping up with a large social network, going to work etc. Also, I am educated within social work, and have almost 10 years of professional experience from community mental health services.

The participants had volunteered to take part in this project because they were interested in creating important knowledge together with me, and they were very curious about my thoughts and writings about what we did together and what they told me. They all wanted insight in this, and a chance to uncover possible misunderstandings and disagreements prior to publication. Because of their investment in the project, as well as wish to be informed about the results, I felt it was important to communicate openly with them about my thoughts, interpretations and writings throughout our meetings. They sometimes asked me what I had found this far, upon which I told them a little bit about my preliminary interpretations and current focus. Prior to publication of the research articles I presented the findings, including our interpretations and discussion, to each of the participants both textually and orally in Norwegian. I then asked for their thoughts about the findings and if our interpretations seemed familiar to

them. All four participants recognized our interpretations, stated that our findings focus on issues that are important to them, and approved publication of the articles.

5. FINDINGS

I will now provide summaries of our findings in each of the three articles, before I go on to present my interpretation of what my main findings are.

5.1 Summary of articles

Summary of article 1

Reed, N. P., Josephsson, S., & Alsaker, S. (2017). Community mental health work: Negotiating support of users' recovery. *International Journal of Mental Health Nursing, 27*(2), 814-822.

The aim of this study was to explore how community mental health workers provide support to users, by investigating professionals' own narratives of how they work. In this article we explore how the community mental health workers describe their collaboration with users in situations they find challenging, uncertain and involving dilemmas. From our analysis, we came to recognize their way of dealing with these situations as negotiations. These negotiations may involve the professional, the user, as well as other parties such as service management, family members or community members. The different parties present their needs, wishes, knowledge and resources to each other, and try to reach shared understandings of how to support recovery through discussions, mediations, reflections, and balancing acts.

One of the challenging situations the community mental health workers talked about was supporting users' when doing activities and engaging in social arenas. They described how in some cases, users wish to be active solely within mental health arenas because these arenas feel safe and provide the support they need to do activities. However, to move forward in their process of recovery, the professionals recognize users' need of challenges and engaging in 'mainstream' community arenas as well. Thus, how and where to do activities was described as an issue of negotiation between professionals and users.

Further, the professionals talked about how users' inclusion in community arenas may have to be negotiated with community members as well, and that they sometimes work as mediators between users and others. One of the professionals described how they work as translators, facilitating communication and understanding

between users and community members. Further one of the professionals described a need to open up 'the space for mental illness', and to make individual adjustments and support available for users. She described this as a challenging task involving both working against stigma and self-stigma, increasing the room for diversity in our local communities, as well as securing sufficient economic resources and dealing with practical issues such as transportation.

These findings underline how collaboration through negotiations facilitate open and respectful communication between professionals, users and others, and allows for all parties to speak their mind and take part establishing shared solutions. We conclude that professionals should initiate negotiations with users whenever possible, to secure user involvement and flexible and individually adjusted services.

Summary of article 2

Reed, N. P., Josephsson, S., & Alsaker, S. (2018). Exploring Narrative Meaning Making through Everyday Activities - A Case of Collective Mental Health Recovery? *Journal of Recovery in Mental Health*, 2(1), 94-104.

The aim of this article was to gain a deeper understanding of how individuals with mental health problems create meaning through doing everyday activities with others. Answering to this aim we present the storied events from my meetings with George, as well as our analysis of these events. The narrative we present in the article is about George and how he got the idea of baking gingerbread at the community mental health center. Further, the narrative shows how he suggested this activity to staff and users at the center, how the others also became interested in baking gingerbread, how they planned making a gingerbread house, and ultimately how the baking unfolded. The narrative makes visible how the persons involved created movement in this activity and tackled obstacles and challenges together through imagining solutions and taking responsibility, trying out ideas on each other, communicating interest and investment in the activity, as well as drawing on each other's strengths. We interpreted these events by use of theory about enacted narrative meaning making, the model of the *mimesis*. Our main finding was that doing activities together with others provides possibilities for what we understand as processes of collective narrative meaning making. Following

this, we suggest that everyday events of doing activities together may appear small and mundane, but still seem to have the potential of contributing meaning and thus become crucial events in narratives of recovery. This article also highlights how individuals with mental health problems may find it challenging to do activities and make meaning on their own, perhaps requiring such collective processes with mental health professionals and others. Additionally, our findings show how these collective processes may be challenging and fragile, having to deal with obstacles and insecurities. Further the findings show how the community mental health centers may be accommodating of such collective narrative meaning-making processes, as they offer possibilities of doing activities and trying out ideas and possibilities together with others in a safe and flexible atmosphere.

Summary of article 3

Reed, N. P., Josephsson, S., & Alsaker, S. (2020). A narrative study of mental health recovery: Exploring unique, open-ended and collective processes. *International Journal of Qualitative Studies on Health and Well-being, 15*(1).

The aim of this article was to explore how mental health recovery unfolds through individuals' engagement in everyday activities. The data material for this article included my participant observations with all four participants in study II. Our findings show how four individuals engage in processes of recovery in their own unique ways, using their everyday experiences and activities as resources for narrative meaning making. Doing activities put the participants in touch with persons and places, offering possibilities for trying out and negotiating meaning and recovery collectively. Further, our findings show how movement in recovery processes may require doing activities in arenas outside of the mental health system, and engaging persons in ordinary community arenas in processes of collective narrative meaning making.

We found that these ongoing collective processes seem both unique, complex and open-ended. Our findings concerning Brad show how meaning making may be dependent on doing activities with others in safe and flexible arenas. Carl also seems to make narrative meaning through his activities and interplays with professionals and users at the community mental health center, just as with Brad. Additionally, Carl's situation also seems to require that he connects with persons and arenas within the

employment market and architecture, which can contribute to his unique plot of being and working as an architect. However, we understand that he has not been able to make such connections yet, leaving his processes of narrative meaning making open-ended. Mary seems to be trying out several possibilities for meaning making, showing how processes of recovery can be complex and ambiguous. We understand that she tries out relevant activities and negotiates and adjusts her possible plots and activities in communication with significant persons. She does not yet know which activities, persons and arenas to focus on, leaving her process of recovery quite complex and ambiguous at this time. Lastly, the story about how Sandra makes meaning through activities at a community mental health center seems to support our findings of how processes of recovery involves narrative meaning making which unfolds in an interplay with others and through doing everyday activities. This story also shows how powerful hope and imagination may be as driving forces for activity and recovery.

5.2 Main findings

I will now sum up the findings in these three articles, before I present my interpretation of main findings. In article 1, from study I, we show how both service users, professionals, community members, family members, service management and others may take part in negotiations about how to solve challenges and provide individually adjusted and flexible support of recovery processes. In study II, we chose to use narrative theory as a resource in studying meaning making, by conceptualizing meaning as coherence, and meaning making as enacted processes of connecting past, present and future by a plot. The findings from the case study in article 2 suggest that everyday activities offer possibilities for engaging in processes of narrative meaning making together with others. Further, by use of theory about the threefold mimesis we show how such processes may unfold collectively, and how they can be fragile and challenging. Deepening our analysis of how personal recovery may unfold as collective and enacted processes of narrative meaning making, article 3 presents findings tied to all four participants in study II and shows how such processes are enacted by several persons, in a variety of arenas. Further, these processes appear unique, open-ended and complex, and involve tying together everyday activities and events both from the past and present, as well as images for the future, by a common thematic thread – a plot.

However, our findings show how these thematic threads may have knots, frizzles or loose ends which need to be sorted out, causing tension and suspense in the processes of meaning making.

I interpret the main findings in this project to be that personal recovery seems to unfold through the contributions of several persons, arenas and activities in enacted processes of meaning making which may be understood as both unique and collective. Through my review of the findings I also found that collective narrative meaning making seems to require ongoing activities and communication regarding plots, activities, actors and arenas in the unfolding narratives. The findings show how these processes appear fragile, challenging and complex. In the following discussion I will explore further the enacted and communicative processes unfolding in collective narrative meaning making and discuss which possibilities, challenges and dilemmas such processes may entail for the persons involved.

6. DISCUSSION

In this PhD-project my aim has been to explore how personal recovery in mental health unfolds and may be supported as processes of meaning making. By use of qualitative, interpretive methods I have sought to create processual knowledge of such unfolding processes. Further, I chose to explore personal recovery and meaning making by use of narrative theory which connects meaning to doing everyday activities. Therefore, I have studied individuals while they are doing everyday activities and based on my narrative theoretical resources, I suggest that through their everyday activities these persons engage in meaning-making processes as part of their personal recovery. In the previous section I presented my main findings of how these meaning-making processes in personal recovery may be understood as ongoing, enacted narratives which appear both unique and collective. Through their everyday activities, I understand that individuals connect with others who may become actors with them in processes of meaning making. I argue that these findings present new knowledge related to my aim. In this section I will discuss these main findings further, their implications for practice, as well as my methods.

6.1 Discussion of main findings

My main findings show how personal recovery may involve collective narrative meaning-making processes which unfold through everyday activities. These processes offer possibilities of meaning in everyday life and recovery, but also appear challenging and complex. When reviewing the findings in all three articles I additionally found that collective meaning making seems to require ongoing communication and collaboration regarding plots, activities, actors and arenas of the unfolding narratives. In the following I will delve into my findings of these collective processes in more detail and explore them further in light of my theoretical resources about the enacted and communicative character of the threefold mimesis (Alsaker, 2009; Ricoeur, 1984). Further I wish to make visible and discuss possibilities and challenges these collective processes may entail for both individuals in recovery, family, professionals and others who take part.

Establishing shared plots

In general, plots are issues or values that are important, but still unfulfilled, for the persons acting. Such issues may help create meaning as 'thematic threads' that mediate connections between past and present activities and events, as well as images for the future, and thus provide coherence in people's lives (Polkinghorne, 1995). However, my findings in study II show how plots may be ambiguous and complex, causing frustrations and experiences of being 'stuck', as well as how individuals may imagine and try out several plots at the same time. Based on these findings, I understand that the possible plots in people's lives cannot be understood as smooth and straight thematic threads which are easy to trace. Rather plots appear as messy threads with occasional knots, frizzles and loose ends, causing challenges and suspense and requiring comprehensive efforts of trying to disentangle and trace them, such as also discussed in article 3 (Reed et al., 2020). This un-linear and complex nature of recovery narratives have also been described by others (Llewellyn-Beardsley et al., 2019).

Further, through my review of the findings in this project I found that collective meaning making seems to involve trying out and establishing shared plots which all contributors can understand, find important, and wish to help facilitate and enact. I wonder: How are such shared plots established? In the following I explore and interpret this further. I will do so in relation to Ricoeur's reasoning about the enacted and communicative character of developing and trying out possible plots for meaning in mimesis II (Alsaker, 2009; Ricoeur, 1984), which I outlined in section 2.3. I draw from the story about Sandra in article 3 to show how establishing shared plots may unfold and be understood.

Sandra's anxiety had disrupted her career of cooking, and at one point she could hardly get out of the house and her situation was gradually getting worse. Her boyfriend, Tim, had on several occasions suggested for Sandra to come with him to the community mental health center. I understand that through making these suggestions Tim communicated that he thought Sandra could need changes in her everyday life, and that he imagined how the center could provide possibilities of this for her. Interpreting this in light of the threefold mimesis, I propose that through these initiatives, Tim was trying out possibilities of making change by communicating to Sandra an imaginable way of doing so. He seemed to pursue Sandra's interest and engagement in this through

providing her with images of doing new activities. Building further on my analogy of plots as thematic threads, I envision this as Tim showing Sandra a bundle of threads, challenging her to grab one and try tracing it.

However, Sandra did not follow Tim's initiatives and refused to go to the center. Perhaps she had a hard time imagining how going to a community mental health center could make meaning for her? How could entering the arena of community mental health services contribute coherence with her previous activities and experiences of being a working mom, always helping and caring for others? However, through his further actions of 'luring' Sandra to come to the center anyways, Tim drove her to try this out. Perhaps he imagined that being physically at the center could make visible some possibilities for Sandra? In my interpretation, Tim communicated a need for change even more insistently through his actions of taking Sandra to the center. Again, I recognize his actions as trying out possibilities of change through making options and images even more available for Sandra. Further, I envision this as if he now handed her the bundle of possible threads to start nesting from, not accepting no for an answer, insisting for her to check them out a little closer.

Our data material shows that as this situation unfolded, Sandra experienced that listening to others' stories at the center made her think about how her current situation threatened her abilities of doing what is most important to her: taking care of her kids. She described this as a sudden realization which drove her to get up and going. Sandra said that she decided that she had to do something to change the situation. Thus, as Tim had hoped for, being at the center did trigger images and realizations for Sandra, of both possible futures and what is important to her. Through our interpretation of all the data material created with Sandra presented in article 3, caring for and helping others, both family and friends, stood out as a very important issue for Sandra, which was about to be disrupted by her mental health problems at the time of these events. I therefore interpret caring for and helping others to be an emergent plot of meaning making for Sandra, offering a possibility to re-establish coherence in her everyday life by mediating connections between past experiences of caring for others, current possibilities of helping out at the center, as well as images of still caring for her children in the future. Continuing my analogy, I envision Sandra being at the center as her holding the bundle

of possible threads, taking a closer look at them, and finding that one of the threads seems familiar, valuable, and appears traceable…

Further, Sandra asked if she could be of help at the center. I suggest that through this action, Sandra communicated to the others present how important caring for and helping others is for her, and she sought possibilities for doing activities related to this at the center. Next, by providing possibilities for Sandra to engage in caring and helping activities, I suggest that both professionals and users at the center communicated back to her that they understand how caring for and helping others is a valuable issue for her, which they wish to contribute to. I interpret their activities as a collective process of trying out and communicating ideas and possibilities of making change for Sandra. Through their activities I suggest that Sandra, Tim, professionals and users at the center communicated and established a shared understanding of caring for and helping others as a plot which can re-establish meaning in Sandra's everyday life. Further, I recognize communicating this shared understanding of a possible plot as mimesis III in the threefold mimesis, bringing some temporary stability which provided a starting point for their further efforts of trying out how to make change in Sandra's life. Thus, in my understanding Sandra chose a thread to trace which she thought could be valuable for her. She also imagined and started trying out how to trace this thread in communication and collaboration with others.

These findings show how collective processes of trying out and establishing shared plots may hold possibilities for persons in recovery of being moved and inspired by the hope and engagement of people around them. Further, these processes may offer possibilities of connecting with actors and arenas which can provide support. However, trying out possible plots also seemed challenging, not always reaching a shared understanding of the meaning making possibilities in the ideas presented. Perhaps because potential coherence between these ideas and Sandra's experiences and future images was not clear? Therefore, I suggest that these processes might entail negotiations[2] to reach shared understandings on which plots can make meaning and

[2] In this discussion I refer to negotiations as a form of communication in collective mimesis processes. I understand negotiations as processes of seeking agreement through sharing knowledge and perspectives, discussions and balancing acts. Further, negotiation processes can be enacted and ongoing, moving between possibilities and choices in particular situations over time (Alsaker & Josephsson, 2003; Lewicki & Wang, 2006; Reed et al., 2017).

should be tried out further. Also, I wonder: what recognizes such shared plots which unite several actors in meaning making?

The findings in study II show how all four participants after periods of disruptive mental health problems seem to engage in collective meaning-making processes tied to issues such as being helpful, caring for others, staying healthy, or re-connecting with work. These issues seemed to have the potential of making meaning from these unique individuals' personal activities and experiences, bringing their past, present and future together. However, I also recognize that in addition to being personal, these issues are all connected to cultural values. Perhaps they are therefore more likely to become established as shared plots and supported by several actors? Bruner (1991) supports such a connection between narrative meaning making and cultural values and writes that narratives are normative and concerned with cultural legitimacy. Bruner explains how narratives make visible a breach in legitimacy which creates drama in the story and further that narratives show how this breach is closed through actions and thus cultural legitimacy, or meaning, is restored. Further, Bruner (1990) has suggested that humans are inherently social – we need and seek belonging, and cultural legitimacy is therefore important to us. However, understanding how cultural meaning is also enacted through practice (Bruner, 1990), I suggest that these meanings are not fixed, but rather continuously created through actions and therefore flexible and open for change. When I interpret my findings in light of this, I understand that mental health problems have disrupted and created drama in the participants lives, preventing them from conducting their everyday lives as they did before and affecting their social relations. Now they take part in enacted and collective processes of trying out new ways of making their everyday life both personally coherent and culturally legitimate. Such an enacted integration of personal and cultural meaning is also reflected in the multidimensional understanding of everyday life which I presented in my introduction, in which the activities of everyday life are suggested to be a mediating structure between person and culture, bringing together the personal and cultural dimensions of everyday life (Højholt & Schraube, 2015).

Hence, collective processes of meaning making in recovery appear normative and moral, providing possibilities of reconnecting the individual to others through recreating cultural legitimacy in their life, doing and pursuing that which is culturally

valued. Continuing my example with Sandra, her mental health problems had disrupted her career of working, but she still had caring abilities, and I suggest that these were valued and cultivated through collective meaning making. Thus, I understand that in addition to providing possibilities of personal coherence for Sandra, caring and helping activities could also restore cultural legitimacy in her life and provide connections with people around her.

Based on these findings I suggest that to establish collective engagement in meaning making individuals in recovery are not free to pursue any issues which may provide personal meaning their everyday lives. From my interpretation follows that shared plots also relate to cultural values, these plots are both personal and cultural. Based on these findings I raise some questions: do all persons in recovery imagine culturally legitimate ways of making meaning? How large is the 'wiggle room' when negotiating shared plots to pursue? How will narrative meaning making unfold if a person chooses to pursue unusual or unfamiliar issues for seeking meaning? What if personal images of how to make meaning clash with professional or cultural ethics? How does professionals current focus on personal recovery and individually adjusted services affect their attitudes towards diversity and their thoughts about what is 'normal'? I am not able to answer these questions based on my findings in this project – however by asking them I wish to make visible how establishing shared plots – what makes meaning for those involved in collective processes – can involve several challenges and dilemmas.

To sum up, my findings and interpretations show how several actors establish shared plots by trying out through activities and communication issues which may contribute both personal coherence and cultural legitimacy. Additionally, through these activities of trying out plots collectively the person in recovery may gain possibilities of being moved, inspired, supported by and connected to others. These processes may also involve challenges and dilemmas of having to negotiate their understanding of which issues may contribute personal coherence and cultural legitimacy, taking into consideration and balancing both the personal history of the person in recovery as well as cultural ideas of what is valuable to do. However, if shared plots are established, I suggest that they make possible further collective engagement and trying out of meaning making through activities. I will explore what this entails next.

Trying out how to enact narratives

My findings in this project show how the contributors in collective narrative meaning making not only try out possible plots together, but also which activities may contribute meaning in relation to these plots. How do they do this, and what possibilities and challenges can this entail?

By exploring my findings in this project further, I found that the persons involved in these collective processes create and try out images and ideas of further activities together, through both activities as well as discussions and negotiations of possibilities and limitations. My findings show how in some situations the participants shared ideas of activities to others verbally, who either gave their support or disagreed with these suggestions. In other situations, images or ideas of what to do were created and tried out collectively. As discussed above, my findings about Sandra show how being at the community mental health center triggered Sandra's images and ideas of volunteering her help there. Thus, activities may provide images and ideas for further enactment. As another example, article 3 presents the findings about Mary, who sought to be an active and contributing person and dreamed of acquiring work within health services. How could she do this? Mary contacted several persons within the employment market to discuss with them how to do this and if they could offer activities for her to engage in. On some occasions, work leaders welcomed Mary's initiatives and provided possibilities for activities, such as opportunities of trying out working at a restaurant or volunteering at a nursing home. However, they also sometimes turned her down, thus communicating limitations for what she could do. Again drawing from the threefold mimesis, I interpret that through contacting persons to discuss possibilities of activities she can do or how they can contribute, Mary engages them in her imagining and trying out of how to make meaning. Through these discussions, as well as sometimes providing opportunities of activities, I understand that the persons she communicates with join her in a collective process tied to her plot of being an active and contributing person. Through their actions and responses, these persons also take part in negotiations concerning possibilities and limitations of what activities she may do to try out coherence.

In my meetings with Mary this appeared as an ongoing, but stuck process – she kept contacting possible contributors but did not seem able to figure out what activities

could contribute coherence at this time. Thus, in my interpretation Mary seemed to linger in mimesis II, initiating communication and collaboration with others, but without succeeding in establishing stable engagement and agreement on how to proceed. Why was this so? Perhaps Mary's images of what she can do are not in coherence with others' expectations? Is she aiming too high, in the eyes of others? Why are they not able to negotiate a shared understanding of activities to try out? Understanding my findings from study I and II together, I wonder if stigma may be part of such challenges as Mary here experiences. The professionals in study I told about lack of understanding and personal adjustments in society, restricting inclusion in mainstream arenas for persons with mental health problems. Based on my findings I suggest that stigma may create diverging attitudes concerning possibilities and limitations for what the person in recovery can do, and hinder agreement on which activities the person in recovery can and should try out. Prejudice and stigma related to mental health problems has also been found in other studies (Chester et al., 2016; Kelly et al., 2010), and I suggest that these issues may pose some additional challenges to persons in recovery when they seek to make meaning in everyday life.

Although sometimes limiting possibilities of activities for individuals in recovery, my finding also show how others may broaden their possibilities. Patricia Deegan has shared her own experiences of how she at one point lost all hope and faith in her possibilities for the future (1997), and similarly my findings show how the participants sometimes seemed doubtful about their possibilities of doing activities. Further, my findings show how in such situations their meaning-making processes may appear stuck, as they seem unable to imagine how to act next. However, my findings also show how in collective processes, other persons may help create movement again. The data material about Sandra shows this quite well: In my understanding Sandra initially seemed stuck, rarely leaving her home and unable to imagine how going to the center could provide meaning for her. However, through their actions her boyfriend and the persons at the community mental health center triggered and encouraged her participation in the activities there, and thus inspired her to imagine possibilities of making meaning, as well as communicated faith in her abilities to help out at the center. How would Sandra's everyday life be now, if Tim had not made his initiatives? How would this have unfolded if the others at the center turned down her request to help out?

In my understanding, these events show how other persons sometimes hold more hope and faith in individuals' strengths and possibilities than they do themselves, and thus inspire and encourage them to try out activities they wouldn't have thought of or imagined trying on their own.

Thus, in my interpretation collective meaning making involves trying out how to enact narratives through activities and negotiations. Further, the different contributors' thoughts and ideas of challenges and possibilities may be both limiting and broadening for these meaning-making processes. In the following I will show and discuss how not only what activities to do, but also with whom and where to do them, are important issues which need trying out in collective meaning-making processes.

Seeking connections with new actors and arenas

My findings suggest that to create movement in collective meaning-making processes those involved need to establish shared plots and try out how to enact these plots. Further, my findings show how these processes entail connecting with new actors and arenas. The findings in study II highlight how the community mental health centers and the professionals and peers there offer a safe atmosphere for trying out activities together with others, and in my interpretation therefore may be valuable arenas and actors in collective narrative meaning-making processes. However, in line with other research (Borg, 2007; Myers, 2016; Tew et al., 2012), my findings also show how the participants may need to connect with actors and arenas outside of the mental health system to try out activities which may provide coherence – such as employment markets, religious communities, family homes or sports activities. Carl for instance, seems in need of making connections within architecture and the employment market, while Mary is seeking support and contributions of trying out productive and caring activities within either health services or her family. Similarly, the professionals in study I underlined the importance of doing activities and being included in mainstream community arenas to create movement in processes of recovery. Following this, I suggest that to create movement in meaning-making processes the persons engaged may have to seek connections with new actors and arenas which can contribute in each unique process. But how is this done? How are new and valuable connections made?

Who to connect with and where to go appears to be important issues in meaning making. My findings show how individuals in recovery try this out through activities and communication with professionals and/or community members, in my interpretation seeking collective engagement. Both Carl and Mary seem to imagine making contacts within the employment market, and Brad says he wishes to meet people with similar interests as him in political discussions, yoga or photography. I understand that Mary is trying this out through contacting possible employers and initiating communication and activities with them, while Carl has contacted the employment office for professional support and work-related activities. Brad, however, does not seem to move forward in seeking to connect with new people and arenas at this time. Perhaps he does not know how to, or do not dare to make contact on his own? Perhaps he could be able to do it with some support from others?

My findings indicate that making connections with persons and arenas that can and are willing to contribute may be a challenge. I understand that both Mary, Carl and Brad seem to struggle with this, not quite knowing who can contribute, or how to reach out and communicate with others in ways that entice them to join forces. The community mental health workers interviewed in study I talked about helping users making connections with 'mainstream arenas', negotiating inclusion and connections with actors and arenas in individuals' local communities. However, they also described this as a challenging task. For instance, they told how they sometimes negotiate with users about making connections, as users may experience a dilemma of choosing between safe and flexible mental health arenas, professionals and peers, as opposed to trying out challenges and opportunities through activities with new and unknown actors and arenas. Further, they described challenges such as stigma and structural hindrances, necessitating negotiations with community members and arenas regarding inclusion. Similar findings are also reported by Farone (2006), who found that facilitating community participation involves both assessment of possibilities, mediating connections between individuals and community arenas, as well as balancing challenge and support.

Learning about these challenges, I wonder: How can connections and collective engagement between persons in recovery and community members be facilitated? My findings do not show much about how this unfolds, but they do show how Mary seems

to be in the midst of trying this out through contacting people, communicating that work is important to her, and seeking contribution and support from them. This was still an open-ended and ongoing process at the time I created the data, but these interactions seemed to provide some connections and opportunities of trying out activities which could help create coherence in her life. Thus, perhaps talking with or meeting potential actors, communicating one's ideas and interests, and getting to know each other is a good way to start? In article 3 I wondered what could have happened if Carl was offered a chance at visiting an architectural firm and connect with someone there. Now I also wonder: what if Mary could try out working in at a nursing home or a clinic? Or if Brad was invited to a local yoga center? Could such experiences and meetings help try out and build the connections with actors and arenas that these persons need to recover further?

To sum up, my findings highlight the important contributions of several actors and arenas in meaning-making processes, as they offer possibilities for trying out activities which may provide coherence. Therefore, who to connect with, and where to go seem to be important issues in these processes, which may be tried out through doing activities, communicating, collaborating and negotiating with others. However, making connections and engaging others appears challenging for persons in recovery and my findings do not show much about how such connections can be made. I therefore suggest that this is an important issue for further research. Also, my findings indicate that mental health professionals may have an important role in facilitating valuable connections between users and others, and I will discuss this further as implications for practice.

Summary of discussion

In this discussion I have explored and interpreted further my findings. I have shown how collective meaning-making processes seem to involve trying out and establishing shared plots, trying out which activities can contribute to coherent narratives, as well as trying out and connecting with actors and arenas who can and will contribute in each unique process. Interpreted in light of the threefold mimesis, I understand that collective processes of meaning making are inspired and triggered by ongoing experiences and activities. Further, through their activities and discussions several persons try out and

communicate regarding plots, activities, actors and arenas. Underway the also negotiate and communicate shared understandings of what is going on and how to proceed. I would like to underline that my findings show how these activities of trying out in the three folds of mimesis unfold intertwined. Thus, processes of meaning making may not be thought through beforehand, conscious and linear. Rather, everyday activities are done in communication with others, and through these activities, images, ideas and possibilities of meaning making may emerge. This conflicts with other, and perhaps more traditional understandings of how meaning making unfolds through activities. Huguelet et al. (2016) for instance, suggests that meaning is created through realizing important values through actions, similarly to how I understand narrative meaning making. However, they describe this as a cognitive process where individuals need to mentalize what their activities might mean to them, as opposed to an enacted process in which the activities inspire meaning making.

Additionally, I have discussed how these collective processes entail both possibilities and challenges for those involved in them. Several studies have found that everyday activities are crucial in personal recovery as they contribute meaning (Argentzell et al., 2012; Doroud et al., 2015; Eklund et al., 2012; Kelly et al., 2010; Lund et al., 2019; Ulfseth et al., 2015). Through this project, I have provided new knowledge about how this unfolds, showing how meaning is inspired by and emerges through everyday activities in unique and collective processes. Through these collective processes persons in recovery may be moved, inspired, supported and connected with others, and gain possibilities of doing activities which may provide both personal and cultural coherence. However, those involved may also experience challenges such as having to negotiate dilemmas between personal and cultural values, communicate and negotiate limitations and possibilities for activities, as well as struggle to connect with and engage the actors and arenas needed for further meaning making.

As a last remark, I would like to underline that the findings presented in this thesis only show temporary glimpses of meaning making, and that my possible and contextual interpretations may or may not be of interest, recognition and inspiration for others. Further, as the recovery processes I have studied are still unfolding, I cannot know if the everyday events of meaning making explored in this project will eventually be events in recovery narratives. I understand personal recovery as a subjective

experience, and although the participants seemed to make meaning through everyday activities in particular contexts, it is unclear if they will eventually experience their everyday life as generally meaningful.

6.2 Implications for practice

In the previous section I explored further how collective processes of narrative meaning making unfold and discussed which possibilities and challenges such collective processes may entail for those involved. My findings make visible how mental health professionals may be involved in collective processes of trying out and establishing shared plots of meaning making, imagining, trying out and negotiating activities which can contribute coherence, as well as trying out and making connections with actors and arenas that may contribute.

Trying out and establishing shared plots as forceful and inspiring driving forces through and for activities appears to me as a crucial part of collective meaning-making processes. I suggest that professionals can make valuable contributions to this in several ways. First, they can contribute by engaging in explorations of the personal history of and important issues for the person in recovery. What activities and experiences lie in their past? What might be their images for the future? What issues and values are important for this person? How can these issues contribute coherence in this person's life? However, as discussed above, shared plots are not only tied to personal values, but also cultural meaning. I therefore suggest that professionals may also have an important role in trying out these cultural contexts of possible plots – perhaps making thoughts about possibilities and limitations visible, being vigilant regarding stigma and prejudices oneself or others may hold, as well as softening up attitudes of what are 'normal' and 'good' ways of conducting one's everyday lives. Further, my findings indicate that trying out how to make meaning demands hope and faith in possibilities for change and recovery, creativity, as well as knowledge about which opportunities lie in the local community. I suggest that professionals may offer important contributions related to these issues.

However, my findings also show how meaning-making processes may be spontaneous and un-linear, unfolding through activities, rather than being well thought of and planned beforehand. This was also discussed in article 2 (Reed et al., 2018).

Following this, I propose that mental health services should provide opportunities for persons in recovery of doing activities together with others. From my findings, it is evident that the community mental health centers are very important in some of these participants lives, and that they provide both activities, persons and atmospheres which accommodate collective meaning making. Following this, I suggest that community mental health centers and other arenas which allow for initiating and doing activities together with others in a safe, flexible, diverse and spontaneous environment are valuable parts of the community mental health services.

Further, my findings show how making meaning may demand trying out new activities and moving into ordinary community arenas, but that this may be challenging as the persons in recovery lack connections with relevant persons in their local communities. How can we engage persons in the communities and build such relationships? Other literature also highlights the importance of community resources in mental health recovery, and problematizes how professional recovery support is mainly provided through collaborative relationships between users and professionals (Davidson & Schmutte, 2020; Davidson et al., 2017; Tanaka & Davidson, 2015). I suggest that facilitating connections between persons in recovery and community members may be an important task for community mental health services, and that professionals supporting personal recovery should not only collaborate with the person in recovery, but also with families, community members and others. Based on my findings, I also understand that this collaboration may involve working against stigma and discrimination, as others have also noted (Chester et al., 2016; Keet et al., 2019; Slade, 2010). Community-based services targeting collective responsibility and reciprocal relationships (Tanaka & Davidson, 2015), as well as citizenship oriented interventions (Davidson & Schmutte, 2020; Fransen, Pollard, Kantartzis, & Viana-Moldes, 2015) have also been suggested by others to complement individual approaches. How can such approaches be organized?

I suggest that clubhouses are organized and run in ways that may facilitate such work, as they both provide relationships with professionals and peers as well as contacts within the labor market, facilitating connections between members and possible employers (Chen, 2017; Tanaka & Davidson, 2015). Based on my findings I also support others who suggest that connecting people by making them meet and learn to

know each other through doing something together (Bromage, Kriegel, Williamson, Maclean, & Rowe, 2017; Cottam, 2018), or through engaging in collective projects based on shared interests, goals and values (Rowe & Ponce, 2020) are possible professional approaches to promote inclusion in local communities as well as meaning in individuals' lives.

Further, my findings point to how collective meaning-making processes demand mutually supportive relationships and joint efforts. Interpreting these findings in light of the communicative nature of the threefold mimesis makes visible how the participants in such collective processes should be able to empathize with each other to create shared understandings, take responsibility and initiative, communicate their ideas and judgments, and help make decisions. Some suggest that individuals in recovery may need support in building such personal capacities that facilitate collaboration, and how these are capacities which professionals may help users build through practice and reflection (Rowe & Ponce, 2020; Ware, Hopper, Tugenberg, Dickey, & Fisher, 2008). Based on my findings, and inspired by Duff (2016), I also suggest that these capacities may be practiced through doing activities together with others, and through experiences of collective meaning making. In line with this, others also point out how engaging in collective projects may improve individuals' self esteem, and consequently also their ability to engage in further activities and connect with new people (Honneth, 1996). Further, I propose that such collective experiences may contribute to positive, upwards 'spirals', or assemblages of meaning making and recovery. Thus, doing activities together with others may help build communicative skills and self-esteem which enable engagement in collective meaning making, supporting my earlier suggestion that facilitating such activities should be a focus for recovery-oriented services.

6.3 Methodological discussion

Choice of methods

We chose qualitative, narrative methods in this project because they are well suited for creating processual knowledge about the complex and unique aspects of personal experiences (Polkinghorne, 1995), such as the issues we have explored here. The good fit between narrative methods and research concerning personal life experiences such as mental health recovery has also been described by others (Spector-Mersel & Knaifel,

2018; Toledano & Anderson, 2017). Spector-Mersel and Knaifel (2018) argue that narratives and recovery build on similar ontological and epistemological understandings, as well as shared emphases on processes of making meaning, change and purposeful activities . Further, the unique narrative-in-action approach was applied in study II because it offers a way of exploring *how* meaning is established and negotiated through everyday activities and situations (Josephsson & Alsaker, 2014).

Thick descriptions are desired in this kind of research as they provide detailed knowledge about relevant contexts and thus an extended basis for interpreting the motivations, intentions and meanings of human actions. Participant observations are better suited for creating thick descriptions than interviews, and are therefore a good way of creating data when using the narrative-in-action approach (Alsaker et al., 2009; Frank & Polkinghorne, 2010). Based on my understanding of how recovery is done, or enacted, through everyday activities, I found doing participant observations of this enactment to be both interesting and fruitful. Through the participant observations I had opportunities of witnessing and taking part in recovery *as it was done,* as opposed to retrieving after the fact stories and experiences of these processes through interviews. I believe that studying actual situations of doing everyday activities is better suited for answering to my aims than collecting after-the-fact recollections and reflections through interviews. My experiences of interviewing professionals in study I confirmed this, as it proved difficult to obtain detailed and contextual descriptions and narratives about how they work. The professionals rather told about their work in general ways, finding it hard to think of concrete examples from their meetings with users.

Rigor

I argue that it is not possible to compose the 'right' story about unfolding personal recovery and meaning making because our understanding of these particular events changes as time passes by and as they are seen in light of past and current affairs (Uggla, 2002). My understanding of what went on during my meetings with the participants might have changed if I continued to meet with the participants, or if I meet with them in a year to learn about what happened since. I therefore find it important to remain open concerning the possibilities of several possible interpretations (Bruner, 1990; Uggla, 2002). However, although there is no 'right' story, I am accountable for

how and what I know (Bruner, 1990). Therefore, I have sought to present our research procedures thoroughly throughout this thesis and the research articles, showing how they were systematic and applying well-documented methods, as well as how our interpretations were grounded in theory and existing knowledge.

The research group analyzed the data material together, and we sought to remain open and interested in the unique situations of the participants both during data creation and analysis. Further, our analysis and interpretations were inspired and informed by both theoretical and empirical knowledge, as well as our professional experience as mental health workers and occupational therapists. I argue that developing our interpretations together in the research team, as well as drawing on our professional experience and theoretical and empirical knowledge, enhances the rigor of our interpretations and that they may be recognizable and of value to others (Polkinghorne, 1995). In study II, our findings and interpretations were also presented to, and discussed with, the participants prior to publication. This was done both as an ethical procedure, as well as to improve validity of the study.

Nevertheless, when searching for connections in the data material as we did in our narrative analysis in study II, we must be open to the uncertainty of our interpretations (Hammersley & Atkinson, 2007). As the presentations of our findings show, we also explored contradictions in our data material, disclosing how processes of recovery are both complex and uncertain, allowing for many different narrative possibilities and interpretations. Thus, we acknowledge that our interpretations are only some of many possible.

In ethnography researchers will always have an effect on the phenomena they study (Hammersley & Atkinson, 2007), requiring reflexivity regarding their impact on the data, analysis and interpretations. In study II, the participants and I created the data together through participant observations, and my previous experiences and personal qualities will have affected our relationships and meetings. Having worked within community mental health services for almost a decade, I am experienced in creating trusting, working relationships with users. I think that these experiences, the participants knowledge about my previous occupation as mental health worker, as well as me being a woman substantially younger than them, might have affected their view of me as non-

threatening, and contributed to creating trusting relationships with the participants in which they felt safe to reveal their thoughts and troubles.

Further I sought to be open and curious about the participants lives, for the most part leaving the choice of activities and topics of conversation up to them. In our meetings, the participants offered insight into their everyday lives, including their personal activities, family relations and thoughts about their situation and doings. The participants generally offered relevant information, indicating that their knowledge about my research interests and the focus of the study prompted them to focus on particular aspects and activities of their everyday lives in their meetings and conversations with me. Nevertheless, on occasion I invited conversations about issues relevant to my study aim, thus influencing the focus and richness of the data. My co-researchers took part in analysis and interpretation of the data-material, ensuring some 'outsiders eyes' on the interaction between me and the participants, and nuancing our understanding of the situations described in the data.

Reflections on further research

This is a project with only few participants, providing processual and in-depth knowledge related to its aim. I suggest more research is needed to nuance and deepen further our processual and contextual knowledge about mental health recovery. One important issue for further research seems to be how connections between persons in recovery and community members and arenas can be facilitated.

Similar to Sutton et al. (2012) and Doroud et al. (2015), I think that long-term, in-depth and contextual studies of unfolding personal recovery may provide us with new knowledge about how recovery is enacted, as well as how it may be supported. My PhD-project certainly involves contextual and in-depth data, but it is not a longitudinal project. I think it would be very interesting and fruitful to apply the narrative-in-action approach when exploring processes of recovery and meaning making over a longer period of time. Further, I also think that using the narrative-in-action approach when exploring our aim in study I, how professionals and users collaborate, could yield interesting knowledge about how mental health recovery is supported. However, while using a narrative-in-action approach might create thick and longitudinal descriptions of events of recovery, researchers will not be able to collect data of all actors, activities

and events contributing in such processes over time. A combination of this approach with for instance narrative interviews, time-geography (Sunnqvist, Persson, Lenntorp, & Träskman-Bendz, 2007), or actor-network studies (Latour, 2005), might provide us with even thicker descriptions of how processes of personal recovery unfold.

7. CONCLUSION

My aim in this PhD-project has been to explore how personal recovery in mental health unfolds and may be supported as processes of meaning making. My findings provide new knowledge related to this aim, and answer to a lack of exploration and knowledge about how personal recovery, meaning making, narrative and everyday activities are related. In short, my main findings show how personal recovery may unfold through enacted processes of narrative meaning making that are unique and collective.

Thus, each unique process of personal recovery is enacted not only by the individual in recovery, but collectively through the contributions of several persons and arenas. Social 'dimensions' or 'factors' of personal recovery have also been described by others, but not in detailed, processual accounts showing how several persons and arenas contribute in particular ways such as I do in this project. My findings seem to offer support, as well as important knowledge, to those who urge research, literature and mental health professionals to pay more attention to social and contextual dimensions of personal recovery. Further, my findings show how everyday activities and inclusion in local communities is crucial for persons in recovery, thus supporting the focus of the ongoing Norwegian strategy for good mental health mentioned in my introduction (Norwegian Ministries, 2017).

To conclude this thesis, I wish to underline that I do not intend to move any control or agency away from individuals in recovery by way of these findings. The individual in recovery should and must take the lead and be the owner and manager of these collective processes. However, additionally I find it important to make others accountable, and to enlighten them about their potentially crucial role in processes of personal recovery, which are both unique and collective.

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ARTICLES & APPENDICES

Article 1

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ORIGINAL ARTICLE

Community mental health work: Negotiating support of users' recovery

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ABSTRACT: *Mental health services have changed over the past decades through an increased emphasis on deinstitutionalization and normalization, and with recovery processes situated in everyday life as a new locus of support. These changes have led to a need for new knowledge and methods concerning the provision of community mental health services. The aim of the present study was to explore how community mental health workers provide support to users, by investigating professionals' own narratives of how they work. Seven community mental health workers participated in narrative interviews, which were subject to a qualitative, interpretive analysis. A primary finding was that community mental health workers provide flexible and individually-adjusted support through engaging in negotiations with users, management, and others. Our findings show both opportunities and challenges of negotiating support, raising the following question for discussion: How and when are negotiations a valuable way for professionals and users to collaborate?*

KEY WORDS: *community mental health service, negotiating, recovery, user involvement.*

INTRODUCTION

Current community mental health services present professionals with new perspectives, contexts, and roles for supporting users in managing everyday life with mental health problems. These developments arose from changes in the mental health field during the past decades, following an emphasis on deinstitutionalization and normalization (Curtis & Hodge 1994; Longden *et al.* 2016; Pedersen & Kolstad 2009; Rosen *et al.* 2012). Research shows that users want safe and predictable care, as well as empowering practices from professionals, depending on fluctuations in their mental health (Rise *et al.* 2013b; Ulfseth *et al.* 2016). Consequently, mental health professionals are advised to mirror these fluctuations, keeping support flexible (Rise *et al.* 2013b). To adjust to the community context and the call for flexible services, recovery has become an important perspective in mental health work in Western countries during the past decades (Anthony 1993; Davidson *et al.* 2005). Recovery is described as the process of regaining control and meaning in everyday life (Borg 2007). It is both a personal (Anthony 1993; Deegan 1996) and social process (Mezzina *et al.* 2006a; Tew *et al.* 2012), which is situated within everyday life (Borg & Davidson 2008; Davidson *et al.* 2005; Ness *et al.* 2014a). Following this, Borg (2007) proposes that the role of 'everyday life helpers' has been assigned to community mental health workers. Everyday life is complex, and involves several 'fields of activity' (Borg 2007; Scott 2009), thus being an everyday life helper involves new tasks, methods, and challenges for professionals (Borg 2007).

It is suggested that recovery-oriented services include the formation of collaborative partnerships (le Boutillier *et al.* 2011) through the establishment of a common ground on which to collaborate (McCloughen *et al.* 2011), and negotiating collaboration while 'walking alongside' users (Ness *et al.* 2014b). Additionally,

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services are increasingly situated in users' homes, which also requires professionals and users to negotiate their roles, shifting between professional and private interactions (Juhila *et al.* 2016). Furthermore, community mental health workers are expected to work not just with individuals but also engage with families and communities, acknowledging recovery as a social process (Tew *et al.* 2012). This implies that professionals should promote citizenships by advocating user rights, and by supporting users' participation and social inclusion (le Boutillier *et al.* 2011; Mezzina *et al.* 2006b), preferably in ordinary environments, as opposed to mental health service settings (Borg 2007). However, supporting community participation could be a complex task for professionals, involving individual adjustment, assessment of possibilities, balancing challenge and support, and mediating connections between individuals and potential social arenas (Farone 2006).

As discussed, recovery-oriented professionals are expected to provide flexible and collaborative services. However, this can be challenging, and Borg (2007) has argued that professionals and managers within community mental health services could experience tension and dilemmas when providing individually-adjusted support of recovery. Such support could conflict with service planning and standardized procedures, due to the complexity of providing support in the unpredictable and changing context of everyday life (Borg 2007). Additionally, Tickle *et al.* (2014), and le Boutillier *et al.* (2015) suggest that there exists a tension within mental health services between the perspectives of recovery and medicine. Although mental health services seek a collaborative, recovery-oriented practice, medical perspectives can be a hindrance, as practitioners still take responsibility by caring for and protecting users (le Boutillier *et al.* 2015; Hansen *et al.* 2004; Solbjør *et al.* 2013; Tickle *et al.* 2014).

The research presented shows how community mental health workers, when seeking to provide flexible and collaborative support of users' recovery, need to balance relationships, adjust to the complexity and unpredictability of users' everyday lives, and manage tensions within the services. However, limited knowledge exists about how professionals accomplish this.

Aim

The aim of the present study was to explore how community mental health workers provide support to users, by investigating professionals' own narratives of how they work.

METHODS

An explorative, qualitative approach was chosen, involving narrative interviews with employees at community mental health services.

Procedure and participants

We contacted two community mental health service departments in an urban community in Norway in order to find participants. The leaders of the departments assisted in making contact with seven professionals, who agreed to participate in an interview; three from one department, and four from the other. The participants represented multiple professions: three nurses, one social worker, one occupational therapist, one sociologist, and one practical nurse. They had all completed postgraduate courses within the areas of mental health, therapy, violence, and/or drug abuse. Their ages ranged from 30 to 58. They had worked in community mental health services from 2 to 17 years, with an average of 11 years.

The main question asked in these narrative interviews was 'Can you tell me about what you do in your work, and how you collaborate with users?'. The professionals were encouraged to tell stories from their work in order to collect detailed information about the actions and contexts that constitute their meetings with users. Follow-up questions allowed the participants to elaborate further on their narratives, as well as being asked specifically how they manage challenges, dilemmas, opportunities, and limitations in their work. The first author and a project assistant conducted the interviews from December 2014 to December 2015. Each interview lasted approximately 1 hour and took place in the offices of the community mental health services. The interviews were audiotaped and transcribed verbatim.

Data analysis

The community mental health workers offered narratives of how they provide support to users, and shared their reflections about their work. The material from the interviews was subject to a qualitative, interpretative analysis, involving the following steps. First, the first and third authors read the transcripts several times to acquire an overview of the professionals' narratives. Second, all three authors contributed to a preliminary analysis of the data. Theoretical knowledge about recovery as a perspective on mental illness and care

(Anthony 1993; Borg 2007; le Boutillier *et al.* 2015; Davidson *et al.* 2005) and everyday life (Borg 2007; Scott 2009) were the analytical resources that guided the researchers' interests and interpretations in this step of analysis. This reflects an 'editing analysis style' (Crabtree & Miller 1999; Malterud 2015). We found that the professionals told several stories about experiencing uncertainty when supporting users, which resulted in dilemmas and challenges for them, and chose these findings as topics for further analysis. In the third step of the analysis, the first author reread the transcripts, and parts of the transcripts in which the professionals discussed dilemmas or challenges were marked. In the fourth step of the analysis, the first and third authors grouped the marked citations into six different situations, which they further explored and interpreted. Understanding the processes of negotiation served as an analytical resource in this step (Alsaker & Josephsson 2003; Lewicki & Wang 2006). The term 'negotiation' refers to a process in which two opposing parties seek to reach agreement through discussions and bargaining. The purpose of negotiation is to reach agreement on a common middle ground (Lewicki & Wang 2006). Negotiation processes can be open and ongoing, moving between possibilities, choice, and compromise in particular situations (Alsaker & Josephsson 2003). The professionals in the present study spoke about situations of uncertainty in their work, giving rise to dilemmas or challenges, which they needed to resolve through processes we recognize as negotiations. In these situations, the professionals discuss, bargain, reflect, balance, and mediate with users, management, and others, all as part of the process of negotiating compromise and agreement on how to provide support. In the present study, we present our analysis of how community mental health workers negotiate their support in four situations in which they experience dilemmas or challenges when meeting users.

Ethical considerations

Ethical approval for the study was issued by the regional committee for medical and health research ethics. The project plan was also sent for approval and support to the director of health in the municipality of study. The researchers informed the participants about the aim of the study, respect for their anonymity, and what it would mean to participate in the project. The participants signed written consent forms prior to the interviews. Names used in this article are fictional in order to ensure participant anonymity.

FINDINGS

Our primary finding showed how community mental health workers manage uncertainty when supporting users. This uncertainty leads to dilemmas and challenges, which the professionals seek to resolve through processes we recognize as negotiations. Further, our findings illustrated how community mental health workers provide support to users in between the contexts of users' everyday lives, the community, and the service system. This also requires the professionals to engage in negotiations with several negotiating partners, such as users, service management, and social networks. Professionals discuss, bargain, reflect, and mediate with users, management, and others in the process of negotiating compromise and agreements about how to support users. We present four situations that show how professionals engage in such negotiations: supporting users' independence, meeting users who have children, individual adjustments in participation, and questioning users' self-determination.

Supporting users' independence: Negotiating a subtle balance

The community mental health workers said that providing support in everyday life entails forming relationships with users, and that this relationship might become an important part of the users' networks and everyday lives:

> Yes, we are one of the few contacts they have. This makes you a part of their network, or even their everyday lives. Yes, you become their contact with the rest of the world. (Klara)

Here, Klara was referring to a dilemma she experiences. Although she understood the importance of forming relationships with users, she was a professional, not a friend. Therefore, she needed to negotiate her relationships with users, finding the right balance between 'private' and 'professional'. The professionals upheld the duration of service provision as an important consideration in negotiating relationships, as long-term relationships could become too private.

Additionally, providing long-term support represented another dilemma to the professionals, as they ran the risk of hindering users' independence and empowerment by 'losing track of the goal', as well as becoming too engaged in users' lives. The professionals talked about a subtle balance of support:

> In this, there is a subtle balance, where our help may become more of a pillow to sleep on. . .We who work here often have big hearts and wish people well, and in the eager moment of helping people, we may wind up being more engaged in people's lives than they themselves are. (Klara)

Here, Klara demonstrated how long-term support creates a deep engagement with users, with the risk of becoming too engaged. This conflicted with her goal of supporting users' empowerment and independence, and she experienced a need to negotiate a 'subtle balance' of support and engagement between herself and the users, by discussing and bargaining their roles and engagement in the process of recovery. Klara also showed how this task has another level of complexity, as users' everyday lives are unstable and changing:

> Things happen in people's lives. They lose their home, their income, or other things, which makes what we talked about yesterday invalid today. We have to make redefinitions all the time. (Klara)

Here, Klara pointed to how changes in users' everyday lives create the need for ongoing redefinitions and renegotiations of her support.

The professionals showed how negotiating the balance of support involves discussing and bargaining with users, reaching agreements on common goals, as well as plans for how to work together and for how long. The professionals also said that keeping working processes time limited and goal directed, and clarifying for users the possibilities and limitations of their support, were clear demands by the service management. Rita expressed how this could be challenging:

> Nowadays, we are supposed to work with a short-term perspective, a short-time relationship. That is what is desired. . .In one way, we are obliged to say something about our experiences of some (users) needing long-lasting help. (Rita)

Rita stated that her management's requirements of providing short-term support meant she could not necessarily do what she thought was best, based on her professional knowledge and experience. She demonstrated a need to challenge management's call for short-term services, and to initiate negotiations with them, trying to reach an agreement on the length of services through discussing and bargaining.

Our analysis shows how these negotiations of relationships and support include users' changing needs and requests for support, professional objectives, and considerations, and demands at the management level on the negotiation table. This reflects the complex and ongoing nature of the negotiations of dilemmas inherent in the 'subtle balance' of support.

Negotiating support in everyday contexts also involves more than the user and the community mental health worker, as shown in the following section.

Meeting users who have children: Negotiating the focus of professional support

Two of the professionals, Rita and Maria, described the dilemmas and challenges of providing services to women with children. They described issues of children's welfare and motherhood as both dramatic and sensitive. Through their work with women who are mothers, they acquired knowledge about these women's families, which gave them an obligation to consider the possible family needs of professional support. The professionals said that, in some situations, they had to manage the dilemma of whether or not to report users' families to child welfare services. In less severe situations, the professionals felt obliged to talk with users about their children's situation and welfare, with the intent of providing support or advice. Maria described how she experienced uncertainty and dilemmas in such situations:

> How much pressure should I put on her? Because I know, I should not press too much. . .Because I might lose her, right? And then, she won't come here. At the same time, I know that the child services are at the other end, watching over these children. They do live in a home with violence. Yes. . .and therefore, they might risk having their kids taken away from them. So this is the dilemma: how much pressure should I use? (Maria)

Rita and Maria both emphasized their professional and judicial responsibility to secure the welfare of users' children, but also expressed a wish to focus mainly on supporting these women. However, in their experience, introducing children as a topic for conversation and support could drive users away from them, pose a threat to their working relationships, and thus hinder the continuation of support to these women. Therefore, Rita and Maria both expressed the dilemma of whether or not to introduce the topic of children. In our interpretation, this dilemma required them to bargain and prioritize different considerations, such as the judicial and moral requirements of protecting children, and their own professional objectives of supporting users and protecting working relationships. As we

interpret these findings, these negotiations do not include users as negotiating partners. Instead, they are performed through the professionals' reflection and evaluation. However, our findings show how the professionals, when choosing to talk about these topics, might initiate negotiations with users concerning their need for support:

> But then, I often explain this to her, talk to her about it. It is important that she knows this; that there is a risk tied to her living there. Because she might need some time to get out, in a way, mentally, that is, and she might not be there yet. She wants to give it another try over and over again, right? But there is a limit for how much time she has available. (Maria)

This quote is an example of how Maria sought to negotiate a shared understanding and agreement with this user about her family's need for support and change. Maria brought her professional knowledge about the risks of raising children in violent homes, and how difficult it might be to get out of violent relationships, to these negotiations. The user brought her personal knowledge, feelings, and preferences to the negotiating table, not necessarily agreeing with Maria. When negotiating, they offered each other their individual knowledge and perspective, and discussed, bargained and balanced these to reach an agreement on how to proceed with the situation.

Further, we found that challenges regarding participation in the local community also require negotiations, as discussed in the next section.

Individual adjustments of participation: Negotiating challenge, comfort, and the space for mental illness

The community mental health workers affirmed that supporting participation in social arenas is an important part of their services. They spoke about supporting users' participation through mapping their interests, helping them overcome insecurities and anxieties, as well as motivating and challenging them into trying new activities. The professionals said that some users choose to participate in ordinary community arenas, while others were more comfortable participating in segregated 'mental health' arenas, as these felt safe and offer opportunities for mutual understanding between the participants. However, the community mental health workers said that supporting users' participation involved the dilemma of providing challenge or comfort for the users. Tom discussed this dilemma in relation supporting users' participation in either ordinary or segregated arenas:

> That is a judgment to make: should I suggest only segregated activities, or should I recommend ordinary networks to a larger extent, those that are not connected to that of being a registered user? If one struggles and feels unsafe and unstable, participating in segregated arenas may be ok, but when we together experience that they (the users) dare to try out some more, are a little more robust and things, then I would like to motivate them to make initiatives in the ordinary arenas. (Tom)

Tom experienced this dilemma because he understood that users' needs change over time, ranging from needing comfort at times, and at other times searching for new challenges. Tom had to adjust his support to users' changing needs, but he recommended ordinary arenas when possible. This reflected his professional goal of supporting recovery through new challenges, but also his acknowledgment that challenges might not always be what the users need and want. In this quote, Tom said 'when we together experience', indicating what we view as negotiations between the professional and service user of what arenas to seek participation in, bringing their own needs and wishes to the negotiating table, and discussing and reflecting with the professional about how and where to participate.

Rita expressed promoting healthy identities, more uplifting environments, and avoiding stigma as reasons for recommending ordinary arenas for participation to users. However, she meant that there was a lack of something between the ordinary and the segregated arenas, and wished for social arenas that were more personally 'adjusted within the ordinary'. The professionals emphasized seeking adjustment in ordinary arenas as another challenging task requiring negotiations:

> Sometimes we try to work against the system, the rest of the 'crowd' in a way. . .The space for mental illness, it is not. . .They often receive segregated services and their own meeting places. The rest of the society is not. . .It either costs money or demands that you are capable of presenting yourself and behaving in certain ways. (Klara)

Here, Klara expressed a lack of 'space for mental illness' as a challenge for participation, but without discussing how she would try to open up this space. However, some other professionals talked about how they function as translators when supporting participation; sometimes helping users understand their own experiences of interaction with others, at other times

helping others understand the user. We interpret these accounts as findings of how professionals function as mediators in negotiations between users and others/social arenas; 'translating' between the parties in order to promote mutual understanding, and bargaining for users 'against the system' to negotiate agreements of participation and inclusion.

In the final section of our findings, we examined situations in which community mental health workers view users' situations as intolerable.

Questioning users' self-determination: Negotiating professional perspectives, morals, and ethics

Through their knowledge about users and their everyday lives, the community mental health workers said that they sometimes find users' living conditions unacceptable, giving rise to moral and ethical dilemmas. Although family doctors are legally responsible for the initiation of coerced treatment, several of the professionals discussed being involved in these processes, because they were often the person who best knew the user.

Klara, posed the following question for reflection: 'Where should the limit go for self-determination concerning how to live?'. She and other professionals discussed the dilemma of respecting users' self-determination, as opposed to protecting users from harm through initiating coerced treatment. Lars shared these reflections:

> I think this is a dilemma: when do we intervene? When do people 'suffer wrong', as they call it?...At the same time, people have the right to 'go under' in Norway. Although, allowing people to go under without interfering is very hard. Then there is also a question about the daily life people lead. Although I do not find it sufficient, some of our users might not be able to cope with any other kinds of daily lives. (Lars)

Here, Lars expressed the uncertainty and dilemma in making decisions of how to support users in these situations. He demonstrated how the legal framework gave him some guidelines, but how they might conflict with his sense of moral obligation to help people in distress. Although he wanted to help, he also acknowledged users' rights to self-determination, and that his opinions of what constitutes sufficient standards of living, might not be the same standards of users. Lars had to negotiate these conflicting considerations through reflection, balancing, and prioritizing, before making his decision about how to act. The professionals also identified other considerations in these situations, such as preserving trusting relationships with users and assessing expected outcomes of forced treatment compared to those of voluntary support. The professionals' accounts of all these considerations, some of them conflicting, illustrate the uncertainty and complexity of these situations.

In interpreting these findings of negotiating support in crises, the professionals did not necessarily include users as negotiating partners. However, one of the community mental health workers, Nora, suggested how coerced treatment could be 'done in the right way'. She proposed that through planning and negotiating prior agreements with users 'in times of peace', it was possible to secure some self-determination, even in situations where coercive treatment was initiated. Nora proposed negotiations of compromise between forced treatment and self-determination, where judicial, professional, and user perspectives are discussed and balanced by professionals and users together.

DISCUSSION

Negotiations of support involve both opportunities and challenges for collaboration between community mental health workers and users, based on the findings of the present study. Therefore, we raise the following question for discussion: How and when are negotiations a valuable way for professionals and users to collaborate?

Our findings show how, in negotiations of support, professional, user, and systemic perspectives and knowledge are shared, respected, and considered by the parties in each particular situation of negotiating support. This implies that negotiations promote user involvement, flexibility, and individual adjustments, which are suggested qualities for the collaboration between community mental health professionals and users (le Boutillier *et al.* 2011; McCloughen *et al.* 2011; Ness *et al.* 2014b; Rise *et al.* 2013b). Therefore, we suggest that negotiations are a valuable way for professionals and users to collaborate.

However, our findings also show how, in particular situations, the professionals chose not to negotiate their support with users. This points to an asymmetrical relationship between professionals and users, in which professionals have the authority to decide when negotiations of support are the preferred way of collaborating. In crises, judicial frameworks and moral

obligations could hinder negotiations with users. Additionally, we suggest that, in such situations, negotiations can be avoided by professionals, as they sometimes question users' abilities and advantages of being involved in decision-making (Hansen *et al.* 2004; Solbjør *et al.* 2013). Furthermore, our findings show how professionals leave users out of negotiations in less urgent situations as well, such as when deciding whether to talk about children or not. In these situations, the professionals spoke about their fear of experiencing disagreement with users, upsetting users to the point of not wanting to continue to receive support. Consistent with findings in other studies (Hansen *et al.* 2004; Rise *et al.* 2013a; Solbjør *et al.* 2013), the professionals in the present study felt responsible for users, and sought to protect and care for them, possibly due to the prevalence of medical perspectives within the services (le Boutillier *et al.* 2015; Tickle *et al.* 2014). Therefore, we suggest that professional responsibility could prevent them from negotiating support with users. Finally, the professionals described situations of tension between the rules and regulations of the service system and the users' needs for support. Such situations demand negotiations with management, as well as users, and could limit the influence of user perspectives in negotiations of support.

As our arguments show, negotiations of support are a valuable way to collaborate, but the professionals do not always view negotiations as possible or desirable to initiate. We argue that the professionals have the authority to decide 'when' to negotiate, demonstrating an unequal relationship between professionals and users. However, do the professionals also decide 'how' to negotiate? We view negotiations of support as ongoing processes between professionals, users, and others, where they discuss and bargain over different possibilities, choices, and compromises (Alsaker & Josephsson 2003; Lewicki & Wang 2006). Negotiations require the parties to share their power, knowledge, and resources. We suggest that if one party undermines the other, forsaking agreement and compromise, the negotiation will falter. Following this, when deciding how to negotiate support, professionals need to seek equal relationships with users, securing enough flexibility and equality for negotiations to proceed.

Based on these arguments, negotiating support with users is a valuable way of securing user influence, flexibility, and individual adjustment of services. However, we acknowledge that professionals do not always view negotiations as a possible or desirable way of collaborating with users.

RELEVANCE FOR CLINICAL PRACTICE

The present study contributes to clinical practice with knowledge about how community mental health workers provide collaborative, flexible, and individually-adjusted support through engagement in negotiations. Furthermore, our findings show how the asymmetrical relationship between professionals and users leaves the authority and responsibility for initiating negotiations solely to professionals. We acknowledge that negotiating with users could be challenging, sometimes even unmanageable, for professionals in a service system with strict procedures and professional paradigms. Nevertheless, we argue that negotiations are a helpful way of understanding how professionals and users within community mental health service contexts collaborate, which might help enhance user involvement and flexibility within the services. We propose that learning more about how and when they negotiate support will help professionals recognize situations where such negotiations are a valuable way of collaborating with users. We suggest that professionals encourage open, reflective, and ongoing negotiating processes with users whenever possible, in order to secure user involvement, flexibility, and individual adjustments of services.

CONCLUSION

The aim of the present study was to explore how community mental health workers provide support to users. The study contributes new knowledge about how supporting users in the community mental health context requires professionals to engage in negotiations with users, management, and others. Negotiations involve new roles and complex collaborative processes, where the user, professional, and systemic perspectives are considered and negotiated in each particular situation. By engaging in negotiations, professionals are able to provide support that adheres to the recommendations for collaborative services (le Boutillier *et al.* 2011; Ness *et al.* 2014b), and meet users' fluctuating needs and wishes (Rise *et al.* 2013b; Ulfseth *et al.* 2016). However, based on our brief discussion, we understand that negotiations might not always be the preferred method for users and professionals to collaborate. More research is needed to shed light on the potential for, and limitations of, negotiating support, focussing on how negotiation processes proceed in different clinical contexts, as well as on what skills and resources might assist with these negotiations. A clearer understanding

of how service systems could adapt to, and enable, negotiations between users, professionals, and systems is also needed.

Methodological considerations

The participants in the present study were recruited by their supervisors who might have chosen professionals purposefully; for example, based on their perceptions of some employees as knowledgeable or loyal to the organization. Being asked by their supervisor to participate might have had an impact on the professionals' decisions to comply, and also could have impacted how they answered the interview questions. Additionally, the interviews in the present study were conducted by two different researchers, which could have affected the results; for instance, through making different decisions on what themes to ask for elaboration on in the interviews. However, from our analysis of the transcripts, no evident differences in the interviews were detected.

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Article 2

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Exploring Narrative Meaning Making through Everyday Activities – A Case of Collective Mental Health Recovery?

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Everyday Activities, Meaning Making, Narrative-in-Action, Recovery

Abstract

Objective: Engagement in everyday activities is important to mental health recovery, as we create meaning through what we do. The aim of this case study was to gain a deeper understanding of how individuals with mental health problems create meaning through doing everyday activities with others. In this article, we present our analysis of the events that unfolded when the participant George, the first author, and several others were involved in baking gingerbread together at a community mental health centre.
Methods: Through a narrative, ethnographic, case study design, we sought to create processual, contextual and in-depth knowledge responding to our aim. We created data through participant observations while doing everyday activities at a community mental health centre, and analyzed them through a narrative approach focused on action.
Results: Through alternately trying out ideas and possibilities to drive the activity forward, as well as communicating shared interest and mutual understanding throughout the activity, the persons involved created meaning collectively.
Conclusion: Our findings show how doing activities with others involves possibilities for engaging in processes of collective meaning making. We understand such meaning making processes as events of recovery, and suggest that we may understand and support recovery as collective processes.

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Introduction

Mental health recovery is understood as multiple processes of regaining connectedness, hope, and optimism about the future, identity, meaning in life, and empowerment[1,2]. Duff[3] has shown how several seemingly remote everyday events of recovery that cohere together accumulate, and together establish 'assemblages of recovery'. Recovery-oriented services are described as person-centred and collaborative, negotiating support adjusted to individuals' interests, goals, and everyday life context[4,5]. However, the recovery approach has been critiqued for this individualistic focus, leaving social or relational recovery processes in the background[6,7]. Duff[3] and Doroud et al.[8] also critiques the lack of in-depth, contextual and processual knowledge about recovery. Duff[3] advocates a shift of focus from recovery goals or milestones, to the mundane, everyday activities, encounters and atmospheres that together enable such outcomes.

Research has shown how mental health recovery progresses through individuals' engagement in activities[8-10], as activities are a source of meaning[11]. However, mental health problems may cause disruptions to individuals' everyday lives, affecting their possibilities of doing everyday activities[12-14], and their social relations[15]. Further, individuals may struggle with connecting hope and meaning to engagement in activities[16] or suffer from low self-esteem[17-18], which can decrease their motivation and ability to engage in activities[19]. Although research points out an important, but challenging, interrelationship between everyday activities, meaning and mental health recovery, there is a lack of processual and in-depth knowledge about how this interrelationship works. Narrative theory may help develop such knowledge, suggesting that we assemble meaning through pulling together activities and events into coherent narratives. In narrative theory, meaning is about coherence, understanding past, present and future activities and events as understandable in relation to each other[20,21]. Roe and Davidson[22] and Deegan[23] connect their understanding of recovery to narrative meaning making, underlining how disruptions caused by mental illness require individuals to engage in processes of re-creating meaning through narrative functions like imagining, negotiating, and trying out new possibilities of creating coherence. Previously published narrative studies provide important knowledge about how individuals with mental health problems create meaning through everyday activities[24-27], underlining how doing everyday activities together with others involves opportunities of negotiating shared meaning[25,26], which may contribute to strengthened agency[27].

Recognizing processes of narrative meaning making, as well as everyday activities and encounters, as crucial in mental health recovery[22,23], the aim of this case study was to gain a deeper understanding of how individuals with mental health problems create meaning through doing everyday activities together with others.

Research Design and Methods

This study makes use of a narrative-in-action approach, building on narrative theory[21,28,29] and the work of Alsaker, Josephsson, and their colleagues[20,24,30,31]. This is

a qualitative, ethnographic approach, involving participant observations. A case study design[32] was chosen, yielding a detailed and in-depth exploration of the meetings with a single participant, George.

Theoretical Resources

Narrative theory has guided both our choice of methods, analysis, and interpretations in this study, and in particular the work of Ricoeur[28,29] and Mattingly[21] who connect narrative meaning with activity.

In a narrative, several activities or events are pulled together into a coherent story that conveys the purpose, plot, or meaning of human activity[33]. According to narrative theory, individuals create meaning through connecting past, present, and future activities and events into coherent narratives[21.28,34]. Further, Mattingly[21] defends a 'theory of emergent meaning' that acknowledges the role of activities in shaping meaning. In other words, narratives may be both told and enacted, and human activities may be viewed as parts of narratives in the making, in which meaning is both constructed and embedded. In this understanding, our current images about 'what narratives we are in' also guide and motivate our future activities, and thus involve possibilities for transformation and recovery[21].

Based on Aristotle's writings on fiction, Ricoeur[28], further interpreted by Alsaker[35], describe how narrative meaning making unfolds through the process of mimesis. They present mimesis as a process with three folds: First actions and events take place (mimesis 1). Next, the person tries out, through thought and activity, his/her images and possible understandings of these events based on social/cultural/historical resources, as well as hopes for the future (mimesis 2). Finally, a current understanding is created, allowing the events to be communicated, through sharing, negotiation and confirmation, as a coherent story with a clear meaning/plot (mimesis 3). Alsaker underlines how meaning making through the process of mimesis is a continuous and flowing undertaking, moving back and forth between the three different folds[35]. In line with this, the narratives and processes of meaning making in focus of this study are not verbally told stories, but rather ongoing, enacted stories of meaning making.

Participant Recruitment and Ethical Considerations

The data used in the present study are drawn from a related study with four participants. For this case study, we chose to further explore the data-material created with George because it yielded valuable findings related to our aim.

To recruit participants for the study, the first author made contact with the leader of three community mental health centres in an urban municipality in Norway. These centres are run by the municipality and serve as local meeting places for individuals with mental health problems. Here, people can come and go as they please, read the newspaper, drink coffee, and converse with others. Both staff and service users

organize activities at the centres, such as meals, art-groups, and physical activity. The leader invited the first author to their house meetings to inform staff and service users about the study. After the meetings, the first author left written information about the study and contact information at the centres. Individuals interested in participating were encouraged to make contact with the first author, either directly or through the staff at the centre. Criteria for inclusion were that the participants experienced mental health problems, and that they were currently living at home in their community, not in a hospital. George made contact with the first author, willing to participate in the study. Before starting data generation, the first author repeated some information about the study and what it would mean to participate, and George signed a written consent form.

The regional committee for medical and health research ethics issued ethical approval for the study (approval number: 2013/2410/REK midt). The authors also sent the project plan to the director of health in the municipality of study for approval and support. We have changed the participant's name and some details to ensure anonymity.

Generating data through participant observations over time and in different situations requires sensitivity and reflexivity regarding how to create an open and trusting relationship, but at the same time keeping some professional boundaries, and planning for how to end the relationship[36]. Throughout the meetings, the first author adjusted her actions, being sensitive to the current situation. To prepare George for the researcher's withdrawal, the first author repeated and confirmed the nature and temporality of the relationship throughout the meetings. In the last meeting of data generation, the first author presented George with the opportunity to ask any questions he might have. The first author also assured that he would receive updates on the status of the project. Additionally, the first author asked George to meet again to discuss the preliminary analysis and interpretations, something he agreed to.

Data Generation

The findings in this case study are based on our analysis of events that took place during the first author's meetings with George. Participant observations followed recommended guidelines provided in the literature on ethnography originating mainly from sociology[37,38]. The first author met with George 8 times, over a period of 6 months. Each meeting lasted from 2-4 hours, while doing everyday activities suggested by George. In general, the participant observations entailed doing activities, spending time together and partaking in informal conversations with George and others present, as well as observing, listening, and asking questions relevant for the study aim. Several of the meetings with George took place at a community mental health centre, joining the art group, baking, or having coffee together in the salon.

Field notes were organized in four parts, following guidelines from literature[37,38]. 1) Before each meeting, the first author wrote some notes about her preparations and pre-understandings for the meeting. Parts 2-4 were written after each meeting, and included 2) a description of the context of the meeting; when, where, what, who, 3) a description of the meeting, of what was said and done as the first author remembered it, and 4) the

first author's current reflections and analytical ideas. These texts, in total 17900 words, formed the data material that we subsequently analyzed.

Data Analysis

We analyzed the data using a narrative, interpretive approach. Our analysis involved a hermeneutical process of studying the data-material, team-discussions of analytical ideas and possible interpretations, and searching for relevant theory and research literature to deepen our understanding further.

In accordance with the narrative-in-action approach, we focused our analysis on unfolding actions and events in the data material. We took particular interest in events involving some kind of ambiguity or suspense. Such situations require individuals to imagine possibilities and deliberate their actions, and may thus be particularly significant to uncover their meanings and intentions[31]. The first and third author both read the field notes to get an overview of the data material. The first author continued by reading the field notes several times, searching for events raising curiosity or questions related to creating meaning. Theory about narrative meaning making and the process of mimesis guided the focus of our readings, and the identification of possible significant events[21] related to our study aim. The first author then read the field notes again, searching for other parts of the data material that seemed interrelated to these significant events. Hence, our analysis followed the principles of a hermeneutic circle of understanding; moving between particulars and wholes, thereby expanding our understanding in concentric circles[39]. During this process, all three authors met on several occasions to discuss preliminary findings and interpretations, as well as how to proceed with the analysis.

As a next step in our analysis, we pulled together the parts of the data-material that we viewed as relevant to our interpretations of significant events to create a coherent story which shows a possible emergent plot or meaning[31]. This helped us both to deepen our understanding of these events and to communicate our findings. Next, the narrative was interpreted further through the joint work of all three authors, drawing both on other parts of the data material, theory, our preunderstandings as occupational scientists, as well as relevant research literature, fulfilling a double hermeneutic circle of interpretation[40]. Through this process, we sought to provide scholarly and theoretic arguments to support our findings and interpretations.

George read the manuscript before submission, and met with the first author to discuss our findings and interpretations. George responded that he could recognize our interpretations of the analyzed events, and that our focus on the relational aspects of everyday activities and meaning making points to issues very important to him. This helped develop our understanding further, and to secure validity of our findings.

Methodological Considerations

We sought to ensure transparency and validity of our research through several procedures. We have described our process of data-creation, analysis, and interpretation thoroughly, making it as transparent as possible through displaying our theoretical, methodological, and professional resources. We discussed our findings and interpretations with George to further ensure their validity. In line with the conception of narratives as socially constructed[21], the narrative presented in the findings section must be viewed as co-created between the participant and the researchers. Although findings and interpretations were discussed with George, they are mainly the authors' and must be viewed as some of many possible interpretations, grounded in theory and professional knowledge. We uphold that our professionally and theoretically grounded interpretations may contribute to our understanding of the phenomena of study, as well as to the field of mental health.

Results

George is a man in his mid-fifties. He is divorced and father of three grown children. Previously, George worked full-time as an academic, volunteered in community work, and was active in a sports-club together with his children. Some years ago, George suffered from severe mental illness and was hospitalized for a while. After hospitalization, he moved into the city to start a new life. George states that he is not able to work anymore, and talks about himself as a retiree. George spends most of his days at the community mental health centre or at home, doing everyday activities like painting, working out, or cooking. He says that he may be 'lazy' sometimes, needing someone to push him to do things, and that the community mental health centre helps him stay active.

The results presented here are grounded in our analysis of the complete data material created with George. To communicate our findings, we choose to present the storied events of two meetings where George and I [the first author] were involved in baking gingerbread at the community mental health centre. For friends and families in Norway, baking gingerbread, and especially a gingerbread house, is a common activity to do before Christmas. Our analysis of these particular events focused on how George and the other individuals involved created meaning while doing this activity together. As we will show, our main finding is that through alternately trying out ideas and possibilities, as well as communicating shared interest and understanding throughout the activity, the participants engaged in a process we have called collective meaning making.

Making a Gingerbread House – Collective Meaning Making in Action

Trying out an idea.

> One day in early December, George and I were reading newspapers together at the community mental health centre, waiting for the weekly house meeting

> to begin. I showed George a newspaper article about artistic gingerbread decorations. George eagerly looked at the pictures for a while, seeming very intrigued by them. Soon after, he contacted the staff at the centre and asked them if it would be possible to bake and decorate gingerbread before Christmas. The staff sounded positive and said that this could be possible but encouraged him to bring his question to the house meeting, which was about to begin. During the meeting, both staff and other service users supported George's idea, and therefore agreed on a date on which to bake gingerbread. The staff said that the centre would provide money for the activity, and George volunteered to go buy ready-made gingerbread dough.

When analyzing these events in light of narrative theory we recognize them as being part of a process of mimesis[28,35]. We understand George reading the article as the first fold of a meaning making process, mimesis 1. Reading the article about artistic gingerbread decorations seemed to intrigue George, perhaps because of his general interest in art and baking. Reading the article also seemed to trigger George's imagination, as he soon envisioned baking gingerbread himself, and wondered about the possibility of doing this at the community mental health centre. Perhaps positive experiences of baking together with others triggered these images of involving others at the centre in this activity? Alternatively, perhaps he seeks other's engagement because he thinks he cannot do this activity on his own? George decided to present his idea to the staff, trying out the staff's evaluation of his proposal. We identify this envisioning of future possibilities and trying out of his idea as events belonging to the second fold of the mimesis process. We suggest that through mimesis 2, George sought both practical and moral support from the staff through trying out their interest in the activity. Further, by being positive and supportive of his idea, the staff confirmed that they shared George's interest and understanding of baking gingerbread as a meaningful activity to do together at the centre. We view the staff and George's communication of shared interest and understanding as joint engagement in mimesis 3, being the beginning of a collective meaning making process evolving through this activity.

However, their shared understanding seemed temporary and fragile, as the staff required George to present his idea also at the house meeting. In our interpretation, the staff viewed the house meeting as an opportunity to try out other service users' interests in engaging in this activity, initiating a new round of mimesis 2. Building on their own experiences and images others also voiced their interest in baking gingerbread at the meeting, thereby creating a new shared understanding of the activity, identified by us as another round of mimesis 3. They decided to go through with the idea, and made further plans. As can be seen from our analysis, we suggest that through these activities, George, the staff, and other service users were engaged in meaning making through the process of mimesis. By moving between events/actions (mimesis 1), testing out the idea (mimesis 2), and communicating shared interest and understanding (mimesis 3), they manifested baking gingerbread as an activity worthwhile doing together at the community mental health centre.

A moment of hesitation.

> George invited me to join them while baking, and about a week later, I met up at George's apartment as agreed upon to go bake gingerbread at the centre. However, when George opened the door, he was not yet dressed for leaving the house… Moreover, he asked me if I would rather come in and drink coffee with him in his apartment… This surprised me, and I hesitated for a short while. I then replied that I was curious about the event of baking gingerbread, and proposed that we should go to the community centre as planned. George agreed on this immediately, got dressed, and we walked to the centre together.

George spent both time and effort in initiating and planning the gingerbread baking. However, when I came to pick him up to go baking that December morning, something had changed... Why was he now hesitant to go, after all his previous efforts to arrange the baking? We suggest that George had become uncertain about the validity of the shared understanding previously created and communicated at the house meeting. Perhaps he has experienced previous situations where others have changed their mind about an activity, or where plans have not come through? In our interpretation, George initiated a new round of mimesis 2, trying out again the first author's interest in going baking by offering an opportunity to back out of the activity. George's hesitation and question prompted the first author to communicate and solidify a collective interest and engagement in baking gingerbread, completing a new mimesis 3. George received the reassurance he needed and quickly re-engaged in the activity as he got dressed and walked to the centre as planned.

Unexpected hindrances causing bewilderment.

> George and I were some of the first persons to come to the centre that day, and George immediately went into the kitchen to prepare the baking. However, he could not find all the dough he had bought… He and the staff searched the kitchen but soon concluded that some of the dough he had bought was missing… Both George and the staff seemed puzzled and uncertain on what to do... They discussed who might have taken it, how much dough they would actually need, and how to deal with this unexpected hindrance. Finally, one of the staff said that she would go to the store and buy some more dough. George seemed relieved by this solution to the problem. While waiting for her to come back, George and I sat down in the salon.

When noticing this unexpected lack of dough, George pondered for a while together with the staff about what to do. It was the staff who eventually initiated a solution and went to buy more dough. In our interpretation, this may be understood as another situation in which George became uncertain and hesitant. Perhaps he was again trying out if the staff were invested enough in the activity to solve the issue and bring the

activity forward. When the staff decided to go buy more dough, they confirmed to George that they were in this activity together, and that they found baking gingerbread to be an activity worth doing.

Creating shared understandings, drawing on individuals' creativity and strengths.

> While waiting for the staff to arrive with the dough, more service users joined in. Some of them had already agreed on baking a gingerbread house together and now engaged in a discussion on how to design it. A female service user, who is a very capable artist, suggested different designs to the others. They soon agreed on making a traditional gingerbread cottage. They asked a male service user, who is an architect, to draw the patterns for the house. He agreed to do this, and with input from the others, patterns in the correct size and design were drawn.

During these events, other service users took initiative and elaborated on George's idea, trying out their own ideas as well. Now George was mostly quiet, listening and smiling while the others were doing the planning, thus confirming others' ideas and initiatives during the activity. We recognize these events as a collective endeavour of mimesis 2, with several individuals alternately trying out ideas and possibilities. In this particular situation, some individuals also experienced opportunities of using their individual strengths and capacities, such as designing and drawing the patterns for the gingerbread house. Finally, through their involvement in these activities, they collectively reached agreement on how to proceed, in our interpretation again having negotiated another preliminary shared understanding, a mimesis 3, of the activity.

Enjoying the finish line.

> The staff finally arrived with the dough, and we all moved into the kitchen to start the baking. The staff helped find the kitchen utensils needed, but then they left us to do the baking on our own. This was the first time baking gingerbread for both George and some of the other service users. They asked the more experienced persons for advice before starting baking. They had some trouble working the dough at the beginning, but after some trying and failing, George decidedly found his own way to do it. Another male service user laughed and said, "Now the baker has made up his mind." While talking, tasting, and enjoying the unique scent of gingerbread, they made many artistic looking cakes, as well as a house. George seemed dedicated while making his fancy cakes. Both staff and other service users told him how well his cakes looked. George smiled proudly and replied, "Thank you."

Throughout these last events, when finally starting the gingerbread baking, George and the others involved seemed both relaxed and joyful. Our findings show how while planning and preparing for this activity, George was uncertain, and the collective

meaning making process seemed fragile. However, in this final part of the activity, any uncertainties seemed resolved. We understand this as a final round of mimesis 3. They now finalized the activity, establishing a shared understanding of baking gingerbread as a coherent and meaningful experience for the group.

As noted above, the first author initially understood George's interest and enthusiasm for baking gingerbread as connected to his interests and abilities in art and baking. However, our analysis shows that doing the activity together with others was crucial in order for George to follow through with his idea. He needed confirmation and involvement from others on several occasions to keep up with the activity. We suggest that the individuals involved in this activity engaged in what we have interpreted as collective meaning making, undertaking the process of mimesis together. Through making use of their narrative abilities of trying out ideas and possibilities, communicating shared interest and understanding, as well as valuing and making use of individual resources, the participants collectively created meaning throughout the activity, a process that was crucial to George.

Discussion

Our analysis and interpretations of the events presented here show how doing everyday activities with others opens up possibilities for negotiating shared understandings and coherence through processes we have called collective meaning making. Although our focus was primarily on George as participant in the study, the participant observations yielded contextual and processual data involving several individuals. Our findings of collective meaning making add to previous research showing how doing everyday activities with others provides us with important possibilities for relational experiences and meaning making[24-27,41,42].

Through our analysis, we came to understand that George strives for collective meaning making in several situations, and that this is crucial for him to achieve in order to go through with activities. George's mental health problems and other life events have interrupted his engagement in activities and relationships that previously have provided him with possibilities of collective meaning making, such as taking care of children, working, or doing sports. Literature shows how such losses are not unique to George[12-15]. Further, experiences of mental illness may have eroded George's self-esteem, affecting his ability to initiate and engage in activities on his own[17-19]. All these challenges are plausible reasons why George and others experiencing mental health problems may need and seek new arenas for doing everyday activities together with others that entail possibilities for collective meaning making.

As we have shown, collective meaning making entails communication of shared interest and understanding, as well as using one's imagination, influence and personal resources throughout an activity. Building on the narrative understanding of mental health recovery presented in our introduction[21-23], we recognize the process of meaning making explored in this study as an 'event of recovery'[3], with a potential of establishing both connectedness, empowerment, and hope and optimism about the future for the

participants. What our findings underline is how such events of recovery may be collective, rather than individual. This collective view of recovery is also supported by Price-Robertson, Obradovic, and Morgan[6] and Duff[3], who propose that some recovery processes, such as creating hope and belief, are both relational and atmospheric. In light of these findings, an important question for discussion and further investigation will be: How may such processes of collective meaning making and recovery be supported?

As we outlined in our introduction, literature mainly describes mental health recovery as an individual process, although social processes are found to be important[6,7]. Further, recovery-oriented services are also mainly person centred, focusing on individuals' recovery in their context[4,5]. In person-centred recovery planning, individuals are first asked about their interests and goals, then possibilities and ideas of meaningful activities are brought forward, and later completed individually or together with others[5]. As opposed to an individual and linear process of creating meaning, our findings show how meaning making processes are evolving, linking together the actions of several individuals, events, and contexts, and require ongoing negotiation and communication of shared meaning and understandings. Further, our analysis shows how the participants' interest and engagement in baking gingerbread was created and enhanced throughout the activity, and how participants were able to insert their influence during the process through trying out their own ideas and wishes for how to further proceed with the activity together. This implies that creating interest and meaning was an emergent, spontaneous, ongoing, and collective process. We therefore suggest that individual and linear processes and recovery planning should be assisted by efforts to facilitate what we understand as collective recovery.

We have shown how collective meaning making is an evolving process of individuals taking turns in trying out ideas and possibilities, craving an atmosphere where individuals can meet and feel comfortable, and that allow for spontaneity, improvising, risk-taking, exploration, and diverse activities. Duff[3] discusses how atmospheres may be staged to promote recovery, and based on our findings we support his suggestion of how open, accessible, and tolerant atmospheres may accommodate for such processes. Our findings suggest that the community mental health centres may provide such atmospheres, as they arrange for individuals with similar experiences and needs for recovery to meet and do activities together, offering both material and relational support. The community mental health centres have also been documented as inclusive and supportive atmospheres facilitating participation and recovery by Elstad and Eide[41].

An important premise for the process of collective meaning making presented here was doing an activity or project together. It was doing something together that opened up for possibilities of meaning making. Although the community mental health centres offer possibilities for collective activities or projects, our findings may call for an enhanced effort to arrange for such possibilities. Perhaps ideas may be drawn from the clubhouse model[43], where all members are viewed, treated, and fostered as contributors to the clubhouse community through reciprocal relationships and collective undertakings. However, our findings underline the importance of keeping the activities and atmospheres open for spontaneity and exploration.

Study Limitations and Future Research

This is a case study, exploring a single process of meaning making. We view the interpretations presented here as only some of many possible interpretations. We propose that more research is needed to nuance and deepen our understanding of recovery as a collective process.

Our findings underline how doing everyday activities with others facilitates collective assemblages of recovery, and we suggest creating safe and flexible atmospheres that accommodate such activities. Although the community mental health centres offer accommodating atmospheres for recovery, recovery literature also highlights the importance of inclusion in 'mainstream' social arenas[44]. An important question for further research and discussion is how to support collective recovery in such arenas and activities as well.

Conclusion

The aim of this study was to gain a deeper understanding of how individuals with mental health problems create meaning through doing everyday activities together with others. Through a narrative-in-action approach, this case study has yielded processual, contextual and in-depth knowledge about how a group of individuals create meaning collectively through activity. We understand such processes of collective meaning making as everyday events of recovery, hence our findings shed light on the interrelationship between doing everyday activities with others, meaning making, and mental health recovery. Further, narrative theory suggests that experiences of activity and collective meaning making may be a source of images, hopes and possibilities for future events[21], thus inspiring and stimulating later activities and contributing to create assemblages of several coherent events of recovery such as Duff[3] describes. In line with Duff[3], we therefore uphold that analyzing and understanding mundane everyday activities and events of meaning making such as the one we have presented here is an important contribution to understanding and supporting mental health recovery.

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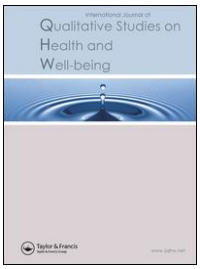
Article 3



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A narrative study of mental health recovery: exploring unique, open-ended and collective processes

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ABSTRACT

Purpose: Guided by narrative theory and by use of a narrative-in-action approach, the aim of this study was to explore how mental health recovery unfolds through individuals' engagement in everyday activities.

Method: Data were created through participant observations with four individuals while doing everyday activities, and analysed through a narrative, interpretive approach.

Findings: The findings show how mental health recovery involves unique and open-ended processes of narrative meaning-making, which unfold through an interplay between everyday activities, places and persons.

Discussion: Based on these findings, we discuss how we may understand and support mental health recovery as collective processes.

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Ethnography; everyday activities; meaning making; mental health; narrative; participant observation; recovery

Introduction

Everyday activities are an important focus for recovery-oriented research and practice. Doing everyday activities is our way of structuring and creating meaning in our lives (Hammell, 2004; Wilcock, 1999), and holds potential for healing and transformation (Mattingly, 1998; Townsend, 1997). The transformative potential of everyday activities has been explored in research on mental health recovery, suggesting that recovery progresses through activities and describing recovery as an occupational journey embedded in everyday life contexts (Borg & Davidson, 2008; Davidson et al., 2006; Doroud et al., 2015; Kelly et al., 2010; Sutton et al., 2012). However, mental illness may bring about major interruptions to individuals' everyday lives and social relations (Zolnierek, 2011), including not being able to do the everyday activities they have previously engaged in (Alsaker & Ulfseth, 2017; Baker & Procter, 2014), and sometimes needing support from professionals and others to carry out activities (Yilmaz et al., 2009).

Acknowledging the importance of everyday activities in recovery, several authors call for more in-depth, processual and contextual knowledge of how processes of recovery unfold through everyday activities (Doroud et al., 2015; Duff, 2016; Ellison et al., 2018; Price-Robertson et al., 2017; Topor et al., 2011). Research shows how recovery is complex and contextually dependent, involving multiple processes of regaining connectedness, hope and optimism about the future, identity, meaning in life, and empowerment (Le Boutillier et al., 2011; Slade et al., 2012), as well as dealing with difficulties (Stuart et al., 2017). Social factors and relationships (Tew et al., 2012; Topor et al., 2006), as well as places (Duff, 2012; Myers, 2016) are found to be important dimensions in recovery. As research suggests a multifaceted understanding of recovery, there has been some critique on research and services that focus primarily on the individual, with social and contextual factors serving only a secondary role (Kogstad et al., 2011; Price-Robertson et al., 2017).

Narrative theory may help understand recovery as processes unfolding through the activities and experiences of everyday life. In a narrative, several elements such as persons, activities, events and contexts are drawn together into a coherent story which conveys a possible plot or meaning of human activity (Polkinghorne, 1995). A narrative plot is a thematic thread related to important issues in individuals' lives which may clarify the meaning of separate actions or events, through connecting them in the narrative as a whole (Bruner, 1990; Polkinghorne, 1995). Narratives can be both told and enacted, and everyday activities may be understood as part of ongoing enacted narratives with open endings, entailing opportunities of healing and transformation (Mattingly, 1998). Further, enacted narrative meaning making is described as an ongoing and creative process of creating coherence through trying out in thoughts and actions plots that connect past and present activities and experiences to our ideas and wishes of future scenarios (Alsaker &

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Josephsson, 2010; Josephsson et al., 2006; Ricoeur, 1983). Thus, viewing recovery as processes of narrative meaning-making inspires exploration of how persons, everyday activities, experiences, hope and visions for the future, places and contexts may be understood in relation to each other and form narratives of recovery.

A narrative understanding of recovery also sheds light on the relational nature of these processes. Bruner (1990, p. 73) writes that inherent in processes of narrative meaning-making is a sensitivity towards others, a "social meaning readiness". If others cannot make sense of our narratives, they may fall apart, requiring us to negotiate and adjust them (Bruner, 1990; McAdams, 2006). Demonstrating the relationality of narratives of recovery, several studies show how everyday activities that put us in touch with others are particularly valuable to create meaning. When doing activities together, the persons involved try out possible plots in collaboration, seeking to create narratives that make meaning to everyone involved (Lindström et al., 2013; Ørjasæter et al., 2017; Reed et al., 2018; Ulfseth et al., 2015, 2016).

Lastly, a narrative understanding embraces the complexities of recovery as un-linear processes. Recovery presents those involved, both the person with mental health challenges, family, friends, professionals and/or others, with hurdles such as having to make difficult choices, having to negotiate and try out several courses of action, experiencing disruptive symptoms, stigma and lack of support and resources, as well as losses, setbacks and failed attempts (P. Deegan, 1988; Reed et al., 2017; Zolnierek, 2011). P. E. Deegan (2002) describes recovery as processes of creating transformation narratives, discovering both one's limits and possibilities. Roe and Davidson (2005) underline how mental illness may result in disrupted life narratives and understand recovery as an effort of re-creating coherence and meaning by "gathering up the pieces" of one's previous life and putting them together again through trying out, improvising, and negotiating. Correspondingly, narrative plots are not associated with straight and smooth threads, but rather messy threads with occasional knots, frizzles and loose ends, causing tension and suspense (Mattingly, 1998). Hence, understanding recovery as narrative processes may help shed light on its complexity and underline its openness to negotiations and rearrangements, instead of viewing it as processes with well-defined dimensions and endings.

Based on the literature reviewed here we understand that processes of mental health recovery are multifaceted, relational and open-ended. We propose that viewing recovery as a process of narrative meaning-making may help understand how persons, everyday activities and contexts are connected in these processes, explore the importance of relationships, and keep in mind the complexities and open-endedness of these processes. Answering to the call for more processual and contextual knowledge about mental health recovery we therefore build on a narrative understanding of recovery in this study, and our aim is to explore how mental health recovery unfolds through individuals' engagement in everyday activities.

Method

Aligning with our narrative understanding of recovery, we chose a narrative-in-action approach for this study, building on narrative theory and methodology (Bruner, 1990; Mattingly, 1998; Ricoeur, 1983, 1986), and the work of Alsaker and Josephsson, and their colleagues (Alsaker & Josephsson, 2010; Alsaker et al., 2009; Josephsson & Alsaker, 2014). This qualitative, ethnographic approach focuses on exploring how individuals make meaning through what they do, when, where and with whom.

Recruitment of participants

The first author contacted the three community mental health centres in an urban municipality in Norway. These centres are run by the municipality and serve as local meeting places for individuals with mental health challenges. Here people can stop by to spend time with others and engage in activities organized by both service users and staff, such as meals, art-groups and physical activity. The centres invited the first author to inform about the study and call for participants at their house meetings, as well as through written information on their notice board. We called for participants who experience mental health challenges affecting their daily lives, who were currently living at home in the community, and who were interested in creating knowledge about mental health and everyday living. Individuals interested in participating in the study were encouraged to contact the first author, either directly or through the staff at the centre. Two men and two women, all in their 40 s or 50 s, contacted the first author willing to participate in the study. Before starting data generation, the participants signed written consent forms.

Data generation

The data in this study was co-created by the participants and the first author, following recommended guidelines provided in the literature on ethnography (Fangen, 2004; Hammersley & Atkinson, 2007). The first author met with each participant 7–8 times, over a period of 6–8 months. Each meeting lasted from 2 to 4 hours while doing everyday activities suggested by the participants. Several of these meetings took place at the community mental health centres, other meetings took place while doing activities such as working out at the gym, hiking in the woods,

or drinking coffee and talking at home. Before and after each meeting, the first author wrote field notes describing her preparations and preunderstandings, the contexts, events and conversations taking place during the meeting, and her analytical reflections after the meeting. These texts, in total about 49,500 words, formed the data material.

Data analysis

We analysed the data using a narrative, phenomenological-hermeneutic approach (Josephsson & Alsaker, 2014; Polkinghorne, 1995). In narrative analysis, the researchers seek to develop or discover plots that displays a linkage between different data elements and how they together make meaning as contributors to goals or purposes (Polkinghorne, 1995, p. 15). We used the narrative understanding of recovery described in our introduction as an analytical framework, guiding our focus and interpretations.

During the process of analysis, all three authors met on several occasions to discuss preliminary findings and interpretations. To begin the analysis, the first and third author read the field notes to get an overview of the data material. The first author then reread the field notes several times, searching for events that raised curiosity or questions related to the aim of the study. Such puzzling parts of the data material may function as "significant events" (Mattingly, 1998), uncovering possible plots (Josephsson & Alsaker, 2014). As an example, Sandra's story about how she suddenly overcame her anxiety and became active at the community mental health centre puzzled us. How and why did this come about? We understood this as a possible significant event and made it the starting point of our analysis.

After having identified possible significant events, the first author read the field notes again, searching for other parts of the data material that seemed connected to them. Following up on our example, we further explored and interpreted Sandra's story about how she became active at the centre by trying out connections with her current situation of being a user-representative and mother, as well as data about her past. Hence, the process of analysis followed the principles of a hermeneutic circle (Gadamer, 1988), expanding our understanding by moving between parts and whole in the data material. Our interpretations were further developed through drawing on narrative theory as mentioned above, as well as relevant research literature about recovery and narrative meaning-making, fulfiling a double hermeneutic spiral of interpretation (Giddens, 1993).

As next step in our analysis, we constructed narratives from these events by pulling them together into stories with a possible emergent plot (Josephsson & Alsaker, 2014). This helped us further develop and communicate the findings and interpretations that we present in this article. The first author then met with each of the participants to present, explain and discuss our findings and interpretations of the data created with them. All four participants stated that the focus of our analysis is relevant and important for them and that they could recognize our interpretations. This improved the validity of our findings. However, it is important to note that the narratives presented here are mainly the authors'. Further, this study explores recovery as it unfolds, hence these are not narratives representing completed processes of recovery. Rather they must be viewed as possible interpretations related to our study aim, grounded in theory and research.

Ethical considerations

The study was approved by the regional committee for medical and health research ethics (approval number: 2013/2410/REK midt), as well as the director of health in the municipality of study. We changed names and details to ensure participant confidentiality. A narrative case study with data from this project is published elsewhere, exploring an everyday event of recovery (Reed et al., 2018).

When generating data through participant observations over time and in everyday situations, we found it important to create open and trusting relationships, but at the same time keeping professional boundaries (Lawlor & Mattingly, 2001). The first author therefore repeated and confirmed the nature and temporality of the relationships with the participants throughout the meetings, keeping the relationships professional. In addition, through working several years in community mental health services the first author has experience in building trusting relationships, communicating and supporting persons with mental health challenges. These experiences assisted the first author's sensitivity and reflexivity regarding the participant–researcher relationship, while being careful not assuming the role of a mental health professional, or "helper", in the conversations and activities shared with the participants.

Findings

We here present our findings, showing how four individuals pursue recovery in their own unique ways. In our interpretation, these individuals seek to create meaning from and through everyday experiences and activities, by using their narrative capacities to try out possible plots through thoughts, everyday activities, and communication. Evident in our findings is how these ongoing processes of recovery are ambiguous and open-ended, as well as how everyday activities involve interplays between places and persons that are essential for these individuals' recovery.

First, we present Brad and our analysis of how his process of recovery seems dependent on organizing and doing everyday activities with others.

Driving thoughts into action through collective meaning-making

Brad is a man in his mid-fifties. He previously lived with his wife and children, worked full-time as an academic, and engaged in volunteer community work. However, some years ago Brad experienced severe mental illness. He now lives alone, receives disability pension and spends several days a week at the community mental health centre. Although Brad is an active contributor in both initiating, organizing and doing activities at the community mental health centre, he also seems to be in search of new possibilities:

> One day while visiting Brad in his apartment, I complemented his view towards a walkway by the river. Brad laughingly replied, "Yes, here I sit in my sofa and watch people rushing by … " Brad confessed that he sometimes feels bored, and that he wishes to become more active. Brad mentioned several activities he would have liked to do, like photographing, political discussion groups and cooking classes. He wished that the community mental health center would offer some of these activities. He also said that he would like to work again, but soon dismissed this idea, saying: "But I would never be able to acquire paid work of my liking, and then I will not feel motivated".

We here understand that Brad is in a process of imagining activities to engage in, that would contribute to becoming more active. Several of the activities Brad mentions are activities he used to engage in before he became ill. Looking back at activities he has previously enjoyed and mastered, he imagines doing some of them again. However, we understand that Brad adjusts his images of future scenarios based on perceived limits and possibilities in his current situation, and consequently chooses not to pursue work as a possibility.

Brad communicates that being active and social are important issues for him, and we therefore wonder if these issues may be possible plots that can connect his active past, with his present activities and images for the future. However, because of the disruptions caused by mental health problems, Brad is unable to engage in the same everyday activities and social networks as before. We understand these disruptions as knots he needs to disentangle, causing tension and suspense, and requiring him to imagine and test new possibilities of being and becoming active. Brad currently seems to rely on the community mental health centre as an arena to do this:

> One day while working out together, Brad told me that he had previously enjoyed attending yoga-classes at the community mental health center. Brad said that he wished to invite a yoga-instructor to the center again. However, seeming discouraged Brad underlined that he is not able to make such initiatives entirely on his own. He told me that he would need help and motivational support from the staff, but they had not provided this … Although Brad was unhappy about this, he sighed and said, "Without the center I do not know what I would do".

Brad here describes that he needs someone to share his idea with, who also takes initiatives to organize and engage in yoga together with him. We understand that Brad recognizes the community mental health centre as a safe place where such interplays may come about. However, Brad's initiative to engage the staff in yoga was unsuccessful, seemingly leaving him unable to drive this idea into action. Thus, Brad's process of trying out yoga is currently in suspense, awaiting the contributions of the staff at the centre to tie up this loose end. We understand that although Brad imagines possibilities for becoming more active, he needs the shared enthusiasm and active engagement of others to drive his ideas into action. Thus, Brad's process of meaning-making seems to unfold not simply through imagining and trying out activities, but through engaging in activities that involve interplay with others where they try out ideas and activities together, and thereby create meaning collectively.

In the next section, we present Carl, and our analysis of how recovery requires engagement in activities, places and interactions significant to his unique process of narrative meaning-making.

Pursuing work as an architect—narrative meaning-making in suspense

Carl is a man in his late forties. Soon after finishing many years of architectural studies, he experienced serious mental illness that disrupted his plans of working as an architect. Carl has now been ill for more than ten years. He leads a busy life, engaging in activities at the community mental health centre and in a religious community. Through our analysis, we noticed that Carl often makes use of his architectural knowledge and abilities in present everyday activities, such as in the art-group. "*The architect in me is visible in my pictures*", he told the first author. The first author also observed that others often talk about, make use of, and praise Carl for his architectural knowledge, in our understanding thus assisting Carl in enacting a role of being an architect. We understand that this role helps connect Carl's past, present and future activities and that it is a potential plot of narrative meaning that several persons share and enact through activities and interplays at the centre. However, presenting new challenges and perhaps possibility to recover further, Carl imagines working in the future:

> During one of our meetings, one of the participants in the art group said to Carl; "I heard that you registered an individual enterprise recently. What does that entail?" Carl confirmed that he had contacted the employment office seeking help to start an enterprise. He was hoping to become engaged in some architectural work. However, he did not quite know how to proceed with this, and said that he would keep receiving support from the employment office.

We found Carl's efforts to start an enterprise quite fascinating. In most of his everyday activities, Carl sought the initiative and support of others, often within mental health arenas. Now he made his own initiatives and sought support elsewhere, trying out possibilities of acquiring work by contacting the employment office and starting an enterprise. We suggest that although the activities and interplays at the centre contribute to Carl's plot of being an architect, they are insufficient for trying out possibilities of finding work. Although the visitors and staff there show their interest and support, they do not engage in work-related activities together with him. Neither do they posit knowledge about architectural work, nor strategic positions within the work market that could contribute to Carl finding work. Acknowledging this, Carl contacts the employment office for support.

However, Carl's efforts to engage in architectural work involved fragile and uncertain dimensions:

> The next time we met, I was curious to hear more about Carl's search for work and asked how things had come about with his enterprise. He smiled and said that not much had happened yet. However, he did have a computer set up with the right architectural programs, and was planning to join an architectural competition, if he could find a work assignment he was interested in doing … I said; 'oh, it sounds like you have most things in place'. Carl seemed hesitant, and replied 'yes, but I might have to set up a home office first … '

These comments of waiting for the right architectural competition, and having to set up an office first, puzzled us. After having started an enterprise together with the employment office, he now seemed left on his own and hesitant to get started. We suggest that Carl lacks opportunities of engaging in activities and places that provide interplays with persons who take part in a collective process of imagining, practicing and negotiating possibilities of work together with him. We propose that, similar to Brad, such interplays are crucial for Carl to continue trying out new possibilities. Therefore, work currently seems unattainable for him, causing him to hesitate and leaving a loose end in Carl's plot. Thus, Carl's process of narrative meaning-making and recovery is still ongoing and in suspense, leaving us with an open ending.

As with Brad, these findings show how everyday activities, places and persons are crucial to narrative meaning-making. Specifically, Carl seems to need activities and interplays through which he can test, practice and negotiate possibilities of finding work. This suggests that in each unique process of narrative meaning-making, some activities, places and persons are particularly significant as contributors.

Next, we attend to Mary and our analysis of how she is trying out several possibilities for narrative meaning-making, underlining how recovery is ambiguous and open-ended.

Working out uncertainties—trying out a plot guiding her in different directions

Mary is a woman in her mid-40 s. As a young adult, she moved to the city to study and then started working as an office assistant. However, after some time Mary experienced mental health problems. She could not manage work anymore and moved back to her hometown to be closer to her family. Currently, Mary lives with her husband. Her parents live nearby, together with her younger brother who has a severe and chronic illness and needs a lot of care.

Throughout her meetings with the first author, Mary often shared her thoughts and wishes about becoming more active and contributing to the society and people around her. Through our analysis, we came to understand that she is currently trying out several possibilities of accomplishing this and that this wish has guided many of her past and current everyday activities, as well as her images for the future:

> While working out at the gym, Mary told me that she would eventually like to acquire regular, paid work. She said, "It is kind of a demand you know, that one should work and make oneself useful". Mary underlined that the money is not that important to her, and further explained, "I try to build trust in the job market through doing volunteer work. However, volunteer work does not demand anything from me, I miss having responsibility. My hope for the future is to acquire paid work within health services".

Drawing on her experiences of volunteer and paid work, Mary currently imagines possibilities of working again in the future. However, throughout her meetings with the first author, Mary expressed her thoughts and doubts about how to tie together her visions of working with her past and present experiences of mental illness. What would she be able to do? How would working again affect her mental health? Who should she make contact with? Nonetheless, Mary showed and told about engaging in activities that may lead her to become part of the workforce. She was reading literature about health, taking on assignments of both paid, volunteer and charity work, and contacting possible employers. Additionally, Mary mentioned having to regain trust from the job market, suggesting that being let back into the workforce may necessitate negotiations with

others. Exemplifying such negotiations, Mary told the first author about her experiences of working in restaurants:

> While continuing our workout, Mary told me that she had tried working in restaurants several times. However, she had received feedback on her strengths and limitations from her work leaders and had concluded that working in restaurants was not for her. "I work too slowly", she said.

Hence, working in restaurants and receiving concrete response from others has caused Mary to deliberate what she is able to do. She seems to agree with these work leaders, admitting that she works too slowly. Accordingly, she adjusts her images for the future, concluding that working in restaurants is not for her. However, despite having to do some trying and failing, negotiations and adjustments, Mary continues her activities of contacting possible employers and taking on volunteer and charity work. Hence, we understand that being an active and contributing person is very important for Mary and that through both thoughts, activities and communication with others concerning work, she is currently trying this out as a plot for narrative meaning-making.

Although Mary seemed very intent on working in the future, she also expressed a strong wish to focus on family matters. Her parents were getting older and would eventually need help taking care of her brother. Mary told the first author that she pondered a lot about whether she should prioritize work or caring for her brother in the future or if it is possible to combine these activities. Both taking care of her brother and acquiring work are future images that we understand may create narrative meaning for Mary, by building on her experiences of work and family life and providing possibilities of being an active and contributing person. Thus, we associate her process of narrative meaning-making with tracing a thematic thread that is frizzled, and which guides her in several possible directions. Mary does not know which strands will lead way further along the thread, and which strands may lead to a loose end. Thus, Mary seems to linger in a process of imagining future possibilities, trying them out through activities and interactions, but then withdrawing again, not yet knowing how to create a working narrative.

Similar to both Brad and Carl, Mary's ongoing process of narrative meaning-making requires interplay and negotiations with significant persons and places, such as workplaces and employers. Further, Mary imagines several, and somewhat competing, everyday activities that could help create meaning, not knowing which activities will eventually connect her experiences into a coherent narrative. This underlines how ongoing processes of recovery are ambiguous and open-ended.

Lastly, we will attend to Sandra, and our analysis of how her images of what is important to her, drove and guided her everyday activities and contributed to a process of recovery.

From anxious passivity to user representative—recovery driven by the plot of caring for others

Sandra is a woman in her 40 s, whom the first author met with several times at one of the community mental health centres in the city. In one meeting, the first author commented to Sandra that she stood out as a resourceful and active person at the centre. Sandra confirmed this, but added that it had not always been like this and then told the story about how she became active at the centre:

> I have experienced anxiety my whole life. My boyfriend of many years, Tim, thought it would be good for me to go the community mental health center. However, I refused, as I did not dare to go. One day as we were going shopping, Tim told me that he had to run an errand at the center, and that I would have to wait for him there. I waited in in the salon, where I sat quietly, looking down at the floor, listening to the conversations going on around me. As I sat there, I heard people talk about their illnesses, use of medications and their side effects, as well as experiences of hospitalization. Listening to these conversations, I thought about how important it is for me to be able to take care of my kids. In fear of losing this ability, I decided never to become so severely ill that I would have to go through such experiences. Consequently, I suddenly got up from the sofa, walked decidedly into the kitchen, and asked the staff if I could help them. In the years to come, I gradually took on new tasks and responsibilities at the center. Having been active at the center for more than ten years, I now serve as a user representative, organize activities, and support others at the center.

Sandra's story about how she became active at the centre intrigued us. How was she suddenly able to defy her anxiety and get up from that sofa? Throughout our meetings, Sandra repeatedly underlined how important it is for her to care for her children. She also told several stories about caring for relatives, friends and neighbours both in her past and in present. Hence, caring for others seemed to be an important issue for Sandra. Through analysing Sandra's story, we understand that she imagined how a worsened mental health could disrupt her ability to take care of her kids and that these upsetting images provided Sandra with motivation to act. Further, based on her previous experiences of caring for others, Sandra had faith in the recovering potential of helping at the centre. This idea of how to get better drove her to get up from the sofa and offer her help to the staff. Thus, at the time of these events, we understand her wish of caring for others as a plot, which drove and guided her activities at the centre.

For Sandra, being able to take care of others was so important, that despite her anxiety she was able to

engage in a range of activities to preserve this ability. This shows how powerful individuals' images of how to create narrative meaning may be as driving forces for activities and recovery. However, Sandra also praised her boyfriend and the staff, underlining how their involvement had been essential for her engagement in activities at the centre. We understand that through their encouragement and actions, they nurtured Sandra's hope and drive to act, and offered possibilities for Sandra to try out activities through which she could both care for others and get better herself. Thus, several significant persons contributed to the ongoing narrative of Sandra getting well and preserving her caring abilities, and their shared activities at the centre contributed to create meaning and support her recovery.

Discussion

Guided by a narrative understanding of recovery (P. E. Deegan, 2002; Mattingly, 1998; Roe & Davidson, 2005), the aim of this study was to explore how mental health recovery unfolds through individuals' engagement in everyday activities. Through our narrative analysis we gained in-depth, processual and contextual knowledge about four unique processes of recovery. Our findings show how both Brad, Carl, Mary and Sandra use their past and present experiences from everyday activities as resources to imagine and try out plots that may support narrative meaning and thereby movement in the process of recovery. Our findings render recovery as ambiguous and open-ended processes of narrative meaning-making, enacted through everyday activities that involve interactions with others, adding to similar findings in other studies (Lindström et al., 2013; Mattingly, 1998; Ulfseth et al., 2015, 2016). Emerging from our analysis, we would like to explore further how we may understand processes of narrative meaning-making in recovery as collective, as well as discuss possible implications for practice based on our findings.

Our findings show how everyday activities put individuals in touch with places and persons. Further, they show how through doing activities together, several individuals share ideas and initiatives, give response to each other, and thereby negotiate and try out possible plots together. In light of these findings, and supported by Bruner's (1990) writings about "social meaning readiness", we suggest that engaging in everyday activities with others involves collective processes of narrative meaning-making. As an example, through the initial actions of her boyfriend, and after offering her help, Sandra came in touch with the community mental health centre and the persons there. For Sandra, persons around her seemed to understand and support her plot of caring for others and therefore provided her with opportunities of engaging in activities and interplays that aligned with this plot. Another example is how Mary, while trying out the plot of being an active and contributing person, engaged in work-related activities that implied interactions and negotiations with both current and possible workplaces and employers. These interplays contributed to adjust and guide her further images and actions, thereby enabling her to continue engaging in a process of narrative meaning-making. Thus, these findings suggest that narratives of recovery are assembled by a myriad of connected contributors and events, including everyday activities, the interactions and contributions of several persons, as well as the places accommodating these activities. Both Duff (2016) and Price-Robertson et al. (2017) underline that interpersonal and contextual conditions are crucial components in mental health recovery, and everyday activities (Doroud et al., 2015), relationships (Tew et al., 2012; Topor et al., 2006) and places (Duff, 2012; Myers, 2016) have already been documented as important dimensions in recovery. However, based on our findings we conclude that these are not just components but also active and crucial contributors to recovery. Mental health recovery unfolds beyond the individual's efforts; processes of recovery are unique—but not individual.

Further, our findings underline how there seems to be certain activities, places and persons that are crucial as contributors in each unique process of narrative meaning-making. These findings are also supported by Duff (2012), who concludes that a place that is enabling for one individual, may not be enabling for another. Unfortunately, relevant contributors may not always be available or in agreement on what possibilities to try out, leaving the process of narrative meaning-making complicated or stranded. An example from our findings is how Carl needs to engage in activities that put him in touch with places and persons that are significant for trying out possibilities of acquiring work. However, currently, he seems left on his own without possibilities of such interplays, causing a halt in his process of narrative meaning-making. Another example is how Brad asks the staff at the community mental health centre to engage with him in organizing yoga-classes, but experiences that they do not respond positively to his initiative, leaving his process of trying out this activity stranded. Professionals are encouraged to promote individuals' drive to act, through inspiring their belief in possibilities of recovery, to imagine recovery narratives, and to have faith in their own abilities to affect their future (P. E. Deegan, 2002). However, our findings of how recovery processes are dependent on the active engagement of several contributors make us wonder: Is it possible to facilitate the collective imagination, hope and enactment of narratives of

recovery? Are there efforts professionals could make to locate and inspire several of the crucial contributors in each unique process of recovery?

We do not have any clear answers to these questions. However, based on our findings we understand that facilitating such collective processes demands specific and contextual knowledge about the unique process at hand, implying close collaboration between individuals involved, both service users, professionals and others. Further, it demands creativity: imagining and trying out how new activities, places and persons can contribute to each particular process of meaning-making. In Brad's case, for example, this collective process seems to have stranded, as the staff at the centre has not responded to his initiatives. Important concerns in this case could be to find out how to facilitate interplays that help Brad proceed. Are there other persons or places he can approach that would engage in trying out yoga with him? Alternatively, are there other activities he could try out, that would engage others at the centre more easily? Similarly, in Carl's case, what places and persons could take part in trying out possibilities of working? Would it be helpful to contact a person who is an architect, and who could engage in work-related activities with Carl? Would a company be willing to take him in as a trainee? Both Myers (2016) and Duff (2012) similarly suggest that mental health professionals may have a role in helping individuals gain access to, or cultivate, local places and interplays which may contribute to processes of recovery. Myers (2016) also underlines that to acquire the opportunities needed to recover, individuals may have to move beyond professionalized mental health arenas and to other arenas such as religious communities, employment or education settings, or family and peer-networks. In the recent years, new arenas focusing on coproduction of mental health services have emerged, such as recovery colleges (Newman-Taylor et al., 2016) and clubhouses (Chen, 2017; Tanaka & Davidson, 2015). These organizations are run by students/members and professionals together and seek to create meaning and movement in people's everyday lives through collective activities such as teaching courses and work projects. While carrying out their collective projects clubhouses tailor tasks and activities to their members' personal pursuits and talents to elicit movement in their process of recovery (Chen, 2017). Further, through their collaboration with other organizations in the community, these arenas offer possibilities of creating relationships between members and persons and arenas outside the clubhouse that are valuable to collective recovery (Crowther et al., 2019). Thus, clubhouses offer both arenas of engaging in collective activities, as well as pursuing personal goals and wishes through specific activities, relationships and arenas relevant to each unique recovery process, and may be very valuable in facilitating collective recovery processes such as the ones we have presented in this article.

Methodological considerations

In this study, we chose to create data through participant observations, which allows for rich and contextual knowledge by collecting data through several meetings, situations and over time (Fangen, 2004). We assessed writing field notes to be the most suited way to record contextual, action-focused data, and therefore chose not to tape-record the meetings. However, doing activities trigger imagination and associations, allowing for spontaneous conversations relevant to current activities and situations. Therefore, when analysing and interpreting the data we explored the first author's notes on both what was done and said during the meetings.

In ethnography researchers cannot avoid having an effect on the phenomena we study (Hammersley & Atkinson, 2007), therefore, reflexivity regarding our impact on the data, analysis and interpretations is important. Hammersley and Atkinson (2007) suggest that rather than trying to eliminate the effects of the researcher, we should try to understand and exploit them. The first author created the data together with the participants, and participant–researcher interactions and conversations were analysed by all authors as part of the data-material. On occasion, the first author influenced the focus and richness of the data by inviting conversations relevant to our study aim. The authors' sought to remain open and curious about the unique situations of the participants both during data creation and analysis. However, theoretical and empirical knowledge, as well as our professional experience as mental health workers and occupational therapists, inspired and informed our analysis and interpretations.

When searching for connections between different parts of the data material with a narrative orientation as we did in our analysis, it is important to remain open to the ambiguity and uncertainty of one's interpretations (Hammersley & Atkinson, 2007). As our findings show, we explored contradictions in our data material, discovering how unfolding processes of recovery are permeated with both complexity and uncertainty, allowing for many different narrative possibilities and interpretations. We engaged in a systematic analytical process of writing field-notes, reading and discussing the field notes in the research group, drawing on theoretical and empirical knowledge, and discussing findings and interpretations in the research group as well as with the participants. We communicate this process thoroughly in this article, making it as transparent as possible, and argue that our findings and interpretations may be recognizable and of value to others. However, we underline that our interpretations are only some of many possible.

This is a study with only four participants, providing in-depth knowledge related to its aim. We suggest more research is needed to nuance and deepen further our processual and contextual knowledge about mental health recovery.

Conclusion

Building on narrative theory we have argued that individuals create meaning through their activities and that such meaning-making processes offer possibilities of transformation and recovery. We therefore chose to focus on everyday activities in this study, and by use of a narrative-in-action approach, we have created processual and contextual knowledge showing how doing everyday activities opens possibilities of creating meaning and recovery together with others. This study is important as it answers to a reported lack of processual and contextual knowledge about how mental health recovery is interrelated with doing everyday activities (Doroud et al., 2015; Duff, 2016; Ellison et al., 2018; Price-Robertson et al., 2017; Topor et al., 2011).

To conclude, our analysis, interpretations and discussion have shown how recovery unfolds as unique, open-ended and collective processes of trying out plots that may contribute to narratives of recovery. In line with this conclusion, we suggest that a focus on person-centred services (Davidson et al., 2017; Reed et al., 2017) should be supplied with activity-based and coproduction-oriented services when supporting recovery.

We suggest that furthering our understanding of mental health recovery requires methods such as the one applied here, as it accommodates the complexity and uncertainty of these processes. An interesting focus for future research would be to continue exploring mental health recovery as collective processes, seeking more knowledge about how we can facilitate such processes.

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Appendices

Appendix 1: Interview guide, Study I

Psykisk helse – innflytelse og deltakelse i hverdagen

Individuelle intervju - spørsmål til ansatte

Bakgrunnsopplysninger

Omtrentlig Alder?

Yrke/utdanning?

Omtrent hvor lenge har du jobbet i …?

Del 1, Hovedtema: hva gjør dere (ansatt) og hvordan samarbeider dere (bruker/ansatt)

Kan du fortelle om hva du gjør i det daglige samarbeidet med brukerne gjennom konkrete beskrivelser? Tenk gjerne over/let fram eksempler som du husker og fortell utfra dette.

Oppfølgingsspørsmål:

Hvor og hvor lenge er dere sammen?

Hvilke aktiviteter gjennomfører dere sammen, og hvilke aktiviteter gjennomfører du/dere eventuelt på egen hånd under møtene?

Hva mener du er viktig i samarbeidet med brukerne / i møte med brukerne?

Hvordan foregår planleggingen av møtene med tanke på aktivitet, sted og tid? Kom gjerne med eksempler.

Hvem tar avgjørelsene og eventuelt hvilke ytre begrensninger og muligheter styrer hvordan møtene forløper?

Del 2, Tema: innflytelse

Hvordan kan du legge til rette for at brukerne skal ha innflytelse på og i egen hverdag? Kom gjerne med eksempler.

Er det noe du skulle ønske du kunne gjøre for å fremme brukernes innflytelse som du ikke har mulighet eller anledning til? Hvorfor er dette vanskelig?

Appendix 1: Interview guide, Study I

Del 3, Tema: deltakelse

Hvordan kan du legge til rette for at brukernes deltakelse i hverdagsaktiviteter i nabolag og lokalsamfunn? Kom gjerne med eksempler fra ditt arbeid.

Hvem samarbeider du/dere eventuelt med?

Er det noe du skulle ønske du kunne gjøre for å fremme brukernes deltakelse som du ikke har mulighet eller anledning til? Hvorfor er dette vanskelig?

Del 4, Tema: utfordringer og dilemmaer

Møter du noen utfordringer og dilemmaer i samarbeidet med brukerne? Kom gjerne med eksempler.

Kan du fortelle hvordan dere løser disse utfordringene og dilemmaene?

Del 5, Tema: muligheter og begrensninger

Er det noe du skulle ønske du kunne gjøre som du ikke har mulighet eller anledning til?

Hva tenker du om framtiden og arbeidet dere gjør?

Er det noe mer du ønsker å si eller fortelle om før vi avslutter?

Appendix 1: Interview guide, Study I

Mental health – influence and participation in everyday life

Individual interview – questions for staff

Background information

Approximate age?

Profession?

For how long have you worked in this unit?

Part 1, main theme: What do you do, and how do your collaborate with users?

Can you tell me about what you do in your work, and how you collaborate with users? If you can, please think about some examples which you remember and provide an answer based on these.

Questions for elaboration:

Where and for how long are you together?

What activities do you do together, and what activities do you engage in on your own in the meetings?

What do you feel is important in your collaboration with the users?

How does the planning of the meetings unfold concerning activity, place and time? Please provide examples if you can.

Who make the decisions, and which contextual possibilities and hindrances inflict on how these meetings unfold?

Part 2, theme: influence

How can you facilitate users' influence in their own everyday life? Please provide examples if you can.

Is there anything you wish you could do to facilitate users' influence which you do not have the opportunity to do? Why is this difficult?

Appendix 1: Interview guide, Study I

Part 3, theme: participation

How can you facilitate users' participation in everyday activities in neighborhoods and local communities? Please provide examples if you can.

Do you collaborate with someone?

Is there anything you wish you could do to facilitate users' participation which you do not have the opportunity to do? Why is this difficult?

Part 4, Theme: challenges and dilemmas

Do you experience any challenges or dilemmas in your collaboration with users? Please provide examples if you can.

Can you describe how you solve these challenges and dilemmas?

Part 5, Theme: possibilities and limitations

Is there anything you wish you could do which you do not have the opportunity to do?

What do you think about the future and the work you do?

Is there anything else you wish to say before we conclude?

Appendix 2: Written information and consent-form, study I

Psykisk helse – innflytelse og deltakelse i hverdagen. Oktober 2015
Informasjon, forespørsel og samtykke – intervju ansatte.

Til ansatte

Forespørsel om deltakelse i forskningsprosjektet «Psykisk helse - innflytelse og deltakelse i hverdagen»

Bakgrunn og hensikt

Dette er en forespørsel til deg om å delta i en forskningsstudie for å være med å utvikle ny kunnskap om hvordan samarbeid mellom brukere og hjelpere kan bidra til økt innflytelse og deltakelse i hverdagslivet for brukere av psykisk helsetjeneste.

Mange mennesker som lever med utfordringer i forhold til sin psykiske helse erfarer også utfordringer i eget hverdagsliv. Betydningen av å kunne ha tilgang til ulike former for støtte i hverdagen framheves i eksisterende forskning. Det understrekes at denne form for støtte må tilpasses den enkelte bruker og de omgivelser hvor vedkommende lever, samt at brukernes innflytelse i egen hverdag og deltakelse må ivaretas.

Det synes på bakgrunn av dette å være behov for å utvide kunnskapen om hverdag og psykisk helse. Samtidig synes det vesentlig få fram mer kunnskap om hvordan dialog og samarbeid mellom brukere og hjelpere foregår på dette området, slik at støtte og andre tiltak kan lykkes.

Hva innebærer studien?

Vi spør deg nå om en forsker kan få møte deg til et intervju med varighet inntil 1 time om hva du gjør i det daglige samarbeidet med hjelper/bruker. Hva består samarbeidet i og hvordan foregår det i ulike aktiviteter? Tenk gjerne over eksempler på samhandling som du husker og fortell utfra dette. Vi spør og om forskeren kan gjøre lydopptak av intervjuene.

Mulige fordeler og ulemper

Denne studien vil ikke påvirke deltakers helse og eventuelt ubehag vil trolig være lite. Vi vil gjøre avtale med deg på forhånd, også om hvorvidt du samtykker til lydopptak i intervjuene. Dersom du synes det er greit at vi gjør lydopptak, vil du på ethvert tidspunkt kunne be om at dette blir stoppet, noe vi da vil gjøre umiddelbart. Vi vil da gå over til å gjøre skriftlige notater.

Appendix 2: Written information and consent-form, study I

Psykisk helse – innflytelse og deltakelse i hverdagen. Oktober 2015
Informasjon, forespørsel og samtykke – intervju ansatte.

Dersom du synes at noen av spørsmålene er for direkte eller upassende trenger du ikke svare. For å ivareta din anonymitet i studien, vil vi gjøre alt vi kan for å sikre at ingen informasjon som du gir kan spores tilbake til deg spesielt.
Deltakelse i studien vil ikke utløse noen økonomiske fordeler eller ulemper for deg. Din deltakelse vil imidlertid bidra til å utvikle kunnskap om de tjenester du er en del av, og dermed bidra til kvalitetssikring.

Hva skjer med informasjonen om deg?
Informasjonen som registreres om deg skal kun brukes slik som beskrevet i hensikten med studien. Alle opplysningene vil bli behandlet uten navn og fødselsnummer eller andre direkte gjenkjennende opplysninger. En kode knytter deg til dine opplysninger gjennom en navneliste.

Det er kun autorisert personell knyttet til prosjektet som har adgang til navnelisten og som kan finne tilbake til deg. Det vil ikke være mulig å identifisere deg i resultatene av studien når disse publiseres.

Frivillig deltakelse
Det er frivillig å delta i studien. Du kan når som helst og uten å oppgi noen grunn trekke ditt samtykke til å delta i studien. Dersom du ønsker å delta, undertegner du samtykkeerklæringen på siste side.

Dersom du senere ønsker å trekke deg eller har spørsmål til studien, kan du kontakte:

Prosjektleder: Nina Petersen Reed, PhD-student, tlf. mobil 93824696 eller jobb 73412752,
E-post: nina.p.reed@hist.no, HiST, FHS.

Eller

Prosjektansvarlig: Sissel Alsaker, PhD, førsteamanuensis, ergoterapeut, tlf. mobil 952 01 475 eller jobb 73 41 22 68, E-post: Sissel.Alsaker@hist.no, HiST-FHS (Høgskolen i Sør-Trøndelag, Fakultet for Helse- og Sosialfag).

Appendix 2: Written information and consent-form, study I

Psykisk helse – innflytelse og deltakelse i hverdagen. Oktober 2015
Informasjon, forespørsel og samtykke – intervju ansatte.

Samtykke til deltakelse i studien

Jeg er villig til å delta i studien

(Signert av prosjektdeltaker, dato)

Jeg bekrefter å ha gitt informasjon om studien

(Signert, rolle i studien, dato)

Appendix 2: Written information and consent-form, study I

Psykisk helse – innflytelse og deltakelse i hverdagen. Oktober 2015
Informasjon, forespørsel og samtykke – intervju ansatte.

To staff

Requesting participants in research project

«Mental health – influence and participation in everyday life»

Background and aim

This is a request for you to participate in a research project with the aim of developing new knowledge about how collaboration between users and helpers can contribute increased influence and participation in everyday life for users of mental health services.

Many individuals who experience challenges related to their mental health also experience challenges in everyday life. The significance of having support available in everyday life is accentuated in existing research. It is underlined that this support needs to be personally adjusted, as well as adjusted to each person's everyday contexts, and that the users influence and participation in everyday life should be ensured.

Thus, there is a need to develop our knowledge about everyday life and mental health. At the same time, it seems essential to develop more knowledge about how dialogue and collaboration between users and helpers unfold in this area, so that support and services can succeed.

What does the study imply?

We ask you if a researcher can meet you for an interview lasting up to 1 hour about what you do in your daily collaboration with users. What does your work entail, and how does it unfold through different activities? We would appreciate if you can think of some situations of collaboration which you remember and tell us about these issues based on these experiences. We also ask if the researcher can audio-record the interviews.

Possible benefits and inconveniences

This study will not affect the participants health, and any discomforts will probably be minor.

Appendix 2: Written information and consent-form, study I

Psykisk helse – innflytelse og deltakelse i hverdagen. Oktober 2015
Informasjon, forespørsel og samtykke – intervju ansatte.

We will make an appointment with you in advance, including whether you consent or not to audio-recordings. If your consent to audio-recordings, we will stop these at any time by your request. We will then write notes instead. If you think some of the questions are to direct or inappropriate you do not have to answer. To ensure your anonymity in the study, we will do anything we can to make sure no information you provide can be traced back to you.

Participation in the study will not result in any economic benefits or inconveniences for you. Your participation will contribute knowledge about the services you are part of and thus contribute quality assurance.

What will happen with the information about you?

The information registered about you will only be used as described in the aim of the study. All information will be stored without names, identification numbers or other recognizable details. A code will tie you to your information in a list of participants. Only persons registered as researchers in this project will have access to this list and have the opportunity to reach back to you. It will not be possible to identify you in the results when the study is published.

Voluntary participation

It is voluntary to participate in the study. You can at any time, and without providing a reason, withdraw your consent of participation in the study. If you wish to participate, please sign the consent form on the last page.

If you later wish to withdraw, or have any questions concerning the study, please contact:

Project manager: Nina Petersen Reed, PhD-student, Cellphone: 93824696, at work: 73412752, E-mail: nina.p.reed@hist.no, HiST, FHS.

Or

Project supervisor: PhD, Assistant professor and occupational therapist, cellphone: 952 01 475, at work: 73 41 22 68, E-mail: Sissel.Alsaker@hist.no, HiST-FHS (Høgskolen i Sør-Trøndelag, Fakultet for Helse- og Sosialfag).

Appendix 2: Written information and consent-form, study I

Psykisk helse – innflytelse og deltakelse i hverdagen. Oktober 2015
Informasjon, forespørsel og samtykke – intervju ansatte.

Consent to participate in the study

I am willing to participate in the study

(Signed by participant, date)

I confirm that I have provided all crucial information about the study

---
(Signed by researcher, role in research team, date)

Appendix 3: poster with information about the study

NTNU

Kunnskap for en bedre verden

Hei!

Jeg er doktorgradsstipendiat ved program for psykisk helsearbeid ved NTNU, og arbeider med et forskningsprosjekt som heter «Psykisk helse - innflytelse og deltakelse i hverdagen».

Det jeg ønsker å finne ut mer om er hvordan du håndterer ditt dagligliv med de utfordringer du opplever knyttet til din psykiske helse.

For å få et innblikk i dine erfaringer vil jeg gjerne snakke med deg, samtidig som jeg deltar sammen med deg i de ærender eller aktiviteter som du bruker å holde på med til daglig. Jeg kan for eksempel bli med deg på handletur, fritidsaktiviteter, turgåing, eller delta under matlaging og annet husarbeid.

Dersom du er interessert i å delta, eller ønsker mer informasjon om prosjektet, kan du kontakte meg direkte på telefon, sms eller e-post. Du kan også ta kontakt med personalet ved treffstedet.

Med vennlig hilsen,

Nina Petersen Reed.

Telefon: 938 24 696 / E-post: nina.p.reed@ntnu.no

Nina Petersen Reed Tlf 93824696 E-post: nina.p.reed@ntnu.no	Nina Petersen Reed Tlf 93824696 E-post: nina.p.reed@ntnu.no	Nina Petersen Reed Tlf 93824696 E-post: nina.p.reed@ntnu.no	Nina Petersen Reed Tlf 93824696 E-post: nina.p.reed@ntnu.no	Nina Petersen Reed Tlf 93824696 E-post: nina.p.reed@ntnu.no	Nina Petersen Reed Tlf 93824696 E-post: nina.p.reed@ntnu.no	Nina Petersen Reed Tlf 93824696 E-post: nina.p.reed@ntnu.no	Nina Petersen Reed Tlf 93824696 E-post: nina.p.reed@ntnu.no	Nina Petersen Reed Tlf 93824696 E-post: nina.p.reed@ntnu.no	Nina Petersen Reed Tlf 93824696 E-post: nina.p.reed@ntnu.no

Appendix 3: poster with information about the study

NTNU
Kunnskap for en bedre verden

Hello!

I am a PhD-student at the program for mental health work at NTNU, and I am working on a research project called «Mental health – influence and participation in everyday life».

What I wish to explore is how you lead your everyday life considering the mental health challenges you experience.

To learn more about your experiences I wish to talk with you while I participate with you in the errands or activities you usually do in your daily life. I can for instance join you while shopping, doing leisure activities, go hiking or participate during cooking or other domestic errands.

If you are interested in participating, or wish more information about the project, please contact me directly by phone, text-message or e-mail. You can also contact the employees at the community mental health center.

Kind regards,

Nina Petersen Reed.

Telefon: 938 24 696 / E-post: nina.p.reed@ntnu.no

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Appendix 4: Written information and consent-form, Study II

Psykisk helse – innflytelse og deltakelse i hverdagen. Januar 2016
Informasjon, forespørsel og samtykke – deltakende observasjon, brukere.

Til brukere

Forespørsel om deltakelse i forskningsprosjektet

«Psykisk helse - innflytelse og deltakelse i hverdagen»

Bakgrunn og hensikt

Dette er en forespørsel til deg om å delta i en forskningsstudie for å være med å utvikle ny kunnskap om hvordan samarbeid mellom brukere og hjelpere kan bidra til økt innflytelse og deltakelse i hverdagslivet for brukere av psykisk helsetjeneste.

Mange mennesker som lever med utfordringer i forhold til sin psykiske helse erfarer også utfordringer i eget hverdagsliv. Betydningen av å kunne ha tilgang til ulike former for støtte i hverdagen framheves i eksisterende forskning. Det understrekes at denne form for støtte må tilpasses den enkelte bruker og de omgivelser hvor vedkommende lever, samt at brukernes innflytelse i egen hverdag og deltakelse må ivaretas.

Det synes på bakgrunn av dette å være behov for å utvide kunnskapen om hverdag og psykisk helse. Samtidig synes det vesentlig få fram mer kunnskap om hvordan dialog og samarbeid mellom brukere og hjelpere foregår på dette området, slik at støtte og andre tiltak kan lykkes.

Hva innebærer studien?

Vi spør deg nå om en forsker kan være tilstede ved planlagte besøk/aktiviteter mellom deg og din kontakt i … . Samtykke vil også innhentes fra tjenesteyteren. Hvis du tillater det ønsker vi også at forsker kan delta alene med deg i enkelte av dine hverdagssituasjoner, for eksempel besøke deg i hjemmet ditt eller være sammen med deg i andre hverdagssituasjoner/aktiviteter som du velger å dele med oss. Forskeren ønsker å være sammen med deg 6-10 ganger i 1-2 timer over en periode på ca. tre måneder. Dette vil bli avtalt med deg for hver gang.

Mulige fordeler og ulemper

Denne studien vil ikke påvirke bruker eller hjelpers helse, og eventuelt ubehag vil trolig være lite. Vi vil gjøre avtale med deg på forhånd i telefon eller e-post. Forskeren vil ikke notere eller gjøre opptak i disse situasjonene, men gjøre notater etter at dere har avsluttet samværet.

Appendix 4: Written information and consent-form, Study II

Dersom du synes at noe av det som blir berørt i samværet er for direkte eller upassende sier du fra om det og vi samarbeider videre. For å bevare din anonymitet i studien, vil vi gjøre alt vi kan for å sikre at ingen informasjon som du gir kan spores tilbake til deg spesielt.

Deltakelse i studien vil ikke utløse noen økonomiske fordeler eller ulemper for deg. Din deltakelse vil imidlertid bidra til å utvikle kunnskap om de tjenester dere begge er en del av, og dermed bidra til kvalitetssikring.

Hva skjer med informasjonen om deg?
Informasjonen som registreres om deg skal kun brukes slik som beskrevet i hensikten med studien. Alle opplysningene vil bli behandlet uten navn og fødselsnummer eller andre direkte gjenkjennende opplysninger. En kode knytter deg til dine opplysninger gjennom en navneliste.

Det er kun autorisert personell knyttet til prosjektet som har adgang til navnelisten og som kan finne tilbake til deg. Det vil ikke være mulig å identifisere deg i resultatene av studien når disse publiseres.

Frivillig deltakelse
Det er frivillig å delta i studien. Du kan når som helst og uten å oppgi noen grunn trekke ditt samtykke til å delta i studien. Dersom du ønsker å delta, undertegner du samtykkeerklæringen på siste side. Dette vil ikke få konsekvenser for din videre kontakt med ansatte i kommunen. Om du nå sier ja til å delta, kan du senere trekke tilbake ditt samtykke uten at det påvirker din øvrige behandling. Dersom du senere ønsker å trekke deg eller har spørsmål til studien, kan du kontakte:

Prosjektleder: Nina Petersen Reed, PhD-student, tlf. mobil 93824696 eller jobb 73412752, E-post: nina.p.reed@ntnu.no, FHS (Fakultet for Helse- og Sosialvitenskap), NTNU.

Eller:

Prosjektansvarlig: Sissel Alsaker, PhD, førsteamanuensis, ergoterapeut, tlf. mobil 952 01 475 eller jobb 73 41 22 68, E-post: Sissel.Alsaker@ntnu.no, FHS (Fakultet for Helse- og Sosialvitenskap), NTNU.

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Psykisk helse – innflytelse og deltakelse i hverdagen. Januar 2016
Informasjon, forespørsel og samtykke – deltakende observasjon, brukere.

Samtykke til deltakelse i studien

Jeg er villig til å delta i studien

(Signert av prosjektdeltaker, dato)

Jeg bekrefter å ha gitt informasjon om studien

(Signert, rolle i studien, dato)

Appendix 4: Written information and consent-form, Study II

Psykisk helse – innflytelse og deltakelse i hverdagen. Januar 2016
Informasjon, forespørsel og samtykke – deltakende observasjon, brukere.

To users

Requesting participants in research project:

«Mental health – influence and participation in everyday life»

Background and aim

This is a request for you to participate in a research project with the aim of developing new knowledge about how collaboration between users and helpers can contribute increased influence and participation in everyday life for users of mental health services.

Many individuals who experience challenges related to their mental health also experience challenges in everyday life. The significance of having support available in everyday life is accentuated in existing research. It is underlined that this support needs to be personally adjusted, as well as adjusted to each person's everyday contexts, and that the users influence and participation in everyday life should be ensured.

Thus, there is a need to develop our knowledge about everyday life and mental health. At the same time, it seems essential to develop more knowledge about how dialogue and collaboration between users and helpers unfold in this area, so that support and services can succeed.

What does the study imply?

We now ask you if a researcher can meet with you for planned visits or activities, perhaps also together with staff at the community mental health center. If needed, consent will also be acquired from the staff. If you consent, we also ask if a researcher can join you in some of your daily situations at home or in other activities and situations you wish to share with us. The researcher wishes to meet you 6-10 times, for the duration of 1-2 hours, in a period of about three months. The appointments will be made as we go along.

Possible benefits and inconveniences

This study will not affect the participants health, and any discomforts will probably be minor. We will make an appointment with you in advance, by phone or e-mail. The researcher will not write notes or audio-record during the meetings, but will write notes after the meetings. If

Appendix 4: Written information and consent-form, Study II

you think some of the questions or issues that come up in the meetings are to direct or inappropriate you should tell the researcher and we will move away from that subject. To ensure your anonymity in the study, we will do anything we can to make sure no information you provide can be traced back to you. Participation in the study will not result in any economic benefits or inconveniences for you. Your participation will contribute knowledge about the services you are part of and thus contribute quality assurance.

What will happen with the information about you?

The information registered about you will only be used as described in the aim of the study. All information will be stored without names, identification numbers or other recognizable details. A code will tie you to your information in a list of participants.

Only persons registered as researchers in this project will have access to this list and have the opportunity to reach back to you. It will not be possible to identify you in the results when the study is published.

Voluntary participation

It is voluntary to participate in the study. You can at any time, and without providing a reason, withdraw your consent of participation in the study. If you wish to participate, please sign the consent form on the last page. Your participation in this study will have no affect on your further contact with the staff in the municipality. If you now consent to participate, you can withdraw later without any consequences. If you later wish to withdraw, or have any questions concerning the study, please contact:

Project manager: Nina Petersen Reed, PhD-student, Cellphone: 93824696, at work: 73412752, E-mail: nina.p.reed@ntnu.no, Institutt for Psykisk Helse, FMH (Fakultet for Medisin og Helsevitenskap).

or

Project supervisor: PhD, Assistant professor and occupational therapist, cellphone: 952 01 475, at work: 73 41 22 68, E-mail: Sissel.Alsaker@ntnu.no, Institutt for Psykisk Helse, FMH (Fakultet for Medisin og Helsevitenskap), NTNU.

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Psykisk helse – innflytelse og deltakelse i hverdagen. Januar 2016
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Consent to participate in the study

I am willing to participate in the study

(Signed by participant, date)

I confirm that I have provided all crucial information about the study

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(Signed by researcher, role in research team, date)