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Ørjasæter, Kristin Berre

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Thesis for the Degree of
Philosophiae Doctor
Faculty of Medicine and Health Sciences
Department of Public Health and Nursing

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Performing Recovery

Music and Theatre Workshop as an Arena for Recovery Processes

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Sammendrag

Introduksjon: Det har vært en økende interesse for at psykiske helsetjenester tilbyr aktiviteter som fokuserer på ressurser fremfor sykdom og problemer for å støtte mennesker med psykiske problemer til å leve verdige og meningsfulle liv. Funn viser at kunstaktiviteter i lokalbaserte psykiske helsetjenester kan bidra til å støtte recovery. Foreløpig eksiterer lite forskning på scenekunst og recovery innenfor sykehuskonteksten. Denne avhandlingen utforsker hvordan scenekunst i sykehus støtter recovery prosesser for personer med langvarige psykiske problemer.

Metode: Avhandlingen kan plasseres innenfor en hermeneutisk-fenomenologisk tradisjon. Datamaterialet ble generert gjennom uformell deltakende observasjon og dybdeintervju med 12 mennesker som var eller hadde vært deltakere i et musikk- og teaterverksted lokalisert på et norsk sykehus. Avhandlingens tre empiriske artikler bygger på hverandre og benytter ulike tilnærminger for å analysere det rike og komplekse datamaterialet.

Funn: Deltakerne i musikk- og teaterverkstedet møtte fleksible, løsningsorienterte og person-orienterte kunstprofesjonelle. Sammen skapte de et ikke-dømmende, aksepterende og utforskende miljø. Selv om deltakerne delte utfordrende personlige livshistorier og løftet frem ulike eksistensielle spørsmål, opplevde de musikk- og teaterverkstedet som en frisone; fri fra diagnose og terapi. I denne frisonen hvor deltakerne gjennomførte et mangfoldig kreativt arbeid basert på sine personlige historier og eksistensielle spørsmål, skjedde transformasjoner som støttet sentrale recovery prosesser. Deltakerne ble utfordret og tok sjanser som ga dem nye ferdigheter og økt mestringstro. De opplevde små positive øyeblikk og fikk nye erfaringer knyttet til identitet og eksistens som kunne tas med i visjonen om en annen fremtid.

Konklusjon: Musikk- og teaterverkstedet ble en frisone som tillot deltakerne å være fragmentert, dysfunksjonell, ressursrik og kreativ på samme tid. Frisonen ga rom for å utøve recovery. Tilgang, fleksibilitet, tilhørighet, eierskap og måten deltakerne samarbeidet med kunstprofesjonelle hadde innvirkning på om musikk- og teaterverkstedet ble opplevd som en frisone med transformativt potensiale for recovery. Deltakerne opplevde deltakelse i musikk- og teaterverkstedet som positivt, men kunstaktivitet innenfor sykehuskonteksten kan by på organisatoriske, strukturelle og menneskelige utfordringer.

Summary

Introduction: In order to support people with mental health problems to live meaningful and valuable lives, there has been a growing interest in mental health services providing activities that focus on resources rather than illness and problems. Although this research is in its infancy, performing arts in community-based mental health services appears to promote recovery. Limited knowledge exists on performing arts and recovery in mental health contexts. To address this knowledge gap, this thesis explores how performing arts in a mental hospital, supports recovery processes for people with long-term mental health problems.

Method: In this thesis, a qualitative hermeneutical-phenomenological framework was used. Data was gathered through informal observation and in-depth interviews with 12 people who were, or had been, participants in a music and theatre workshop located within a Norwegian mental hospital. The three published articles in this thesis build on each other and use different approaches to analyse the thick and complex data.

Findings: Participants in the music and theatre workshop met flexible, solution-oriented and person-centred arts professionals. Together, they created a non-judgmental, accepting and exploratory environment. Despite participants sharing challenging personal life stories and dealing with different existential questions, they experienced the music and theatre workshop as a free zone; free from diagnosis and therapy. In this free zone where the participants conducted laborious creative work on their personal stories and existential questions, transformation processes that supported central recovery processes occurred. The participants were provided with new experiences of their own identity and their being in the world. They were given an opportunity to face new challenges and risks, which provided them an opportunity to develop new skills and increased self-efficacy. Furthermore, they experienced glimpses of positive moments and a vision of a different existence, that could be picked up as the threads of a new life.

Conclusion: The music and theatre workshop became a free zone where the participants were allowed to be simultaneously fragmented, dysfunctional, resourceful and creative. In this free zone they performed recovery. Accessibility and flexibility, belonging and ownership and the way that participants engaged with the professionals had an impact on whether the music and theatre workshop was experienced as a free zone with transformative potential for recovery. However, providing a music and theatre workshop in a mental hospital creates challenges at organizational, structural and human levels.

Acknowledgements

Honestly, conducting a PhD in health science was not at the top of my list of life achievements. Several people, asked me if I would be interested in applying for a PhD position. I always declined. I instead wanted to be a clinician and a mother. I also thought that writing a thesis would be a lonely job and I was not ready for that. The wonderful collaborations with my colleagues in the Bachelor`s programme in Social Education at Nord University changed my mind. I have never worked with a more welcoming, critical, hardworking and professional group of colleagues. I thank all of you. Oddbjørn Johansen, Hilde Guddingsmo and Ingunn Skjesol Bulling deserve an extra thank you. Oddbjørn, I cannot think of anyone better at convincing people to do things they never thought they could. Hilde, thank you for your interest and willingness to share your knowledge of the arts. Ingunn, as I remember it, we were both unsure about applying for a PhD position. I will be ever grateful that we promised to support each other. Now, almost for five years later, you have kept your promise. I have appreciated all our conversations, critical reading, discussions, and “academic uphill trips” with you. Our collaboration is unique and I look forward to working with you in the future.

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and journals as soon as they have been published. You have become my guide within research and supervision. In addition, I want to thank to my coauthors, Larry Davidson, Theo Stickley, and Ottar Bjerkeset for their insightful contribution making up this thesis. Nord University also deserves a thank you for funding this thesis.

I also want to thank my fellow PhD students Hilde, Ingunn, Wenche, Hanne, Marianne B, Marianne N, Stine and Else Marie at Nord University, Campus Namsos. They have all been absolutely fantastic. It has been a privilege to be part of this generous and supportive environment. Over the years we have shared knowledge, experience, joy, sorrow and frustrations. I also offer thank you to my colleagues who are affiliated with the Master`s Programme in Mental Health at Nord University; they have shown interest in my research and contributed to my sense of belonging. Heidi Haug Fjone deserves a special thank you for trying to remind me that I am not a superwoman and therefore need to take breaks from my PhD work. In addition, a huge thank you to Hege Rasmussen and Ingunn Bosnes; we have been friends for decades and worked together clinically. Therefore, it is amazing that we also became PhD fellows. Thanks for all the conversations, encouraging SMS exchanges and cosy dinners during our last years as PhD fellows.

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I have had a life outside writing this thesis, even though I think my family and friends would argue against this. I need to make an excuse for not managing my duties as a devoted lover, present mother and good friend during the last few years. Hopefully my friends and family, can soon start to count on me again. Finally, and most importantly, I want to express my love and appreciation to Espen and our four children, Tale, Heine, Ask and Hedda. They are the most precious people in my life and I look forward spending more time together.

List of publications

Article 1:

Ørjasæter, K. B. & Ness, O. (2017). "Acting Out" Enabling meaningful participation among people with long-term mental health problems in a music and theater workshop. *Qualitative Health Research, 27*(11), 1600-1613. https://doi.org/10.1177/1049732316679954.

Article 2:

Ørjasæter, K. B., Davidson, L., Hedlund, M., Bjerkeset, O., & Ness, O. (2018). "I now have a life!" Lived experiences of participation in music and theater in a mental health hospital. *PLoS One*, 13(12), e0209242. https://doi.org/10.1371/journal.pone.0209242.

Article 3:

Ørjasæter, K. B., Stickley, T., Hedlund, M,. & Ness, O. (2017). Transforming identity through participation in music and theatre: exploring narratives of people with mental health problems. *International Journal of Qualitative Studies on Health and Well-being,* 12(1). https://doi.org/10.1080/17482631.2017.1379339.

Abbreviations

NTNU	The Norwegian University of Science and Technology
MTW	Music and theatre workshop
REK	The Regional Committee of Medical and Health Care Research Ethics
NAV	Norwegian Labour and Welfare Service
WHO	World Health Organization
UN	United Nations
CRPD	Convention on the Rights of Persons with Disabilities
DPS	District psychiatric centre
ICD	International Classification of Diseases
DSM	Diagnostic and Statistical Manual of Mental Disorders
PRCH	Program on Recovery and Community Health

To Kristen Grødem

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1. Introduction

This thesis focuses on recovery and performing arts in mental health. It is a qualitative hermeneutical phenomenological study exploring the experiences of participation in performing arts to support recovery processes for people with long-term mental health problems. The quote below, from Isak, one of the participants, gives us a sense of how performing arts have influenced his life:

> Participation in the music and theatre workshop is probably the reason why over the last four years I only have been admitted [to hospitals], to a small extent, and is the reason why I am so well-functioning and as healthy as I am now and is the reason why I somehow seem to have a career as an actor. And it might be the reason why I am still alive.

Isak seems to ascribe many of the positive changes in his life over the last few year to his participation in the music and theatre workshop (MTW). As Isak sees the performing arts probably contributed to needing less treatment, increased health and well-being, enabling a career and giving sufficient meaning to choose life. Isaks' story is one of many stories that have emerged in this research where people with long-term mental health problems have shared experiences associated with participation in the MTW. The participants had different stories, experiences and reasons why they had chosen to attend the MTW. Their experiences are diverse. Although, there was variation in how and to what extent the MTW influenced their lives, all the participants got something out of being involved. In this thesis, I address the diversity and complexity of the lived experiences of participation in a performing arts program. I explore how the MTW could be seen as an environment in which recovery was performed in the context of mental hospital. Moreover, I discuss some of the cornerstones needed to make this environment transformative and identify some challenges that arts activities face in mental health contexts.

In this introduction, I start with some turning points in my professional practice that shaped my choice of research topic. Then, I show how this thesis builds on current knowledge, why this knowledge is needed and how this thesis contributes to current gaps in the research field. The aim and research questions are presented before I provide a description of the research context and clarify central concepts. At the end of the introduction, I outline the contents of the thesis.

1.1 Turning points for the thesis

In this chapter, I present three turning points from my professional life as a mental health professional and a university lecturer, that influenced my choice of research topic. These turning points have also affected how I undertook the research and how the empirical material has been understood and interpreted. To visualize these turning points, I make my position as a researcher more transparent, in line with the tradition of qualitative research (Malterud, 2011).

> I am excited. Waiting for the curtain to rise. The concert hall is full. I'm wondering what sort of performance I am going to see. Today's performance does not include professionals, but amateur actors and musicians with a long history of mental health problems and drug-related issues. In the last year, employees at The Norwegian University of Science and Technology (NTNU) and St.Olavs Hospital, department of mental health care, have held creative workshops with patients who have wanted to use their creative abilities and to show their own material. Several of this evening's "actors and musicians" I have seen in the corridors of St.Olavs hospital where I am employed as a therapist. There are some added elements of anxiety with tonight's performance. Will everyone turn up? And in what state? What will they perform? Will everyone be able to get through it? The curtain goes up and my attention is caught immediately. (An evening during the Fall 2007 at the ISAK Cultural Centre in Trondheim)

Little did I know that this particular evening would be a turning point in my professional life. The performance had a huge impact on me. It was of great quality and the participants on stage managed to set in motion a broad spectrum of my emotions. During the performance I felt joy, sadness, surprise and love. Even though I had been working in the field of mental health for many years, I came to realize that I still carried prejudices about people with mental health problems. The prejudices included both the ability to carry out tasks, capacity and potential. As a mental health professional in specialist health services, I realized that investigating the patient's resources and potential had taken a back seat to concerns about risk and a focus on illness and problems. This performance reminded me that I had to refocus my attention on the resources of the patients, because increased mobilization of these resources could create a positive outcome for treatment and a better quality of life.

The second turning point came with my professional acquaintance with Linda. The contact I had with Linda led to my increased awareness of the importance of investigating patients' capacity and potential. Linda challenged my belief in what was possible after a long period of illness and convinced me that recovery is possible for those with a poor prognosis for recovery. When I met Linda, she had 15 years of experience of admissions to mental hospitals. Many of these admissions resulted in long-term stays. I became Linda's outpatient therapist and she surprised me by having a treatment goal of returning to work. My first thought was that this was unrealistic. Linda exhibited a high pressure symptoms of mental illness. She heard voices and kept seeing blood running down the walls. She drank alcohol in order to be able to leave her flat, always carried a knife for protection and self-harmed often and seriously. I was unsure what to do. How was it possible to imagine Linda being able to cope with a work environment? As an out-patient therapist, I felt a responsibility for advising her about the realities of her situation and the importance of working on her symptom pressure, before it was possible to focus on returning to work. She must have read my facial expression well and continued: "I don't think I will become free of the symptoms, but I don't get any better staying at home without anything meaningful to fill my days! I just would like to live a normal life, with a permanent job, so I too can have normal conversations!" She was right, of course. When she had lived mainly either in a hospital unit or in isolation in her own flat, she had limited opportunities to be active and participate in her local community. In *The plan for stepping up services within mental health* (Helse-og omsorgsdepartementet, 1998), user involvement in treatment is underlined as important. I had to reflect on, if she who wears the shoe will know best where that shoe pinches, shouldn't I then accept Linda's knowledge of her own experience? I became afraid that the goal of returning to work would become a failure for her and a possibility for colleagues to ridicule me as a naïve mental health professional. I got the impression that her wish to return to work had been brewing for quite a while. For that reason, it was difficult to ignore her wish. Because of this, Linda's treatment goal became the guide for our common goal. We both knew that this was a challenging goal and that collaborating well with the psychiatric in-patient unit would be necessary.

During the treatment contact with Linda I become conscious of how we as professionals have power to define a patient's motivation and treatment goals. I became uncertain whether we, to a large enough degree, recognize and trust the patient's own experience and competence. Although I knew it would be demanding working towards Linda's treatment goals, I was not prepared for the resistance within the treatment system. As an out-patient therapist at the mental hospital, I was unsure whether out-patient treatment alone would be sufficient in order to reach Linda's treatment goals. In consultation with Linda I agreed to a meeting with the consultant psychiatrist at the in-patient unit to work out guidelines for possible future admissions. Linda did not wish to take part, but had ideas about shorter periods of admission, a maximum of 1-2 weeks. Her experience had shown that shorter periods of hospitalization with clearer treatment goals had the best effect. Upon my meeting with the consultant psychiatrist I was surprised to be met instead by staff from the unit. The staff expressed little will to cooperate with the out-patient clinic as regards possible hospitalizations for Linda. In my view it became a paternalistic meeting. The staff on the ward accused me of having been "brain washed" by Linda in order for her to gain entry into the ward. As she was diagnosed with borderline personality disorder, one of many diagnoses, she was not welcome on the ward. This was explained with research showing that patients with this diagnosis respond badly to hospitalizations. But Linda had return to work as her treatment goal and did not wish to spend months and years in the psychiatric unit. She wanted to get on with her life. My experience was of the consultant questioning my expertise and use of treatment resources for a person not deemed to profit from treatment. I felt a growing irritation and had to hold on to the table to avoid bellowing. No collaboration between patient, unit and out-patient department came out of this meeting. I was not giving up. Linda deserved a chance. I contacted the ward consultant at the clinic and managed to get an agreement with another unit in the region. We were ready to start the collaboration for Linda's treatment goal. Linda's own experience and knowledge were listened to and had a positive outcome. Linda worked really hard to reach her goal and was rewarded with getting back to work full time. She has become an example of how we as professionals cannot discount patients' goals even if we are not sure these goals are possible. What can appear an impossible goal can in fact become possible if the patient wants it enough and the support system cooperates in good as well as in bad times.

The struggle for a more human treatment system taxed my energy. I had to make a choice; stay calm and carry on as before in a biomedical paradigm, go in fighting and probably break my neck, or take a break from the treatment side and switch to the university sector with a goal of educating system-critical but caring health- and social workers. I chose the latter. The third turning point came when I started as a university lecturer at the bachelor program for *Social Education* at Nord University (formerly Nord-Trøndelag University College). My new colleagues had a more holistic view of human beings than my former colleagues at the mental hospital. In addition, they appreciated critical reflection, creativity and innovation. My then leader, Oddbjørn Johansen, encouraged me to draw up a project proposal for a doctoral fellowship position. It was expected that such fellowship should relate to "culture, activity and participation" which was the chosen focus for the bachelor program at that time. That performance at the ISAK Cultural Centre quickly sprang to mind. If I was to immerse myself into research topic for four years, it had to be addressing culture, arts and mental health. Finally, I had the opportunity to link my long-standing self-interest in the arts, previous education in social work and work experience within mental health care.

1.2 Positioning the thesis

In this chapter, I review the research undertaken on recovery, mental health and the arts. The aim is to provide a brief overview of relevant research, that helps to set the context for understanding the thesis.

Despite mental health problems being seen as a major public health challenge (WHO, 2013), historically they have been relatively ignored (WHO, 2001, 2018). In 2001, WHO (2001) issued a report that acknowledged this: "Mental health – neglected for far too long – is crucial to the overall well-being of individuals, societies and countries and must be universally regarded in a new light" (p. IX).

According to Pelletier, Davidson, and Roelandt (2009) this *new light* is recovery and go on to claim that there is a need to reorient mental health services to make them recovery-oriented. This means a greater attention to supporting people with mental health problems to achieve their own aspirations and goals and facilitate access to human rights such as participation in meaningful activities (WHO, 2013). Then, the total needs of the individual as a whole person become the focus, and not solely the problem. This thesis builds on growing understanding that participation in meaningful activities can be important building blocks in people's recovery process (Andresen, Oades, & Caputi, 2003; Davidson & Johnson, 2013; Le Boutillier et al., 2011; Leamy, Bird, Le Boutillier, Williams, & Slade, 2011; Salzmann-Erikson, 2013). However, there is relatively sparse evidence in the recovery literature exploring the meaning of such activities in the life of people with mental health problems. There exists some research on work as a meaningful activity (Borg, Veseth, Binder, & Topor, 2011; Doroud, Fossey, & Fortune, 2015; Hansen & Bjerge, 2017; Topor, 2001) and there is a growing interest on arts activities to promote and create socially inclusive local communities

(Baklien & Carlsson, 2000; Fancourt, 2017). In 2002, Richard Smith, the then-editor of the British Medical Journal, urged the British government to spend more money on the arts (Smith, 2002). He proposed diverting 0.5 % of the health care budget to the arts and thereby improving the health of people in Britain. According to Smith (2002): "If health is about adaptation, understanding and acceptance, then the arts may be more potent than anything that medicine has to offer" (p. 1433). This is supported by people with mental health problems who advised the mental health system to prioritize research on meaningful activities, such as the arts (Thornicroft, Rose, Huxley, Dale, & Wykes, 2002). This thesis is a response to this call.

The potential of the arts in care and recovery have a long history (Clift & Camic, 2016). However, Clift and Camic (2016) claim that the growth of interest using the arts in therapeutic and healthcare interventions evolved at the beginning of the twentieth century. They argue that this relate to increasing recognition that biomedicine is limited in what it can offer, that the provision and quality of health and social care services face an uncertain economic future and that health care services alone cannot help improve wellbeing and support recovery. Internationally, there has been increasing interest in connecting participatory arts with recovery (Makin & Gask, 2012). The research field is young, and the two initial studies (Lloyd, Wong, & Petchkovsky, 2007; Spandler, Secker, Kent, Hacking, & Shenton, 2007) exploring the relation between participatory arts and recovery were published in 2007. Both were linked to visual arts. Since then, several studies have connected visual arts and recovery (Argyle & Winship, 2015; Gwinner, Knox, & Brough, 2013; Gwinner, Knox, & Hacking, 2009; Howells, Zelnik, Anthony, & Gill, 2009; Lawson, Reynolds, Bryant, & Wilson, 2014; Stickley, 2010; Van Lith, Fenner, & Schofield, 2011). With one exception (Howells et al., 2009), these are based in Australia or the United Kingdom. Until I began my PhD research in 2015, a limited number of international studies (Moran & Alon, 2011; Sapouna & Pamer, 2014) linked the benefits of the performing arts (music or theatre) and recovery. In 2011, Moran and Alon (2011) published the first article linking performing arts to recovery. They used a combined qualitative and quantitative research design to investigate two 10-week playback theatre courses at Boston University for people with serious mental health problems. Their findings demonstrated a significant positive change on the playback impact scale ($z = 3$, $p = 0.05$, $n = 9$) and some positive trends on the Rosenberg's self-esteem scale and personal growth and recovery scale, although these were not statistically significant. The qualitative findings showed personal and interpersonal benefits. Because of attending the play-back courses, the participants highlighted an increased feeling of (a) fun/relaxion, (b) creativity/self-expression/spontaneity and (c) being part of a group. Then, Sapouna and Pamer (2014) investigated three 8-10 weeks arts programmes in Cork, Ireland; two music workshops at an acute-in patient unit and a day centre respectively and one animation workshop at a city art gallery. Their research demonstrated the transformative potential of the arts to create environments conducive to recovery. The music workshops, provided the participants a space to connect with themselves and their feelings, build relationships, discover personal resources and to take more satisfying social roles in their lives. In addition, Sapouna and Pamer (2014) suggested that the arts have the potential to create more egalitarian relationships between staff and patients and to help staff to see patients beyond their diagnosis. Interestingly, they also pointed out some challenges in offering arts activities in biomedical contexts; the risk of losing creative potential if arts adopt a clinical focus rather than being psychosocial interventions.

During the time I have been writing my thesis some interesting studies has emerged exploring the benefits of performing arts on the process of recovery (Faigin & Stein, 2015; Lagacé, Briand, Desrosiers, & Larivière, 2016; Perkins, Ascenso, Atkins, Fancourt, & Williamon, 2016; Shakespeare & Whieldon, 2017; Torrissen & Stickley, 2018). These studies have used different arts forms, like singing (Lagacé et al., 2016; Shakespeare & Whieldon, 2017), drumming (Perkins et al., 2016) and theatre (Faigin & Stein, 2015; Torrissen & Stickley, 2018). The length of the arts programs varies: 10 weeks (Perkins et al., 2016), eight months (Lagacé et al., 2016) and long-lasting participation (Faigin & Stein, 2015; Torrissen & Stickley, 2018). All these arts programs are described as community based, despite one of them being located at a mental hospital (Torrissen & Stickley, 2018). The studies were undertaken in English speaking western countries, with the exception of one Norwegian study (Torrissen & Stickley, 2018). Findings from these studies have demonstrated that the performing arts have the potential to connect people. Through performing arts, people with mental health problems described developing of relationships (Lagacé et al., 2016), friendships (Shakespeare & Whieldon, 2017) and a sense of being part of a "family" (Torrissen & Stickley, 2018). Having a facilitating environment was described as important. Lagacé et al. (2016) highlighted a normalizing environment as essential for arts activities to be successful and described these as possible in community settings outside standard health care. Other studies focused on performing arts as an inclusive activity with a supported (Shakespeare & Whieldon, 2017), accepted and respectful (Sapouna & Pamer, 2014) and safe environment (Perkins et al., 2016). Some of the studies highlighted that performing arts have the potential to help people with mental health problems to create a healthy, positive (Lagacé et al., 2016; Torrissen & Stickley, 2018) and artistic identity (Faigin & Stein, 2015; Moran & Alon, 2011). Interestingly, people with mental health problems experienced that participating in performing arts gave them a chance to laugh, feel happiness and joy (Shakespeare & Whieldon, 2017; Torrissen & Stickley, 2018) and gave hope and optimism in life (Lagacé et al., 2016; Torrissen & Stickley, 2018). Despite some insight on performing arts and its potential to facilitate a positive environment, promote hope, belonging and a positive identity through community-based arts programs, there exist limited knowledge empirically and very little "thick data" on how people with long-term mental health problems experience performing arts in the context of mental hospitals.

In summary, research demonstrate that the arts provide a safe and inclusive environment. Participants in the arts programs got an opportunity to discover personal resources, develop an artistic identity and create satisfying social roles. Furthermore, research shows that participants in arts programs got a chance to build relationships and develop close ties. Finally, research demonstrate that the arts provide people with mental problems an opportunity to have fun and become more hopeful about their future.

1.3 Arts programmes in mental hospitals

None of the published literature considers arts programmes aimed at recovery that are delivered within the context of a mental hospital nor the additional challenges that such a context brings. Arts programmes maybe even more beneficial in mental health institutions because many people, particularly those who are frequently admitted, could benefit from such interventions as part of what helps them to be discharged and move to recovery. However, one of the challenges for the adoption of such approaches in traditional mental health institutions is that such institutions are mainly governed by a reductionist biomedical paradigm that has contributed to human rights violations (e.g. patients are excluded, neglected, coerced and abused) (Human Rights Council, 2017) and isolate the person from the community outside the institution.

Traditionally, when arts activities are located within a mental hospital, they are run by arts therapists and conducted as music- or drama therapy. These activities are often shaped as part of a treatment plan with a clear beginning and end. There is limited evidence of how participants experience arts programmes in mental hospitals that are not considered therapy. This thesis seeks to address these issues and gaps in the literature by focussing on a unique arts programme delivered within a mental hospital and its implications for recovery. Participants in the workshop, that is the object of study, were not refereed as part of a treatment plan, and the programme did not have a distinct start and finish, and is not integrated into a formal approach to diagnosis or treatment. In many ways the workshop resembles community-based arts intervention but is delivered within a mental hospital.

Indeed, it is this biomedically controlled context which creates what Sapouna and Pamer (2014) consider particular challenges. Therefore, this research also engages with two different sets of potential implications of participating in the art programme. The first relates to the consequences of participation in terms of stigma and exclusion, whereas the second considers the scope for participation to support a transition to mainstream activities outside of the hospital following discharge.

In summary, this thesis intends to be an answer to the request for knowledge and understanding about new and different thinking in the mental health services, the need to create environments within the mental hospital context that takes care of the whole person, including a person`s strengths and resources, not solely the part that is considered “ill” and the need for a closer link between the hospital and the community outside.

1.4 Aim and research questions

The aim of this thesis is to explore and develop an understanding of on how people with long-term mental health problems experience performing arts in the context of a mental hospital, what they perceive as an important foundation for arts participation and whether performing arts support their recovery process. This thesis seeks to broaden and deepen the understanding of the relationship between performing arts and recovery to increase knowledge about the complexity of the phenomenon. The following overarching research question guides the research presented in this thesis: *How can performing arts support recovery processes of people who experience long-term mental health problems?*

Based in the aim and the overarching research question, the following sub-research questions were developed:

1. *What enables participation in performing arts?* (Article 1)

2. *What do performing arts add to the lives of people with long-term mental problems?* (Article 2)
3. *How is identity affected by participation in performing arts?* (Article 3)

The order of the articles reflects the evolution of the research, from general research questions around enabling participation and value of participation in performing arts, to the more specific research questions around participation in performing arts and identity.

1.5 The research context

The MTW is an institutional mental health theatre and music group that has been part of the leisure program for patients at a Norwegian mental hospital since 2003. The mental hospital has employed a theatre director full-time to run the MTW. Grødem (2008) describes the MTW from his position as a theatre director:

> The MTW is a living organism where creative trains move from station to station, people and thoughts meet at new stations and create new situations. A unique collaboration between arts professionals, former and present patients, as well as supporters at the hospital. From this collaboration, arts emerge. Built from the underground and brought up in the daylight. Daily walk in this amazing network and wonder about everything I got from the travellers on this track. They carry with them an insight from stations where I have not been, but they convey their experiences in such a way that I am informed by their pictures. Unique pictures of lived life, but always recognizable. I am a kind of station master who receives gifts from the travellers in the form of texts, music and impulses. I see them travel and come back. Sometimes they are enriched, other times robbed. But we meet. (p. 1)

The hospital management gave the theatre director the responsibility for creating a cabaret for the hospital's 100th anniversary in 2004 (Grødem, 2008). Patients from forensic, acute, intermediate and rehabilitation units at the hospital were invited to help create this cabaret in close collaboration with professional artists. The MTW was planned as a one-time phenomenon in conjunction with the anniversary (Grødem, 2008). However, it was decided to continue when hospital management, professionals, patients and their relatives saw that the project generated positive experiences on both an artistic and a human level for the patients.

The goal of MTW is to support people with mental health problems to use their inherent abilities and develop these to increase self-confidence, create mastery and health improvement while stimulating networking (Grødem, 2008). The MTW is for people who are, or have been, admitted to acute, intermediate, rehabilitation or forensic unit, or who are long-term outpatients at the mental hospital. In addition, the MTW is open to people who have been discharged from the mental hospital and mainly live their lives in the community. Some of those who participate in MTW have also had the opportunity to use the arena as work training facility in collaboration with the Norwegian Labour and Welfare Service (NAV).

Despite the fact that the MTW is located in a mental hospital, the activity is not intended for therapeutic purposes, but rather is conceptualised as a leisure activity. Involvement in the MTW is voluntary and does not need a referral. Furthermore, there is great flexibility with regard to the frequency and duration of activity. No exclusion criteria exist in relation to diagnosis, condition or previous experience and knowledge within the arts.

MTW is located in an old mental hospital. In Norway, old mental hospitals are traditionally designed as large asylums in rural area. The hospital area which MTW was located was also in a rural area and consisted of several huge old stone buildings. However, the building that houses the MTW was different from the others in the hospital area. It looked like an old small private detached house of wood and was decorated more like a home than an institution. In this house, several rooms were dedicated to the work in the MTW, which included separate rooms for costumes and rehearsals. There was also a mixing room for recording and editing audio and video and offices for the theatre director and the participants.

From the outset, a key principle in the MTW was to use text, image and musical material from the participants themselves aiming to utilize their specialized knowledge (Grødem, 2008). Participants were approached as co-creators and they took part in all levels of the production process, based on their skills and interests. They were involved in script writing, singing, playing instruments, creating costumes, technical support and other tasks. Participants were encouraged to bring their poems, written drafts, diary notes, melodies and songs to the theatre director. The participants, with support from the arts professionals, could transform the material into a dialog for a written play. The theatre director had overall responsibility to make sure that the material was presentable, had a clear message, and was not too private or raw.

The participants had weekly rehearsals, where they read and portrayed characters based on written scripts. In addition, through their participation in the MTW, they could have formal and informal appointments with the theatre director and some hired arts professionals to create or further develop their own lyrics and musical expressions.

1.6 Clarification of central concepts

In the following section I identify the central concepts of the thesis including: mental health, mental health problems, participatory arts, performing arts and recovery. Below, I clarify the central concepts and how they should be understood and read in this thesis. One of the central concepts, recovery, is further elaborated in chapter 2.

1.6.1 Mental health, mental illness and mental health problems

In this thesis the understanding of mental health embraces a positive orientation. Mental health is conceptualised as: “a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community” (WHO, 2013, p. 6).

Mental health is a resource and basic human right, which has a value in its own right. The WHO (2018) points out that mental health is an integral part of health, and more than the absence of mental suffering. Since mental health is seen as fundamental to our ability to think, emote, interact, earn a living and enjoy a full life, supporting, protecting and restoring mental health is of importance for individuals, communities and societies throughout the world (WHO, 2018).

There exist multiple ways to delineate experience from people who have been in contact with mental health services. Mental illness, mental disorder and mental disability are used as medicalised terms where their usefulness is connected to biomedical contexts (Ringer, 2013). In DSM-V, mental illness is referred to as a discovered diagnosed disturbance in an individual’s condition, emotion regulation, or behaviour that reflects a dysfunction in the psychological, biological or developmental processes underlying mental functioning (American Psychiatric Association, 2013). Several users of mental services have stated that they are uncomfortable with linking their condition to illness, but it is hard to find a term that is appropriate and which generates universal agreement (Riddell & Watson, 2014). Keyes (2014) two continua model of mental health has the potential to bridge mental illness and mental health (Provencher & Keyes, 2011). According to Keyes (2014) mental health and mental illness is related, but belong to different dimensions. This implies that a person can be in good health in one continuum, but simultaneously have visible diagnostic symptoms in the other continuum. Such an understanding matches well with the values of recovery and could be helpful facing questions like "How can you be recovered if you still have the mental illness?" (Slade, 2009, p. 126). In line with Ringer (2013), I sought a term that acknowledging the suffering patients experience, but at the same time did not reduce these experiences solely to an illness-framework. While Ringer (2013) use mental distress, I decided to use mental health problems in this thesis. Like mental distress, mental health problems includes that people experience problems, but avoids limiting people's experiences to the framework of diagnosis and illness where the source of illness or defect lies with the individual. In this understanding, problems can be seen as a result of, or rather affected by, the society the person lives in. However, as mental health represent a diverse multidisciplinary field, various terms can be used and the same term can be understood differently in different contexts. When publishing my second article, the reviewers and the editor of the scientific journal required me to use the term mental illness instead of mental health problems to avoid stigmatizing mental illness. This was discussed with my co-authors. Although we saw it differently, we chose to comply with the wish of the reviewers and editor.

1.6.2 Participatory arts

Within the field of arts and health, different terminology is used to describe arts activities (Fancourt, 2017). There are also distinctions between countries, where Scandinavian countries have referred to *cultural activities*, while English-speaking countries have used *arts activities* (Sigurdson, 2015). Initially, I was most familiar with the Scandinavian field, which resulted in cultural activity as the chosen term. As I became more acquainted with the arts and health research community internationally, I switched to arts activities and participatory arts.

In health and social services, varied types of arts programs are on offer to people with mental health problems (Fancourt, 2017). These arts programs can be divided into three main categories: *arts therapy*, *arts on prescription* and *participatory arts*. The MTW would be best placed within participatory arts. Participatory arts implies participation in creative activities organized within the health service, but carried out together with professional artists or art workers with a focus on the creative processes and how these processes may promote feelings of accomplishment and well-being, and vice a versa (Fancourt, 2017). Participatory arts aim to reach specific groups, such as people with mental health problems. Despite participants having long-standing mental health problems, artists who facilitate such arts programs have limited or little training in psychotherapy (Stickley, Wright, & Slade, 2018; Torrissen & Stickley, 2018) which means that the main focus will be on creative processes and not on illness. Usually, the participatory programs take place in hospitals and locally based mental health meeting places, but also at more open venues locally, for example libraries, houses of culture and art studios (Fancourt, 2017). The creative activities within participatory arts programs can cover several mediums across performing arts and visual arts.

1.6.3 Performing arts

In this thesis, performing arts are described as a medium within participatory arts. The performing arts are a form of art where the involved artists use their voices, bodies and objects to convey artistic expressions in front of an audience. Performing arts includes a range of forms and the most common ones are music, dance and theatre (Thomson & Jaque, 2017). According to Thomson and Jaque (2017) the unique aspect of performing arts is the reality that the performers and audience gather in a specific venue at a specific time to share the experience of the performance. The aesthetic appeal is perceived to have major value within music, theatre and dance work (Thomson & Jaque, 2017). This aesthetic appreciation in performing arts may be bound by time and place, but performance works have a potential to transcend time and place in the audience's lived experiences (Thomson & Jaque, 2017). Both the capacity to transcend time and place and the meaningfulness, which Thomson and Jaque (2017) highlight as characteristics of performing arts, are further discussed in chapter 5.

1.7 Outline of the thesis

The thesis is laid out in the following way:

Chapter 1. In chapter one I offer a short overview of the focus of the thesis, personal turning points for shaping my study of mental health, performing arts and recovery. I position the thesis in the research field and present the research context. This chapter goes on to explain the aims of the study and clarifies the central concepts before outlining structure of the thesis.

Chapter 2. Chapter two presents recovery as the primary theoretical perspective of the thesis.

Chapter 3. In this chapter, I describe the research methods and design. Additionally, research ethics and trustworthiness are discussed.

Chapter 4. The findings discussed in the three articles are summarized in this chapter.

Chapter 5. This chapter contains a discussion of the thesis' findings. It is divided in four main sections. The first section will discuss how the MTW can provide a free zone that supports recovery processes. The second section consider the cornerstones of the free zone. The section that follows, identifying challenges a free zone in a mental hospital faces. The final section addresses some implications of this research and lesson learned for policy, practice and research.

Chapter 6. Finally, in chapter six, I make some final comments.

2. Theoretical perspective

In this chapter, I describe and clarify recovery as the theoretical perspective in this thesis. Firstly, I will point out an increased attention on mental health and the emerging need for moving away from the biomedical paradigm. I give a presentation of recovery, which I propose to be a new paradigm in mental health. Secondly, as recovery is a dynamic, varied and multifaceted concept and contains various understandings, I clarify my perspective of recovery as a process for living with mental health problems. I give a brief presentation of the civil and human rights as the foundation to the recovery understanding called *recovery in*. Next, I present an argument for why I see recovery as a multidimensional process. Finally, I visualise the CHIME framework, which is an of the most popular frameworks used to describe various recovery processes. In this thesis, I address recovery as both a paradigm and a process.

2.1 A need for a new paradigm in mental health

Psychiatry is in crisis as the medical model has failed to meet and treat people with mental health problems (Aarre, 2010; Bracken et al., 2012; Kingdon & Young, 2007; Oute & Ringer, 2014; Pūras, 2017; Whitaker, 2014). Radical changes are proposed in knowledge (Glover, 2005; Priebe, 2016; Ørstavik, 2008), power transfer (Ørstavik, 2008) and working methods (Aarre, 2010). A genuine collaboration between user movements and mental health services will take place (Bracken et al., 2012). To encompass this, a new paradigm in mental health is needed (Topor, Borg, Di Girolamo, & Davidson, 2011). In Mental Health Action Plan 2013-2020, the WHO (2013) reported that mental health services need a recovery-oriented approach that emphasises supporting people with mental health problems to achieve their own aspirations and goals. Worldwide, the emphasis has shifted from treatment to recovery.

Mental health services are required to support people with mental health problems to reach a full range of human rights, experience the best health possible and participate fully in society without stigmatisation or discrimination. In more recovery-oriented approaches, the professionals attempt to be person-centred, support decisions, facilitate risk-sharing, and contribute to creating growth in the people they support (Anthony, 1993; Davidson, Drake, Schmutte, Dinzeo, & Andres-Hyman, 2009; Davidson & White, 2007; Karlsson & Borg, 2017; Roberts & Wolfson, 2004).

Norwegian political health policy documents have revealed a need for change in mental health services (Karlsson & Borg, 2017). In White's paper 25 (1996-97), *Openness and Totality [Åpenhet og helhet],* the Norwegian mental health services received a bad evaluation (Helse- og omsorgsdepartementet, 1997). This policy document revealed that patients did not receive sufficient help, the subject specialists felt inadequate and the authorities had challenges in offering the population adequate services (Ørstavik, 2008). *The Plan for Stepping Up Services Within Mental Health [Opptrappingsplanen for psykisk helse]*, Parliamentary Bill no. 63 (Helse-og omsorgsdepartementet, 1998), commented on the lack of treatment of mental health problems and showed the flaws in all links of the treatment chain. The challenge, however, was that mental health services did not properly evolve with the paternalistic culture, the one-sided view of knowledge, or the power balance between professionals and people with mental health problems, but rather did more of the same. It became apparent that the forces that ruled in the mental health field were stronger than the political guidance (Ørstavik, 2008). As Ørstavik (2008) proposed, the plan period was probably needed to acknowledge the real challenges in the Norwegian mental health services and to gather the necessary powers and experiences to begin the transformative work. Time has come to transform words into practice to make a genuine shift in paradigm (Glover, 2005). A change of direction towards recovery-oriented services needs to be more than altering a name and an organisational location (Glover, 2005; Ørstavik, 2008).

For decades, in the Norwegian welfare state model, the public has taken the responsibility to ensure the well-being of the Norwegian population; those unable to support themselves have been provided help (Halvorsen, Stjernø, & Øverbye, 2016). However, the Norwegian welfare state model is under great pressure financially, politically, and socially pressure (Halvorsen et al., 2016). Despite a political agreement on further public responsibility, changes are needed for the welfare state model to stay sustainable in the future. According to national health policy papers, future health service will require reviewing radical changes with regard to forms of cooperation and the organisation of services, support people to take greater responsibility for their own health (Helse- og omsorgs-departementet, 2014-2015) and implement recovery (Helsedirektoratet, 2014). During the last 10 years, a recovery-oriented perspective has taken hold in Norway, and there has been an increasing emphasis on developing locally-based health care services in line with recovery-oriented practice, visualising the importance of the everyday life (Borg & Davidson, 2008) and making the social aspects of the recovery process visible (Borg et al., 2011; Mezzina et al., 2006; Ness, Borg & Davidson, 2014; Ness, Borg, Karlsson, Almåsbakk, Solberg & Torkelsen, 2013). However, there is still a need for mental health services to continue working on changing the understanding of what mental health is, which is knowledge that should be in the forefront, and how to give lived experiences with mental health problems a more prominent voice in the development of future mental health services (Bracken et al., 2012; Ørstavik, 2008).

2.2 Recovery as perspective

2.2.1 Civil and human rights as foundations for recovery

Recovery is an old concept: in clinical medical contexts, it has been around for almost 200 years and has meant getting back to normal, not being ill (Slade, 2009). Patricia Deegan (1988) pointed out a different understanding of recovery. She proposed an understanding of recovery as a process in which people living with mental disabilities are not rehabilitated, but rather, they are recovering a sense of self and purpose within and beyond the limits of the disability (Deegan, 1988). These two different ways of understanding have existed side by side for the past 30 years. However, their dissimilar shades of meaning generate different data and have been a source of confusion around the concept (Roberts & Wolfson, 2004). In this thesis, I use the latter understanding of recovery, i.e. recovery as a process of living with problems, which has its roots in the psychiatric survivor movement in the United States. Through making experiences of living with mental health problems visible, the psychiatric survivor movement put the spotlight on equal civil rights and the right to citizenship and fought for protection and respect for these rights (Davidson, 2006). The psychiatric survivor movement could no longer accept that people with mental health problems had to wait to be allowed or enabled to live their own lives with access to their own homes, building friendships, establishing families, participating in meaningful jobs or activities, and pursuing their dreams (Davidson et al., 2001). The movement stated that, if they were let in to the everyday life of the community, recovery was possible (Davidson, 2006; Davidson et al., 2001). The psychiatric survivor movement were active on the political agenda, emphasising the need for societal and mental health system changes (Pilgrim & McCranie, 2013).

Judy Chamberlin and Patricia Deegan are two user activists who have been pivotal in promoting equal civil and human rights for people with mental health problems. Chamberlin

(1998) stated that people, independently of country and government, have had their rights taken away due to their mental health problems. She also queried why documents relating to rights have begun with the phrase “ the rights of the mentally ill” as if this group has special or different rights from the rest of the population. Deegan (1987, 2002, 1988, 1992, 1993, 1996) has made a significant contribution to the recovery field through her conceptualisation of recovery as a process, showing how recovery processes could look from a user perspective. Her slogan “Nothing about us, without us” was also apparently borrowed from the disability movement. Deegan (1987, 1996) has underlined that people with mental health problems would like to be supported by professionals in the mental health system but have revolted against suppression and the dominant basic thinking within the traditional systems of psychiatry. She has been at the forefront of demanding that the mental health system of recognises people with mental health problems as ordinary citizens who can make decisions on their own, instead of being treated as objects and second-class citizens.

Enacted in 2006, the United Nations Convention on the Rights of Persons with Disabilities (CRPD) acknowledged that people with disabilities, including those with mental health problems, should be viewed and treated as free and active people of society with equal rights. Again, supported by CRPD, the rights of people with mental health problems were put on the agenda. Despite Norway ratifying the convention as late as in 2013, the equal opportunities and antidiscrimination commissioner showed that Norway still denied rights to people with disabilities (Likestillings- og diskrimineringsombudet, 2015). With the assistance of a benevolent paternalistic attitude, health professionals have breached vital human rights with the explanation that they know best what the person needs and thereby are justified in pushing through remedial action without the patient’s consent (Aarre, 2010). Therefore, Chamberlin’s (1998) question is still valid:

> Why do we take one group of people, those labelled “mentally ill” and deny them basic human rights? Can it really be ethically correct to limit people against their will, force them into submitting to procedures against their will, reassess their life choices on the basis of them having mental problems? (p. 406)

Now that recovery has become the heart of the mental health system and dominates the policy ground around the world (Slade, 2009), mental health professionals need to be conscious of the origin on civil rights (Davidson, 2006). Lately, policymakers, researchers, and the good will of well-intended professionals across different contexts and countries have been accused of colonising the recovery perspective (Davidson, 2006; Karlsson & Borg, 2017; Le Boutillier et al., 2015). Recovery is then considered to be owned by the mental health services, where financial and administrative priorities dictate the practice rather than the users' needs (Le Boutillier et al., 2015). Therefore, there is a need to remain vigilant in keeping the civil rights and citizenship issues on the agenda in relation to recovery.

2.2.2 Conceptualising recovery

Today, recovery is a dynamic and varied concept with no clear consensus on its meaning (Davidson & Roe, 2007; Pilgrim & McCranie, 2013). The understanding varies depending on who is asking, who is interpreting, in which context, to which audience, and what purpose it is used for (Jacobson & Greenley, 2001, p. 249). The use of recovery in research, practice, policy and politics has resulted in a variety of directions and terms. Different communities have used denominations like clinical recovery (Slade, 2009), personal recovery (Anthony, 1993; Slade, 2009), natural recovery (Mudry, Nepustil, & Ness, 2018), social recovery (Mezzina et al., 2006; Topor et al., 2011), relational recovery (Price-Robertson, Obradovic, & Morgan, 2017) and recovery with either a capital *R* or lower-case *r*, i.e., capital *R* visualizes a practice which highlights civil and human rights and where diversity is appreciated and lower-case *r* represent a practice focusing on standardization, efficiency and measurement (Karlsson & Borg, 2017). The challenge with the different denominations is that the field may seem fragmented and inconceivable. As I will claim, the different denominations and directions have much in common and there are quite a few overlaps. Therefore, I am not convinced whether the current subdivision is optimal or even useful. It might be better returning to the two main understandings of recovery, which Larry Davidson and David Roe (2007) have called *recovery from* (recovery as an outcome) and *recovery in* (recovery as a process). If recovery is seen as a process of living with problems, so called recovery in, then it might highlight which aspects of the recovery process should be made visible, instead of giving another new name of recovery in a field that is already flooded of denominations. At the same time, it must be emphasised that recovery is not and should not be one thing, but many different things (Davidson & Roe, 2007) since diversity is desirable in terms of understanding, knowledge and practices.

In this thesis, I describe the understanding of recovery through a *recovery in* perspective. As Davidson and Roe (2007) suggested, for those who do not recover fully from their mental health problems in the near future, there may be little success in continuing to treat the illness, in hopes of reducing its effects. For these people, it could be better to learn how to live with their problems and then support their rights to live a safe, dignified, and meaningful life in their community (Davidson & Roe, 2007). This way of conceptualising recovery will, as I see it, link closely to the understanding of the psychiatric survivor movement that put fundamental civil rights and citizenship in the driver's seat to enable people living valued lives in communities without discrimination and stigmatisation.

Regardless of whether the discussion refers to *recovery from* or *recovery in*, both understandings have developed over the last three decades. The idea that people can *recover from* severe mental health problems represented a major challenge to the status quo in the mental health field in the 1980s (Anthony, 1993; Davidson, O'Connel, Tondora, Styron, & Kangas, 2006). People with mental health problems were chronic cases, with little hope for living meaningful and socially integrated lives as full citizens (Pilgrim & McCranie, 2013). However, 40 years of longitudinal clinical research showed health improvement in people with severe mental health problems (Harding, Zubin, & Strauss, 1987). If recovering is something people with mental health problems do, an increased interest among clinicians and researchers of the recovery from perception occurred on how recovery can and should be operationalized, measured and validated (Liberman, Kopelowicz, Ventura, & Gutkind, 2002). Traditionally, clinicians see recovery as an outcome, judged by a clinical expert and are strong in their beliefs on finding explicit operational criteria linked to the level of signs, symptoms, and flaws associated with the illness and identification when remission has occurred (Slade, 2009). The recovery from perspective has many advantages because it seems clear, distinct, reliable, and comparatively simple to define, measure and link to dysfunctions or quality of life in other parts of life (Davidson & Roe, 2007). However, from a recovery in perspective, recovery is not seen as an outcome, but viewed more in terms of the prolonged disability, impairment, or secondary consequences that results from the mental health problems rather than in terms of the problems per se (Davidson, O'Connel, et al., 2006). As already described, recovery in is built on the subjective experiences of living as well as possibly regardless of symptoms, diagnoses, and problems. This understanding challenges the main attention on getting rid of symptoms and returning to the same status as they were in before they got ill. Setting a goal of being fully recovered can be difficult to achieve and not very desirable because mental health problems are experienced as non-linear, whereas symptoms and functioning wax and wane over time (Davidson, Tondora, & Ridgway, 2010).

2.3 Recovery processes

2.3.1 Various understandings of recovery as a process

Although *recovery in* shows that recovery is a process, there are different understandings of the kind of process this is. Is it a personal, social, or relational process? Or should it be seen as a combination of these processes? I argue that the psychiatric survivor movement saw people with mental health problems in a larger context as part of a wide human community. As it became important to disclose that people with mental health problems were a heterogeneous group of people who should be treated as unique individuals with different needs and in need of different approaches to recovery, a strong emphasis lays on the personal narratives of living with disabilities. These narratives encouraged life to seeing people living with mental health problems as resourceful, and with an ability and right to make choices related to their own lives (Sayce, 2016). Recovery was thus proclaimed by the much-used definition from William A. Anthony (1993): "as a deeply personal, unique process where the individuals themselves could change their attitudes, values, goals, skills and/or roles" (p. 527). This definition of personal recovery has been valuable in seeing recovery as a process and in highlighting the important personal aspects of a recovery process. However, the spotlight on the intra-psychological processes within the individuals, might have overlooked the fact that recovery unfolds within social and relational contexts. Rose (2014) criticised the strong focus on seeing recovery as deeply personal, because human beings are not isolated. As people, we are mutually dependent on each other; we are relational beings (Gergen, 2009). Amongst the environments facing recovery as a social process, a person's life and experience cannot be seen separately from the social contexts they are happening in. The person's everyday life needs to be emphasised, where access to a home, financial means, work and meaningful activities are considered pivotal (Borg & Davidson, 2008; Mezzina et al., 2006; Schön, Denhov, & Topor, 2009; Topor et al., 2011). Therefore, according to Mezzina et al. (2006), socialisation in the local community is preferred. This is because it might decrease social exclusion, marginalisation and could be of importance to experience real citizenship, which is seen as an important goal of recovery in (Mezzina et al., 2006). Recovery is also highlighted as a relational process in which the interpersonal relationships are seen suffusing all aspects of recovery. Key interpersonal relationships could be friends, family members, professionals or others in the person's local community (Mezzina et al., 2006; Price-Robertson et al., 2017; Schön et al., 2009; Topor et al., 2011). Through these relationships, the individuals would be able to redefine themselves as persons. The social world is seen as the medium which makes personal transformations possible (Schön et al., 2009).

It might be too simple and narrow to say that recovery is either a personal, social, or relational process. Human beings are part of a social context that would be inappropriate to ignore. It can be said that individuals and the world are mutually connected (Heidegger, 1927/2007). Consequently, as I see it, recovery could be described as a multidimensional process where the persons cannot be seen regardless of the personal, structural, social, and relational dimensions surrounding them. In this thesis, I conceptualise recovery as a multidimensional process of various transformations through interacting with others to live a meaningful and valued life as equal citizens. Inspired by Deegan (2002), I use transformation instead of change, because I see the processes as constantly moving towards becoming new, while change can be seen as more static as a final stop.

2.3.2 A conceptual framework of recovery processes

Based on a systematic review and a narrative synthesis, Leamy et al. (2011) developed a conceptual framework of recovery processes. The recovery process comprised the following categories and is given the acronym CHIME:

- **C**onnectedness: peer support, support groups, relationships, support from others and being part of the community**.**
- **H**ope and optimism about the future: belief in the possibility of recovery, motivation to change, hope-inspiring relationships, positive thinking, valuing success, and having dreams and aspirations**.**
- **I**dentity: dimensions of identity, rebuilding or redefining a positive sense of identity and overcoming stigma**.**
- **M**eaning in life: meaning of mental illness experiences, spirituality, quality of life, meaningful life and social roles, and social goals and rebuilding life**.**
- **E**mpowerment: personal responsibility, control over life, and focusing upon strengths.

According Leamy et al. (2011) the CHIME recovery processes could support reflective clinical practice, because, from a recovery-in perspective, the goal of mental health professionals is to support recovery for people living with mental health problems, and there is a potential to evaluate practice in relation to its impact on these processes (Leamy et al., 2011). Interestingly, none of the CHIME processes focus directly on the mental health problems, because living meaningful and valued lives seldom includes illness. Mental health problems can nonetheless be a hindrance to living well, but through one or more of the CHIME processes, recovery is supported. So, I was immediately interested in the conceptual framework of recovery processes created an immediate interest for me because I found that the overall processes described in CHIME were in close accordance with my findings. However, there might be several challenges with the CHIME framework. From my understanding, the analysis is based on a perception that recovery is a unique and individual process. Although the framework includes some social, relational and structural aspects, it appears that the analysis is seen from intra-psychological processes and achievement (Price-Robertson et al., 2017). According to Price-Robertson et al. (2017), with the exception of connectedness, the other recovery processes like hope, identity, meaning and empowerment are mainly constructed intra-psychologically. While it is common to indicate that empowerment include political empowerment of people as a group, it might be surprising that the subcategories of empowerment in CHIME are described as “personal responsibility”, “control over life” and “focusing on strengths” (Price-Robertson et al., 2017).

3. Methodology

In this chapter, I elaborate on the philosophical worldview and clarify the research strategies and design, focusing on how data was generated and analysed and what ethical considerations had to be taken along the way. Furthermore, I demonstrate some validity procedures used to establish credibility (Creswell & Miller, 2000). Conducting a PhD thesis involves finding one's role as a researcher (Klevan, 2017). Therefore, I share some assumptions, wonderings, and choices from my journey becoming a hermeneutical-phenomenological researcher.

As a researcher I used a complex combination of various research lenses. A research lens could be understood as something that both facilitate and influences perception, evaluation and understanding (Savin-Baden & Major, 2013). I choose my research lenses after facing a variety of possibilities. Choosing research lenses was important to revealing my choices, including which choices I had opted out of and to feeling more confident in the choices I had made. Inspired by Savin-Baden and Major (2013), Figure 1 provides an overview of my research lenses in this thesis.

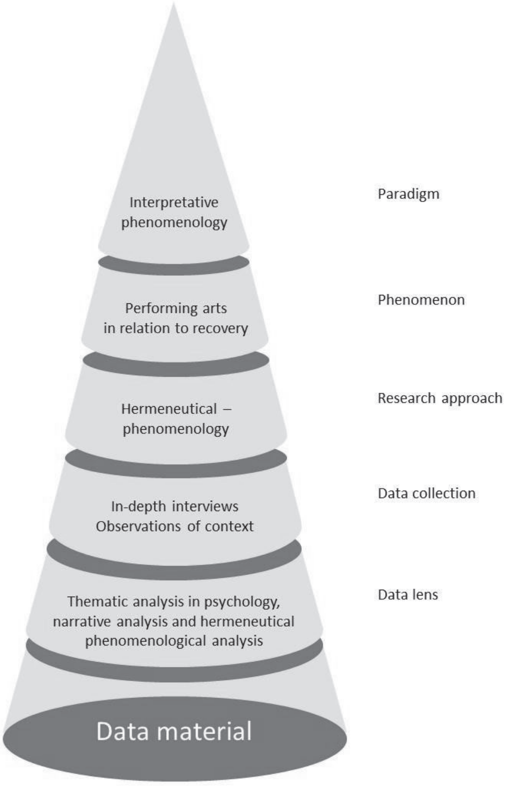

Figure 1. Set of lenses

3.1 Methodological framework

This thesis is based in a phenomenological paradigm, building on the assumption that a human being's lived experiences valid knowledge and that the world emerging for the individual is the real world, independent of being perceived in our practical use or in scientific research (Zahavi, 2003). Edmund Husserl, the founder of phenomenology, claimed that knowledge is based on people`s lifeworld; the world they live in, as they take for granted daily and they are familiar with and do not question (Zahavi, 2003). Husserls slogan *"Zu den sachen selbst*" *[go back to the things themselves]* visualise that our experiences should decide our theories rather than that theories should decide our experiences (Zahavi, 2003). In this thesis, I return to the phenomenon itself and let it speak for itself (Heidegger, 1927/2007). Thereby, a return to our lifeworld is preferable for our scientific investigations, where there is a need to study phenomena as they appear to human beings. However, as Heidegger (1927/2007) emphasises, our being is always the *being-in-the-world (Dasein)*. This means that we do not experience the world as isolated subjects, but as people who exist in a given time, place, and relationship to the world. Inspired by Heidegger, I understand that we and the world are mutually independent and thereby reject a dual-world doctrine of a divide between the world as it is for us and the way it appears to itself (Heidegger, 1927/2007). From this perspective, phenomenology is understood as the science of the phenomenon, where the focus of the analysis will be on being (*Dasein*). This involves analysing how the phenomenon appears to us in our being-in-the-world (Heidegger, 1927/2007).

Early on in my research journey, it became clear that I wanted to get hold of lived experiences of performing arts and recovery from a first-person perspective. This led me to read literature on phenomenology. As my reading progressed, it turned out there was a rich selection of phenomenological research approaches springing from different philosophical traditions. Nevertheless, phenomenology could be divided into two main categories (a) descriptive and (b) interpretative phenomenology which follow Edmund Husserl's and Martin Heidegger's philosophical traditions respectively (Finlay, 2011). However, all phenomenology is descriptive in the way that one seeks to describe rather than to explain. Researchers subscribing to the category of descriptive phenomenology are faithful to Husserl's project about seeking or catching the universal essence of the phenomenon (Finlay, 2011; Lopez & Willis, 2004). Descriptive phenomenologists attempt to stay as close to what they have been given in all its richness and complexity (Giorgi, 2009). Amadeo Giorgi, an

American psychologist, has been central in developing Husserl's philosophical ideas into a scientific method within psychological research. The researcher has *bracketed* earlier knowledge and understanding of the phenomenon through phenomenological (transcendental and eidetic) reduction attempts to capture its essence. Researchers within interpretative phenomenology have expanded on the descriptions of the core concepts and essence as to look for meaning and importance built into our common life practices (Lopez & Willis, 2004). Interpretative phenomenologists argue that researchers cannot avoid bringing themselves into their research. Instead, researchers should attempt to be reflexive. Additionally, the context becomes more important and the hermeneutic circle in phenomenology is used. The research discoveries are plaited together by the researcher's interpretation and the context.

Phenomenology can be understood as a continuum between being more or less descriptive or interpretative, where all researchers must clarify his or her position in the phenomenological landscape (Finlay, 2011). However, it can be challenging to place the research within a descriptive – interpretative dichotomy (Finlay, 2011) as no phenomenological study is either descriptive or interpretative. All phenomenological studies have parts that are descriptive and parts that are interpretative. In Figure 2, I visualise the continuum of phenomenology, where at the beginning of the doctoral journey, I placed myself at the end of descriptive phenomenology and during this thesis, I have moved towards an interpretative phenomenology.

Figure 2. Continuum phenomenology

At the beginning of my research journey, I placed my research within descriptive phenomenology. I thought that if I bracketed earlier knowledge and understanding of the phenomenon, I could catch the essence of the phenomenon through a phenomenological reduction. Inspired by Giorgi (2009), my original plan was to investigate performing arts in relation to recovery as devoid of presuppositions as possible, whereby my own presumption were to be set aside, and the phenomenon was to emerge in its real essence. I was confident that with the help of bracketing, I could stay alert and set my own preconceptions and experiences aside so as to express the investigated phenomenon's essence as precisely as possible, without adding nor subtracting any of what emerged. Throughout my clinical work in psychiatry, I had the impression that health and psychological research had to be done within the same tradition as natural science. When I discovered Giorgi's descriptive phenomenological research method in psychology (Giorgi, 2009), I got inspired to think that research within the hospital context also could be done within human science. As I saw it, Giorgi (2009) clarified the possibility of being objective and finding the essence of a phenomenon in qualitative research as long as the researcher adopted a phenomenological attitude. As a researcher I was to function as the analytical tool. To be objective, I thought it would be enough to investigate my preconceptions before starting the interviews. Inspired by Malterud (2011), I identified my starting position as a researcher by reflecting over the following questions: What is my experience with arts activity? What is my specific background and clinical experience? What is my theoretical framework at the upstart of the study? What do I expect to find, and why exactly? However, when I conducted three trial interviews with people in my own social network who had lived experience with performing arts, I felt that Giorgi's psychological phenomenological method provided little room to reflect on my own position as a researcher and how this influenced the research process and the findings. In addition, I felt the descriptive phenomenology approach restricted me. I experienced too much distance from the data material and understood that I wanted the data material to *speak more to me* during the research process and in addition I wanted to incorporate the context. It became clear that a descriptive phenomenological approach was not consistent with my worldview and there was a need to explore the interpretative part of the phenomenological continuum. Again, I was in search of a phenomenological approach that was compatible with an analysis that gave most meaning to the answers the research questioned. Interpretative phenomenology in general and Van Manens (1997, 2014) phenomenology of practice in particular appealed to me for three reasons; (a) the meaning of a phenomenon is seen as complex and manifold, (b) the researcher needs to embrace an attitude of wonder and (c) writing is seen as the method. The way these have influenced the research process, and how specific the analysis process is can be seen visible in more detail in chapter 3.5.

3.2 Access to the research context

Due to being unfamiliar with arts activities in mental hospitals, I was dependent on getting access to such an arena to carry out this research. My first contact with arts activities in a mental hospital was through Assistant Professor Vigdis Sæther at NTNU. Sæther was one of those responsible for *Trøste of bære, en cabaret på gal scene [Oh my god, a cabaret on a mad stage]*, the production I saw at ISAK Cultural Centre in 2007. Because the institutional theatre disbanded shortly after the production, Sæther recommended getting in touch with a theatre director she used as a sparring partner establishing the institutional theatre in Trondheim.

I established contact with the theatre director in the spring of 2013 to potentially research the MTW. Throughout the next months, we had several phone conversations, emails, and discussions about project sketches to get to know each other and to assess whether the MTW could be used as a research arena for this thesis. My preliminary contact with the theatre director, resulted in the first steps towards outlining the research and developing questions. Along the way, I realised that my first thought of conducting a case study with 6-8 people with lived experience of personality disorders could be challenging to follow up as closely as I had suggested. I noted that the MTW was open to all people within the mental hospital regardless of mental health problems and was not aimed at specific diagnostic groups. Instead, the theatre director put emphasis on describing the creative characteristics of the participants in the MTW rather than focusing on their diagnoses. I started to wonder about this. Because the activity took place at a mental hospital, I found it interesting that the theatre director was uncertain whether he really had a clear view of the participants' diagnoses. The information I gained from the theatre director led me to conduct an interview study, which allowed me to explore this further.

Whyte (1993) stressed the importance of connecting with key persons to gain entry into the field. In this study, the theatre director was an important person who enabled me to gain access. The theatre director contributed by introducing the research within the context of the hospital, let me have access to space and equipment and facilitated contact with prospective participants. After the theatre described and anchored the research with the hospital administration, all active participants and others with whom the theatre director had been in contact were informed that the MTW was to be the subject of the research. In the autumn of 2014, I was invited to a performance, where I was given the opportunity to meet the actors and musicians. Through the theatre director the participants at the MTW had the opportunity to get to know me and ask questions about the research under planning. This was important so that I could gain an impression of the MTW before I prepared the interview guide.

Shortly after the Regional Committee of Medical and Health Care Research Ethics (REK-Midt) approved my study, I held a recruitment meeting with the theatre director. I decided that all presently active actors and musicians would be invited to participate. To ensure some variation in the selection, I encouraged the theatre director to choose people of varying ages, who used different artistic expressions, and who had a wide variety of experience, length of participation, and era in the MTW. In the middle of May 2015, the theatre director distributed flyers about participating in the research to 14 active participants and six previous participants. Beforehand, I had wondered whether the flyers could have been handed out at one of the rehearsals, and that this could have led to more pressure to take part. Additionally, the participants could also have misunderstood who the contact person for the research actually was. Therefore, the theatre director informed the participants that he would send out a letter on my behalf, making it clear that he had not given me access to their contact information. As such he prepared them for the letters to arrive. The letters included a short introduction to the proposed PhD study, an agreement of participation form, and an invitation to an informational meeting about the research.

I carried out the informational meeting before the study started and held it in a closed café in the same location in which the MTW held rehearsals. Participants were served buns, chocolates, coffee and tea. As well as introducing me and my research, the meeting was held to inform participants about the thesis, research ethics, and publication process. The participants were curious about me as a person. Like Whyte (1993), I gained an understanding of the participants' view of the research as fine, as long as they experienced me as a trustworthy person with good intentions, and they knew the theatre director had vouched for me.

3.3 Recruitment and description of the participants

Based on contact with the theatre director, my original plan of recruiting participants on their clinical diagnoses was viewed as challenging to complete and had to be omitted. Instead, I decided the inclusion criteria for recruited people should be as follows: (a) current or previous participation at the MTW for more than three months and (b) lived experiences with long-term mental health problems lasting more than two years. Participants who did not fit the inclusion criteria were excluded. Additionally, if people at the time of interview were assessed to be in a confused state due to drugs or in acute psychosis, they were excluded. Twelve people were included in the research from the beginning, and one participant chose to withdraw consent halfway through. To prevent disclosure, I chose to include the person in Table 1 because I described the sample in detail in Article 1. All information in the table is from the participants' own descriptions.

Table 1. Background Information of Participants

Background Information (*N* = 12)			
Sex	Man	Woman	
	4	8	
Age	20–29	30–39	40–49
	3	3	6
Income	Work	Work assessment allowance (AAP)	Disability pension
	2	4	6
In a relationship	Yes	No	
	5	7	
Have children	Yes	No	
	4	8	
Beginning of mental problems	Before age 14	Before age 20	After age 20
	4	4	4
Number of years in mental health services	2–10	11–20	More than 20
	1	8	3
Familiar with theatre before attending MTW	Yes	No	
	4	8	
Familiar with music before attending MTW	Yes	No	
	7	5	
Number of years in MTW	0–2 years	3–5 years	6–10 years
	2	5	5

The participants claimed having mental health problems and used the classified diagnoses from diagnostic manuals such as the *ICD-10 (WHO, 2000)* and *DSM-V* (American Psychiatric Association, 2013) to describe their conditions. Many participants identified three to six concurrent diagnoses, whereas others were unsure how many diagnoses they were registered within mental health services and chose to solely operate with diagnoses they felt familiar.

Table 2. An Overview of Self-Reported Diagnoses

Diagnosis	Participants (*N* = 12)
Anxiety/depression	7
Dissociative disorder	4
Bipolar disorder	3
Personality disorder	5
Eating disorder	3
Schizophrenia, other psychotic disorders	5
Attention-deficit disorder (ADD/ADHD)	4
Posttraumatic stress disorder (PTSD)	6
Substance use disorder (alcohol and drugs)	4

3.4 Data collection

In this section, I describe how I proceeded to collect data for this thesis. The data collection mainly consisted of interviews with the participants at the MTW. In addition, I spent time at the MTW to become familiar with the research context.

3.4.1 Becoming familiar with the research context

To become familiar with the MTW I had initially planned to take part in a performance, a dress rehearsal, and some ordinary rehearsals. When I came to the MTW and met the participants and the theatre director, I learned that they wanted me to attend more activities to get more of an inside view of their working duties and simultaneously see the MTW in a larger context. I realised that there were more settings than the ones I had planned for, which could be interesting to attend to gain insight into the MTW. While observing various activities at the MTW, I conducted informal conversations with the participants, the art professionals and others involved. I felt the need to earn a large measure of trust in order to get access to the participants. By investigating the context in more depth, I experienced a larger level of trust from the participants that I could manage the data material in a worthy way.

As time went on, I was given entry into many settings in which the participants took part. At the beginning, I was a bit reserved and had the idea of “observing” without being an active part. However, it became clear that in this environment, that would be inadequate. The participants needed to get to know me as a person and to learn what I stood for before they could decide what they wanted to share with me in the interviews. The reason for participating in these activities and having informal conversations was to get an overall understanding of the context. No separate analyses were conducted based on the conversations and meetings, even though these activities influenced my understanding of the whole and its parts. Through my observations of the context, I gained a wider understanding of the MTW's ways of working, cooperation, and unity among participants and within the group. Through my own participation in these activities, I came to appreciate the participants' creative processes and the quality of their work, as well as the theatre director's role and ability to see the resources of the participants more clearly.

3.4.2 In-depth Interviews

I chose to conduct in-depth interviews to grasp the first-person perspective (Kvale & Brinkmann, 2015). Before the interviews, I devised an interview guide that contained a broad outline of themes and questions that the interview would cover in order to understand the phenomenon. Inspired by Kvale and Brinkmann (2015), the interview guide consisted of the following: initial questions, personal questions, follow-up questions, specific questions, and closing questions. The interview guide was flexible and consisted of three main parts: participation in the MTW, contact with the mental health services, and recovery. I aspired to use open, wondering, and searching phenomenological questions in order to receive full descriptions and reflections related to the participants' lives (Kvale & Brinkmann, 2015; Van Manen, 2014). Despite always bringing the interview guide with me to the actual interview setting, I integrated the questions where they felt natural in the conversation with the person being interviewed. I memorised the questions so that I could concentrate on the participants and the stories they told me. I attempted to create conversations in which I would interrupt the participants' stories as seldom as possible. To avoid breaking the flow of the conversation, I kept a notebook in which I jotted down themes and areas that I wanted participants to expand upon later in the interview. If participants anticipated topics that were supposed to be tackled later in the interview, I altered the order of the questions (Kvale & Brinkmann, 2015; Thagaard, 2013).

The in-depth interview demanded a lot of me as a researcher with regard to both knowledge about the subjects and my ability for social interaction. I experienced the first minutes of the interview as decisive for creating a safe interview environment. As a researcher, I had to be attentive, and interested and at the same time show understanding and respect for what came out in the interview (Kvale & Brinkmann, 2015). As Kvale and

Brinkmann (2015) pointed out, conducting in-depth interviews demands that the researcher is skilful, has the ability to be flexible, and is able to improvise. Despite preparing well for each individual interview, I never knew what stories and themes would come up. This reminded me of my previous experience as a mental health therapist in a mental hospital. Despite therapeutic and research conversations being different (Kvale & Brinkmann, 2015), I found having clinical experience with treatment conversations to be an advantage to creating a safe environment for interviews, as well as having the ability to be flexible in the interview situation.

Of the 20 who were asked, 12 people agreed to take part in the interviews. To complete the interview stage, I planned to have four interview periods lasting 1 week each during June - October 2015. Each participant was formally interviewed once, and the interviews lasted between 46 and 138 minutes, on average 88 minutes. I chose to do a maximum of two interviews a day to ensure the presence and opportunity to reflect on each separate interview. Within the planned interview periods, those taking part could choose the time and place for the interviews. Through the theatre director, I gained access to an office in the same building in which the MTW held rehearsals. This led to eight of the participants electing to carry out their interviews in "my temporary office". The remaining four chose other locations. One preferred to meet at home, whereas another chose her own office. Two of the participants were hospitalised at the time and for that reason preferred to conduct the interview in the unit. One interview was conducted in a common room at a district psychiatric centre (DPS), and the other was held in a locked visitors' room in a forensic hospital. When the interviews were held in "my office", I made tea and coffee beforehand. I set out two identical chairs partly turned towards each other and partly turned into the room to avoid a demand for eye contact during the interview. Those taking part could choose which chair to sit in and were also offered the option to move it around the room in order to feel comfortable. From my own clinical practice, I had experience with different needs regarding what is perceived as a comfortable distance and understood that the placement of chairs can matter to secure retreat or an overview of the room and situation. If I interpreted the participant as being uncomfortable or restless during the interview, I included this thought in the conversation. For example, I could say, "I'm experiencing you as being restless, and you seem stressed – is that a correct assumption?" Depending on the situation, I might enquire whether the participant needed a cigarette break, a toilet break, or fresh air. There were also occasions where I ensured that the participant had understood that it was fine to break off if the subject matter felt too uncomfortable.

The interview appointments were determined by mail or phone days, weeks, or months in advance. If the appointments had been made a long time beforehand, I made contact via e-mail, or phone the week before to confirm the appointment. Already during the first set of interviews, appointments were altered. I had just finished the first interview when the theatre director contacted me to inform me that the next one had to be postponed. The participant had contacted the theatre director to ask him to pass on the message to me. Thus, I understood that I had to be prepared for more changes in appointments. At the same time, I became worried about whether I would be able to conduct the interviews within the scheduled time. The following is a sequence from a memo during the first interview period:

> I feel the despair. I know that people with long-term mental health problems can have mood swings and that the situation can change quickly. However, it is that feeling of having travelled 700 km for one interview! In desperation, I find myself calling a participant who just attended the information meeting to enquire about the possibility of doing an interview the next day. The person accepts the invitation and I feel a bit calmer. (Memo excerpt, June 2015)

Of the four interviews planned before setting off, only one was conducted, though at a different time than planned. The reasons for the alterations were complex, ranging from serious illness in the family to political meetings, double bookings, forgotten appointments, and changes in health. I realised that carrying out the interviews could be a challenge. Upon returning home to Namsos, I had conducted two interviews, so I was worried whether it would be feasible to finish 12 interviews within the four allotted interview periods. Even if I tried to plan in good time and had dialogues with all the participants about interview times, I had to be prepared for both changes and cancellations just before the interviews were about to take place. I realised the need for flexibility if the interview study was to be successful. This challenged me in terms of how many interviews I ought to book per day and how much time I should allot for each interview.

I did not start any interviews without a signed consent for participation (Ruyter, 2003). Immediately before each interview, I informed participants about the use of recording equipment and note taking. In circumstances in which the participant expressed uncertainty about the use of recording equipment, I discussed in more detail how the recording would be used and kept safe. We also agreed that the participant could ask to stop the recording, if necessary, to erase the recording. During a couple of interviews, I chose to pause the recorder when the participant told stories of which few others had knowledge or talked about shame-related themes the person did not wish to have recorded. I informed the participants that during the interview or afterwards they could let me know if there was anything on the recording that they wished would not be included for publication, although they had still elected to share the information in the interview to increase my understanding of the phenomenon under investigation.

3.5. Data analysis

In this section, I present and make visible the meaning of having an attitude of wonder, the use of member-checking, hermeneutic-phenomenological writing and working seminars for the analysis of data. Furthermore, I will describe the analytical process, including the analysis approaches and steps of the articles.

3.5.1 Having an attitude of wonder

A good phenomenological study always begins with wonder (Van Manen, 2014). As I see it, wonder is an important aspect of being human-, and the most mundane everyday experiences can bring us into a state of wondering. Wonder is not really about the unusual and extraordinary (Heidegger, 1994) but is more related to amazing everyday happenings and the extraordinary and unusual in what we usually experience as the usual and ordinary (Hansen & Herholdt-Lomholdt, 2017). Van Manen (2014) claimed:

> Wonder is that moment of being when one is overcome by awe or perplexity – such as when something familiar has turned profoundly unfamiliar, when our gaze has been drawn by the gaze of something that stares back at us. (p. 360)

The wonder places us in the gap *in between* (Heidegger, 1994), between the familiar and unfamiliar, the concrete and abstract, the simple and the complicated. Wonder introduces the possibility for something unusual in the usual and the usual in the unusual, which is important in everyday life, where there is a constant danger of normalising these phenomena (Heidegger, 1994). For me, wonder was been important in the analysis process because it created an openness to the world. I strived to adopt a phenomenological attitude, but felt more comfortable with the hermeneutic phenomenological understanding of the phenomenological attitude. The hermeneutic phenomenological attitude involves the researcher searching for genuine openness and sensitivity (Van Manen, 1997) instead of taking a non-judgmental position in which previous assumptions and knowledge are set aside (Finlay, 2011). My goal was to become open and mentally present so that I could be aware of what is given. By being empathetic and genuinely wondering, in addition to being self-aware both in relation to my own position and to the perspectives that are personally, culturally and historically located, I provide the possibility for the phenomenon under investigation to emerge. According to Professor Emeritus Anders Lindseth (lecture given 15th November 2017 at Aalborg University, Denmark), the phenomenon under investigation speaks very quietly, so it is important to listen carefully to what it has to say. I experienced this as a demanding task, which required experience and practice. I found my experience as a mental health therapist to be useful because I have been trained to listen well to what the patients say. However, I felt that phenomenological research required me to dwell more, release from traditional ways to see what is given, and remain open to seeing the "ordinary" in a new light.

Striving for openness to the world was important during the interviews and the analyses afterwards. In the interviews during which I managed to be open to what was given, I also experienced that the conversation flowed well. This was also pointed out by Carina, one of the participants in this thesis:

> In the meeting with you there is no prejudice, you are completely open. It is so good to say really everything, and it just came like a waterfall. I started on a thought, then a new one came and this despite a terrible day.

Although I experienced my previous clinical experience as an advantage, I also experienced situations in which my background and work experience were obstacles to being open. For example, after completing and transcribing four interviews, I met with my supervisors to talk about the preliminary analysis. Through the discussion with my supervisors, I became aware that my previous background as a mental health therapist contributed to me "closing off" the MTW into being solely an offer of treatment. In becoming aware of how my understanding was closing myself off, I was given a new opportunity to open myself up to the phenomenon. This experience confirmed that I was born into a tradition and that this tradition influences the way I interpret the data. The phenomenon could not appear without my preconception and theoretical background (Heidegger, 1927/2007). Therefore, my long-standing relationship within the context of mental hospitals affected the way in which I viewed the MTW. My preconceived ideas and repertoire of interpretation, which on the one hand were necessary for understanding, were on the other hand blocking a deeper acknowledgment because they limited other interpretations.

3.5.2 Hermeneutical phenomenological writing as analysis

Writing is the core of hermeneutic phenomenological analysis (Saevi, 2005) and is referred to as the method in phenomenology of practice (Van Manen, 2014). The focus on writing was the trigger for my interest and has become an important part of the analytical process. According to Saevi (2005), the researcher needs to develop an ability to be sensitive to how the text expresses the researched phenomenon:

> To be able to hear subtle undertones of the language that describes the materialized world surrounding us, we become listeners, not only to what speaks, but also to how it speaks in order to overcome the immediate familiarity of the world. (p. 94)

The ability to dwell has been made possible for me through writing. That is why I have come to understand writing as my arena for wonder. At times I felt that I needed to write before I could reflect on the theme. Saevi (2013) emphasised the fact that a special and laborious writing process is required to create a phenomenological text that balances between the individual and the universal in lived experiences. I have tried to adapt my writing tempo to have time to dwell on what is emerging, at the same time allotting enough time and space for the phenomenon to emerge from itself. This has been a difficult balancing act in a doctorate process in which I am continuously conscious of deadlines. Simultaneously, as a young and impatient researcher it has been challenging for me to learn to dwell comfortably in “a room of hesitancy” (Saevi, 2013, p. 5). I have undergone a challenging writing process in which I have continually been in dialogue with the text, trying to see the text with “new spectacles” and challenging myself to ask repeated questions about what the text is really about. Hermeneutic phenomenological writing has become a form of cultural education and self-understanding (Van Manen, 1997). In the same way that this thesis has required me to go deep into myself, the writing has demanded the same for the phenomenon to emerge. In so doing, I have produced a considerable amount of text to dwell on and to justify abundance and ambiguity from the experiences. My writing has become a complex process of rewriting.

Until I attended the PhD course “Wonder in qualitative research and practice-based and existential phenomenology” at Aalborg University, Denmark, in the autumn of 2017, I described writing as my only area for wonder and that the phenomenon sprung out of the dialogue I had with the text. During this PhD course, I had to negotiate with the syllabus literature to write an essay on my phenomenological wonderings. Reading Finn Thorbjørn Hansen's (2012) article "One step further: The dance between poetic dwelling and Socratic wonder in phenomenological research" challenged my thinking related to the use of writing as an arena for wonder. In Hansen's view (2012) Van Manen attributed too much room to writing and reading in phenomenological research. Hansen (2012) claim that the importance of "the lifeworld", dialectic Socratic dialogue and common questions related to living and being present are not given enough space. At first, I disagreed with Hansen, which encouraged me to read more of his articles. Again, I had to ponder on my own practice and pose new questions about established truths. Was it possible that I had taken for granted other arenas that are important for my possibility to dwell? By pondering, I became aware of not having sufficiently illuminated the importance of my working fellowship with a PhD colleague and the use of member-checking during the thesis. It became necessary to involve more nuance because the existing picture did not show enough diversity of methods used in the data analysis. Phenomenological writing has been an important starting point for wonder with me. However, when I get stuck and cannot go further, frequent working seminars with a colleague with a different subject background, interests, and experiences contribute to critical inquiry, and new wonderment and help to widen my horizons and enable me to enter into dialogue with literature and my own written texts.

3.5.3 Workshops and member-checking

Hansen (2012) stated that there is a need for a more wonder-based dialogical phenomenology. He argued that: "a phenomenology where Socratic critical and dialectical thinking and questioning is allowed and where a Community of wonder and not "just" a Community of inquiry is displayed and practiced" (Hansen, 2012, p. 15).

Although, Van Manen (1997, 2014) allowed for both the "lyrical impulse" and the "Socratic impulse", Hansen (2012) accused the phenomenology of practice of involving too much focus on writing and reading enterprises. As described in chapter 3.5.2, it was not until the autumn of 2017 that I understood that I had under-communicated the importance of dialogues with others related to the data material and different aspects of understanding being. In a way, I had established a system for dialogue without being aware that I was doing so. There are two arenas that I want to emphasise as particularly important: working seminars with a PhD colleague and member-checking with the research participants.

Close to five years ago when I and a colleague started the project-writing for the PhD positions, we organised working seminars regarding our joint need to have a critical reader of the text material. Since then the working seminars, hereafter called workshops, developed into an arena for deeper conversations on themes we encounter in our doctoral journeys. In the workshops with analysis on the agenda, I have brought written texts and we have opened up a joint dialogue with and about the text: What does the text convey as it stands now? What do I really wish to say? Which associations do I get when the other talks about my draft text? Could there be central aspects, which I have not conveyed in writing at the present time? In the workshops, held at intervals of one to three weeks for around five years, I have experienced that questions and discussions with my colleague have brought me more uncertainty where there has been room for a more existential kind of wonder. We have discussed the meaning of a moment, day-to-day living and what makes life good. Deeper still, we have asked, what is the meaning of life? It seems especially interesting that the more we have dwelled on these questions the more amazing they have become. Looking for recognisable aspects in own PhD colleague's experiences has become an enriching process and an important part of expanding and concretizing my experience of what my data material is about. The workshops have thus made it possible for me to dwell comfortably in "a joint room of hesitation". Through dialogues about discoveries, analyses, and alternative understandings of the data material, the workshops have been important for testing the argument and recognising how my own background and experience could have influenced my interpretations and understanding. In this work, I have gained new insight into the data material, as well as a clearer understanding of what it means to be human.

Originally, I planned to send the articles to the participants when they were published. This plan changed considerably when I met the participants. I discovered that they were interested in the research process and expressed a desire to contribute. They showed an interest in my preliminary analyses and asked whether it would be possible for me to present some findings as I progressed in the research. I pondered upon this before deciding to enter into a dialogue with the participants. As a clinician, I have been particularly interested in dialogue. I realised that I could use dialogue, which I believe was one of my strengths as a clinician, in the research. As a researcher, it was important for me to give the participants a voice, including in the data analysis. Therefore, I wanted to create an arena for member-checking. Member-checking implies that the researcher brings data, analytical themes, interpretations, and conclusions back to the participants in the study (Creswell & Miller,

2000) to test whether these aspects align with their experiences. The first time I presented preliminary findings I was surprised by the commitment, how the findings affected the participants emotionally and the extent of constructive feedback from the people present. The meeting turned into an arena for discussing preliminary results and reflecting together on whether participants could identify with the material presented. I felt that the participants present posed good, but critical questions about the findings that contributed to me gaining a wider understanding of the themes that had emerged in the analysis and provided growth for new wonder and perspectives, which I had to work on further. Because both the participants and I as the researcher experienced member-checking as constructive and valuable, I conducted three member-checking group meetings and several individual meetings face to face, by phone and by e-mail during the research (see Table 3).

Table 3. Overview of the Use of Member-Checking

Article	**Type**	**Content**
Article 1 "Acting out"	Individual	Dialogues face to face and by e-mail around anonymity, central themes, and understanding of these themes and discussion of the published article.
	Group	Group dialogues around preliminary themes, different understandings of these themes, and use of concepts.
Article 2 "I now have a life"	Individual	Dialogues face to face around the preliminary themes.
	Group	Group dialogues around the themes, discussion, and implications for practice.
Article 3 "Transforming identity through participation in music and theatre"	Individual	Dialogues face to face, by phone, and by e-mail around the individual narratives, analysis of the narratives, and theoretical perspectives in discussion. In addition, dialogues around the publication process and evaluation of the member-checking process.
	Group	Group dialogues around the article focus, how to present the findings, and how to ensure the participants' anonymity.
Writing up the thesis	Individual	None
	Group	Group dialogues around the thesis, with a particular focus on preliminary discussion and implications for practice.

When it came time to write the third article, I experienced the theme of identity transformation as personal and sensitive. The interviews had been conducted 1-1,5 years earlier, which meant that the participants did not have a fresh view of the proceedings. Similarly, there was a real possibility that the participants had experienced major changes and gained a new understanding of themselves and their identity in the intervening period. I pondered several methodical as well as ethical choices related to the writing of this article and felt that it could be appropriate to discuss thematic issues with the participants themselves. I considered handing out their own interviews entirely in transcribed form, but because of mixed experiences (Carlson, 2010), I chose instead to introduce a few narratives that were in their early drafts. This practice is supported by Creswell and Miller (2000) who claimed that member-checking works best when using "polished" interpretative parts such as emerging themes and patterns. In this group meeting, there was great agreement among the participants that they did not want to mix the stories of the participants to create the narratives. They rather wanted each narrative to be based on solely one person, although this could present greater challenges in securing anonymity within the group. I explored how the participants wanted to be involved in the preparation and analysis of the narratives, and we agreed that I could contact the participants who had given comprehensive descriptions of the abundance and diversity in identity transformations. I worked individually with the participants who wanted to collaborate to shape and analyse the narratives. Additionally, these participants became important discussion partners in the writing process on the findings and discussion.

Conducting member-checking in this way has shown me that the method can be pivotal in avoiding a situation in which I as the researcher violate participants' understanding of themselves (National Commitee for Research Ethics in the Social Sciences and the Humanities, 2016). The close contact with the participants was challenging; at times, I felt that both the data and the participants were at stake. I experienced a demanding balancing act between giving the participants the right to use dialogue and commentary to safeguard interpretation experienced as meaningful for the participants and my commitment as a researcher to make independent interpretations and summaries of data even when these are not in agreement with the participants' understanding. Despite finding this dialogue-based member-checking challenging, I have nevertheless experienced the dialogue with the participants as very valuable and instructive for me as a researcher.

In the same way as writing has been important, workshops and member-checking have been pivotal in the data analysis. As I see it, the writing and reading process in this thesis has enabled poetical dwelling, while the use of workshops and member-checking has contributed to Socratic dialogue. Together, they have developed a good interaction, or as Hansen (2012) might have put it, they have created a dance or balance between poetic dwelling and Socratic dialogue. The combination of having enough space for writing alone and frequent conversations with others has been important. Working with this thesis has revealed that I have a significant need to be engage in individual processes, where I can close my office door and finish my text without interruption. However, this does not exclude the need for dialogue. The combination of writing, dialogues with the participants, and workshops has developed a "community of wonder".

3.5.4 Process of exploring structures of meaning

In this section, I provide an account of the process of exploring structures of meaning. The analytical process has not been streamlined, where I could move from one step to the next. I have moved back and forth between all the steps as required to identify patterns of similarities and dissimilarities in the lived experiences of the phenomena under investigation (Van Manen, 1997). The analysis has been an intense, recurrent, creative, and complex process- that is a "free act of seeing meaning" driven by hermeneutical *epoche* and *reduction* (Van Manen, 2014). Thus, I have not experienced the analysis as a quick, mechanical, and rule-bound way of working to get a hold of central themes. Similar to Savin-Baden and Major (2013), I have looked at the data analysis as an ongoing process that began with my first meeting with the MTW. The way I conducted my work and the working methods used in this process have been diverse and some are already described in chapters 3.5.2 and 3.5.3. Some of my choices on how to conduct the data analysis were made consciously at the beginning, whereas others have been subconscious, accidental, or came about along the way. Overall, I analysed the data material based in the interviews of the data material was made based on the transcripts of the interviews, analytical memos, and writings I produced along the way through discussions with the participants in member-checking and workshops with a PhD colleague. The data material consists of a large number of memos, mind maps, and 350 transcribed pages from the interviews.

Early in the process, I prioritised becoming acquainted with the data material to get an overall impression. I transcribed all the interviews shortly after their completion with the help of the data analysis software NVivo 11 (Qualitative Solution and Research International, 2015), included verbal language and my interpretation of the tone of voice, timing, pauses, emotional state and body language were included in the transcriptions. The interviews were a unique opportunity for me to become familiar with the data material (Braun & Clarke, 2006). In line with Bird (2005), I saw transcribing as a key phase in the data analysis. I listened to recordings and read through the transcriptions. I engaged in dialogue with the material by asking questions about of the text in a curious and inquiring manner (Clarke, Braun, & Hayfield, 2015). I wrote down or recorded notes on discoveries that might lead to looking at the material again.

Inspired by Finlay (2012), I wrote all logged thoughts and reflections as memos in a digital notebook called Evernote. In addition to writing memos, I also produced oral memos on my digital recorder. These memos have been central for me as a reflexive researcher in trying to be thoughtful and critically self-aware of my own behaviour and the relational interaction in the research, as well as how these relations have been influential (Finlay, 2012). During the interviews, the memos were especially related to the embodiment, the interaction between researcher, and participant and ethical challenges. I aimed to written or oral memos before and after interviews and after activities in which I participated. In addition, I also used memos when choosing the road ahead. Summing up, I used memos to describe and reflect upon: (a) technical conducting of an interview such as the use of interview guide and recorder, place of interview and formulation of questions, length, interruptions, and disruptions during interview; (b) themes brought up by participants, which could include themes the participants were concerned about, themes that were experienced as interesting, surprising, or challenging or themes that were left out or had little focus; (c) dynamics between the researcher and participant during the interview, member-checking and other meeting points; (d) use of verbal and nonverbal language, which included responses with one-syllable words or richer descriptions, eye contact, mimicry, nearness versus distance, and bodily uneasiness; (e) choices in the research process, which involved positioning the philosophy of science, choices between analytical approaches, and theoretical frameworks of references; (f) ethical issues and dilemmas, which included approval, informed consent, confidentiality, possible later repercussions of participation, choice of place, and time for interview.

Hermeneutic phenomenological research strives towards a rich and manifold understanding, rather than simplifying the phenomena (Saevi, 2005; Van Manen, 2014). To accommodate this, I have endeavoured to bring out the complexity and diversity of the phenomena under investigation by establishing more in-dept and breadth into the data material. The data analyses, in the three articles in this thesis, are based on each other. The first article focused on what people with mental health problems experience that enables meaningful participation in a MTW. While working on generating the growing themes in this article, I realized that the data material contained rich descriptions of the attributed value of arts participation from the perspective of the participants. In the second article, I was therefore keen to take a broader view and explore in depth what participation in the music and theatre workshop added to the lives of the participants. During the analysis of articles 1 and 2, it became clear that the data material also contained stories related to different transformations the participants had experienced through their participation in MTW. The extent of such transformations seemed significant and was particularly prominent and voluminous in relation to aspects of identity. In the third article, I felt a need to go deeper into these stories. The focus of this article became the meaning of participation in the MTW related to the participants' experience of their own identity.

In this thesis, three different analytical approaches (see Table 4) were used to analyse the data material. The process of choosing the analysis approaches, has not been a straightforward process. After I decided to do away with Giorgi's (2009) descriptive psychological phenomenological method, I went through a longer process of selecting approaches for the analysis. Because I was primarily looking within the paradigm of phenomenology, I considered Malterud's (2011) text condensation, Smith, Flowers and Larkin`s (2009) interpretative phenomenological analysis (IPA) and Van Manen's (2014) phenomenology of practice. Although Van Manen's (2014) phenomenology of practice appealed to me, I was uncertain because this approach did not offer a clear recipe of how to complete the analysis and I perceived it as too philosophically bound. As I had challenges in deciding on a phenomenological approach, I chose thematic analysis for the first article (Braun & Clarke, 2006; Clarke et al., 2015). The thematic analysis seemed flexible and could be deployed independently of the epistemological framework. A trigger for electing thematic analysis, was that Braun and Clarke (2006) claimed that it is useful for novice researchers who are looking for a recipe when searching for patterns in the data material. As I wanted to explore whether some elements were prominent for enabling meaningful participation, I was convinced that the thematic analysis could accommodate this. I spent a lot of time on the analysis to identify and make note of relevant characteristics in the data material. I organised the data in meaningful groups and tried to show opposites in the data material. I coded as many themes as possible and recoded repeatedly to make them more specific (Clarke et al., 2015). Nevertheless, I experienced that something did not give sufficient meaning. Gradually, I understood that my challenges with coding had to do with the overarching phenomenological philosophy, which is geared towards generating larger central meaning units. Van Manen (1997) warned against the use of coding in phenomenological research, as codes simplify, generalises and have difficulties fully justifying the phenomenon. This acknowledgment became an important step in the process towards generating richer phenomenological themes of meaning. From a starting point with Braun and Clarke’s (2006) thematic analysis in psychology, I eventually modified the analysis with phenomenological language (Van Manen, 1997). Through this process, I became more familiar with Van Manen's (2014) phenomenology of practice. Therefore, when analysing the data material in the second article, I found it more natural to use an analytical approach that was theoretically bound to phenomenology. I chose Van Manens (1997, 2014) phenomenology of practice. The plan was actually to use this approach in the third article that focused on transforming identity. However, I experienced the participants` identity stories as being much more complex and manifold than a thematic sentence could possibly contain. I wanted to keep the participants` identity stories intact by theorising from the particular case, rather than from component themes across cases (Riessman, 2008). I came across Riessman (1993, 2008) narrative analysis and I decided to create narratives based on the data material and theorise these. At first, when I tried to present the narratives as mutually exclusive, I felt like violating the data material. The relief was great when I realised that I could employ cross-cutting themes and present the narratives in an ideographical long narrative form so that the complexity and diversity in identity transformations could be embraced.

Formulating overarching themes was a long-lasting analytical process in all three articles. According to Van Manen (1997), the linguistic transformation is a creative hermeneutic process. By oscillating between the part and its whole, my understanding altered at the same time as new understanding emerged, and vice versa (Van Manen, 1997). I posed questions to the themes in different ways to become aware of whether the themes in fact captured what I wanted to describe. Here, in addition to the workshop with PhD colleague, I found that the discussions with participants in member-checking were fruitful. Hermeneutical phenomenological researchers are encouraged to gather inspiration from philosophy, humanities and social sciences for an expanding insight into interpretative work, but also in the understanding of data material in new ways (Van Manen, 2014). I have had many inspirational sources in my work. I have read literature in psychology, sociology, existential philosophy, and recovery, been on mountain walks and academic uphill trips with PhD colleagues, listened to different radio programmes and watched news and TV series. Even in periods allocated to relaxation and breaks from the research, I have had experiences that have enriched my understanding or have inspired the naming of central themes and subthemes in the different articles. I have strived to dwell on the phenomenon and to become open to the uniqueness of the experience and to the text's development to show the importance of the phenomenon (Saevi, 2005). By utilising an attitude of wonder, I have been able to look at the text with fresh eyes and have posed new questions on what the text says. However, I contradicted Saevi (2005) who argued that understanding comes through dialogue between the researcher and text. Rather, I have experienced that the exchange between writing and the interplay with the surrounding world (Chapter 3.5.2 and 3.5.3) are decisive towards producing phenomenological articles.

Table 4. Overview Analysis Approaches and Steps

Article number & short title	**Epistemology**	**Analysis approach**	**Analysis steps**
Article 1 "Acting Out"	Hermeneutic phenomenology	Modified thematic analysis (Braun & Clarke, 2006; Clarke et al., 2015) with phenomenological language (Van Manen, 1997)	1.Becoming immersed in the data 2.Generating units of meaning 3. Developing emerging themes 4.Reviewing, defining, and naming themes 5.Writing up an understanding
Article 2 "I Now Have a Life"		Van Manens (1997, 2014) phenomenology of practice	1.Naive reading—"holistic reading" 2.Extracting descriptions of the lived experiences with the phenomenon from each interview transcript 3.Developing emerging themes based on all interview transcripts 4.Creating short "interpretative condensed synopses" 5.Reviewing, defining, and naming themes based on discussions with participants and researchers 6.Writing up an understanding through phenomenological reflective writing
Article 3 "Transforming Identity Through Participation in Music and Theatre"		Narrative analysis inspired by Riessman (1993, 2008)	1.Becoming familiar with the data 2.Summarising the essence of each story told 3.Developing emerging themes based on all stories told 4.Cross-cutting themes emerged from discussion with participants, colleagues, and researchers nationally and internationally 5.Writing up

3.6 Research ethics

People with mental health problems, especially those who are being treated at mental hospitals, are considered a vulnerable group in research, which requires increased attention on research ethics. Therefore, I have made ethical considerations throughout the entire research process; during recruitment, during the interviews, and throughout the analysis and writing process of this thesis. An assessment must always be made to decide whether vulnerable groups should be included in research and how such research can be adapted and implemented in an ethically justifiable manner (National Commitee for Research Ethics in the Social Sciences and the when tHumanities, 2016). I have tried to facilitate this research in line with the current national guidelines and laws (Kulturdepartementet, 2017; National Commitee for Research Ethics in the Social Sciences and the Humanities, 2016). As the objective of this thesis was to bring forward knowledge about health and illness, I applied for project approval at the Regional Committee for Medical and Health Research Ethics (REK). REK approved the study in April 2015 (2015\476\REK-Midt).

3.6.1 Informed consent

No research project is ever free of the risk of psychological damage (Ruyter, 2003). However, damage can be reduced by paying increased attention to treating participants with respect, assessing whether the benefits outweigh the possible unpleasantness and risk for the participants and securing approvals and anonymity. The fact that the participants were assessed as a vulnerable group by REK, demanded further responsibility during the whole research process (National Commitee for Research Ethics in the Social Sciences and the Humanities, 2016). In the case of side effects, I considered it appropriate to offer psychological help. The participants had the opportunity to talk to a psychiatrist if the need arose. In the information leaflet about the study the psychiatrist's name, phone number and e-mail address were provided to the participants. The psychiatrist was solely responsible for clarifying the participant's situation and to assess the need for conversations or further treatments within mental health services as a direct result of participation in this research.

3.6.2 Ethical considerations in the research

In accordance with Kvale and Brinkmann (2015), I have been mindful of ethical approaches to the problems during the research process, which I will address in the following.

Consent and decision competence

In line with ethical guidelines (National Commitee for Research Ethics in the Social Sciences and the Humanities, 2016), all participants needed to sign a written consent prior to the interview. Some participants had signed the consent form several months before the interviews were conducted. For that reason, it became important to repeat information on their rights in relation to voluntary participation, insight into the material and information on the study's outcome, prior to the actual interview. I placed special emphasis on the participants' right to withdraw from the study without having to give a reason and without fear of negative consequences for treatment or contact with the mental hospital. After about 1,5 years one of the participants chose to withdraw. I withdrew all data material relating to this person from the analysis in articles 2 and 3 and did not use it further in the thesis. It has nevertheless been challenging to assess what should be used when writing up this thesis as this person is part of the material in article 1. I also pondered on whether it would be breaking the research's ethical guidelines to use background data from this person in the thesis. I have also pondered upon whether it would be problematic to pull this person out of the background table, as some of the information in this table also occurs in article 1, and the person who withdrew may become visible. Additionally, I found the process of participants' withdrawal to be a useful experience as a researcher, and the experience might be of interest to other researchers as well. Nevertheless, protecting the person's integrity and anonymity is so important that it would be unethical to use material to show this process.

I have also been challenged on ethical assessments relating to when it might be justifiable to conduct an interview, bearing in mind the participants' symptomatic pressure and general health condition at that specific time. Along the way, I had to decide who would make those decisions. Would it be the participants themselves, me as the researcher or mental health professionals who knew the participants well? On a personal level I found it unethical to take this decision away from the participants themselves, as I generally believe people will know their own health situation best of all. From my perspective, as human beings we are usually able to feel how we are and whether it would be sensible to expose ourselves to such a situation at any time. Together with my supervisors, we continually discussed research ethics and legislations. We committed to the view that people with mental health problems in most cases can assess themselves whether an interview is feasible and that we as researchers have a special responsibility and need to consider this in relation to each participants (Kulturdepartementet, 2017; National Commitee for Research Ethics in the Social Sciences and the Humanities, 2016). I was unsure several occasions during the thesis. On one occasion, the participant had asked for a separate meeting to get more information about the study. This person brought two health professionals from the hospital to conduct a meeting with me. I found myself in a situation where I interpreted the person as being in an acute psychotic phase, but the person expressed a strong wish to participate in the study with the argument that people with serious mental health problems seldom have the chance to express a voice in research studies. I received a written consent to take part. At the time, I did not feel it would be defensible in research terms to interview the person and was also unsure about the consent being valid (National Commitee for Research Ethics in the Social Sciences and the Humanities, 2016). Rather than reject the person, I engaged in dialogue and asked this person to decide when it might be appropriate to conduct an interview. In this conversation, I found that the participant preferred to conduct the interviews when being sufficiently mentally stable. The person confirmed own mental state as being chaotic and agreed it would be good to postpone the interview. We decided that I would be in touch by phone 2 months later to enquire whether the situation had changed enough for an interview to be possible. During the appointed phone call the person confirmed a change in mental state, and the interview was carried out a few weeks later, but with a new written consent.

Anonymity

In the phenomenological research wherein I focused on lived experiences securing participants` anonymity can be an ethical challenge. I transcribed the data material into Norwegian *Bokmål* to avoid linguistic peculiarities making recognition possible. The research participants were all given pseudonyms. Some stories or quotes were omitted for publication because of a great danger of recognition. It became especially challenging to secure anonymity in relation to article 3, where I presented data material in ideographical long narrative form. Because intensity and the extent of dialogue-based member-checking increased in the writing process, anonymity was given even more credence.

To increase the possibility of critical comments on participation in the MTW, it was important that the participants could take part without informing the theatre director who had consented to take part. The participants themselves chose to inform the theatre director about their participation. At their own investigation, the participants had conversations with the theatre director before and after the interview as preparation or debrief. I did not initiate this contact. The participants chose the theatre director as a go-between when they were admitted to a hospital or wanted me to know about special incidents or needs before interview. It became clear that the participants utilised the person they already trusted and continued to use the support system they had been given by participating in MTW to tackle a new setting, such as the research interview. The fact that the theatre director was preferred as someone to talk to rather than the assigned psychiatrist was both interesting and surprising.

The participants were open about their own participation and knew each other well, and this fact would turn out to be a challenge with regards to securing anonymity within the participants. When collecting data, I discovered that the participants knew each other better than I had expected beforehand. They had good knowledge of both existing and previous participants, MTW productions and each other's parts and texts. It became challenging to select quotes without recognition within the group. In several instances, it was not sufficient to rewrite quotes into Norwegian *Bokmål* because the other participants recognised the situation or the way it was being described. Sometimes I was aware that recognition could happen within the group and could discuss this with each participant. Other times it was difficult for me to foresee that the situation described could in fact be identified by other participants. During the completion of the interviews and in the dialogue-based member-checking, anonymity became a subject for discussion. Participants claimed recognition was unproblematic precisely because they knew each other so well through conversations and texts in MTW. As the researcher, I had a special responsibility (National Commitee for Research Ethics in the Social Sciences and the Humanities, 2016; Ruyter, 2003) to be careful in selecting quotes and subjects to limit the possibilities for recognition within MTW, and outwards towards the general public. As there are few MTWs in Norwegian mental hospitals, and none that are organised in the same way as the one I worked with, there could be a danger of someone tracing the actual MTW and its participants. The fact that the MTW is also a group in the public eye and an active part of the cultural life in Norway implies there is much picture- and video material available, in addition to interviews, newspaper articles, TV broadcasts and reviews on the Internet.

The right to a voice versus the risks in taking part

In research that involves human beings regard and respect for the research participants' welfare always take precedence over science and society's interests (National

Commitee for Research Ethics in the Social Sciences and the Humanities, 2016; World Medical Association, 2013). In planning this thesis, I was concerned with assessing the consequences of the participants. The fact that people with long-term mental health problems are considered a vulnerable group in an ethical research context made it important to be aware that this thesis could put them and their families in a vulnerable position. At the same time, there is a danger that people with long-term mental health problems will be excluded from the opportunity to take part in important research that will benefit them (National Commitee for Research Ethics in the Social Sciences and the Humanities, 2016). The focus ought to be on how we may adapt and organise in an ethical and justifiable way instead of problematising on whether research ought to happen. It is important to ensure that people with long-term mental health problems are not overlooked as research participants because of chaotic health and an exaggerated fear of further damage. It should be ensured that their voices also appear in the research. However, I have the responsibility to ensure that the research is conducted in accordance with ethical principles and that the participants involved are offered follow-up services to process problems that might emerge as a result of participation in the research (National Commitee for Research Ethics in the Social Sciences and the Humanities, 2016). Simultaneously, it would be naïve to rule out that the participants can be placed in vulnerable situations, even if the research is undertaken according to the ethical principles of research. The challenge lies in the fact that, as a researcher, I must be aware of getting into situations where I cannot read up on the correct decision to make, as well as where I must make individual assessments in the encounter with each individual research participant. Guidelines for research ethics visualise the researchers responsible for avoiding harm (National Commitee for Research Ethics in the Social Sciences and the Humanities, 2016). I have nevertheless experienced the difficulty in knowing whether topics discussed in the interview could contribute to traumatisation of the participants. Throughout this thesis there have been many situations requiring individual assessments that have been discussed with supervisors along the way. These instances have been in relation to who can partake in the study, in which phases of their illness they can safely be involved in the research, expanding individual as well as group member-checking during the research, distinctive stories that may impair the protective anonymity or vulnerable stories the participants are relating for the first time.

Doing sensitive research

Still, many people with long-term mental health problems are stigmatised by being characterised as dangerous (Sayce, 2016). This is despite the fact that most are peaceful people. Nevertheless, in pressurised situations, a few may cause others injury. As the researcher, I had limited knowledge on the people I was to interview. I had to consider how to conduct myself in the interview setting, as I neither had knowledge of the participants nor their state of health at the time of the interview. I leaned on my many years as clinician where I have acquired competence in reading body language, being observant in relation to physical proximity and distance, and being on the alert for risk factors. I have previously been good at establishing rapport and calming threatening situations. With the belief in my own ability to be flexible and to quickly perceive and continuously analyse, if challenging situations should occur, I did not want to take special measures to interview the participants.

I had to decide on time and place for the interviews. I decided to let the participants express their preference for the place of interview. In those instances where the participants wanted to do the interviews in the vicinity of the hospital, I chose to use a building in the hospital grounds during periods when no one else was present in the building. The interviews were conducted on the second floor in an office with few escape routes. However, as the participant arrived, I made a quick assessment as to whether I should conduct the interview in a common room on the ground floor with more escape opportunities. I never found this option necessary, in any of the interview sessions. Once, when one participant wanted to conduct the interview at home, I was uncertain whether to let someone else know where I had gone. However, if I told anyone where I was going, the participant would be identified. I therefore decided to notify the theatre director that I was going for an interview at someone's house without telling him who this person was. When conducting an interview in a forensic unit, only the time was arranged beforehand. I neither asked nor received information from the staff in advance about the person being interviewed. I had no idea why the person was hospitalised or if I should take special precautions. I preferred to interview the person without the staff present if this was in line with the participant's own wish. The staff accepted this but chose to sit outside the visiting room where the interview was taking place, in case any of us wanted to interrupt the interview at any time.

3.7 The quality of the research

As a researcher, I need to think critically and strategically about how to ensure the quality of the research. In this section, I discuss key approaches that have been of importance to ensure quality in research. There are various techniques to increase research credibility (Creswell & Miller, 2000). In the mid1980s, Lincoln and Guba (1985) emphasised that qualitative studies needed different criteria for credibility than traditional quantitative studies. In this thesis I have elected to use Creswell and Miller's (2000) two-dimensional framework for validity, which includes (1) the lens used by the researcher and (2) paradigm assumptions. Of the nine validity procedures that Creswell and Miller (2000) connected to the two-dimensional framework, I have considered researcher reflexivity, member-checking, and peer-debriefing as key approaches to ensure validity of the analysis in this thesis.

3.7.1 The researchers' reflexivity

Qualitative and quantitative researchers have personal bias that will influence the interpretation of data (Creswell & Miller, 2000; Malterud, 2001, 2011). Making the researcher's position transparent is considered important in qualitative research. Finlay (2002) stated that an awareness of the researcher's own role in the research should be part of a thoughtful, conscious self-awareness, which is called reflexivity. For me, reflexivity has been part of the entire research process. My background and position influenced the investigated phenomenon, the point of view of the research, which methods I considered relevant in relation to the study's purpose, which discoveries that emerged, and the conclusion's framework (Malterud, 2001). As a researcher, my use of reflexivity has enabled me to self-reveal assumptions, views, and biases that have contributed to shaping the research (Creswell & Miller, 2000). My upbringing, surrounded by music, dance, and trips to India, Mexico and Cuba has made a lasting impression. The same goes for my work experience in psychiatry and my acquaintance with colleagues at the bachelor programme for social education.

In particular, my knowledge of psychiatric health provision made it possible to quickly gain a picture of the participants' contact with the treatment system. The participants appreciated my previous experience from psychiatry. Some expressed that they felt safer in the interview setting because there was no need to explain all structures, abbreviations, and tribal language used in psychiatry. They could solely focus on stories relating to their own art participation and recovery. At the same time, my knowledge and experience as a mental health therapist had a flipside. I have probably taken the participants' understanding for granted, and lost interesting aspects of their understanding of terms and concepts.

As a clinician, I have developed the ability to listen carefully, and to create a safe environment in which to share difficult experiences. I have gathered a rich amount of data connected to the participants' interests and abilities to share and that can also be attached to my ability to listen. Even if I was aware of this throughout, I was still afraid that my focus on creating a safe interview framework might lead to some participants feeling seduced into sharing more than they had planned. I attempted to compensate for this by having a dialogue about it along the way, thus enabling them to let me know if they felt they had said more than they felt comfortable with.

At the start of the PhD thesis, several quarters warned me about using my clinical experience because research and treatment are very different. Therefore, I had an excessive focus on how to separate the role as a clinician from the role as a researcher. The challenge was that I was the instrument in both. Although the purpose of research and treatment is different, it became clear to me that I had to be myself. I had to find my place as a researcher. Any attempt separating these roles strictly made me even more frustrated and confused. When I accommodated myself, and my experiences from clinical work, I was able to shape my role as a researcher. Then, I experienced that many of my personal characteristics and abilities from clinical practice could also be utilised in the research.

3.7.2 Member-checking

With reference to Lincoln and Guba (1985), member-checking is one of the most central techniques to assess the credibility of research studies. I have used member-checking (see Chapter 3.5.3) to increase the research's accuracy, credibility, and validity by discussing data, themes and interpretation throughout the PhD thesis with the participants, individually and in groups (Creswell & Miller, 2000). According to Doyle (2007), member-checking can contain many forms. Usually member-checking is employed once. However, I have used member-checking as a continuous dialogue-based process in the interview setting, analysis phase, and discussion of the results (see Table 3 and Chapter 3.5.3).

3.7.3 Peer-debriefing

It is important that someone who is familiar with the research or the phenomenon under investigation to evaluate the data and research project as a whole (Creswell & Miller, 2000). Through the establishment of a system for peer-debriefing, the credibility of the research is increased (Creswell & Miller, 2000). Lincoln and Guba (1985), stated that this could happen through a person who acts as a reviewer, which gives support, acts as the devil's advocate, challenges the researcher's presumptions, pushes the researcher onto the next methodological step, and poses challenging questions related to methods and interpretations. In this thesis, I have used five different debriefing systems to a differing extent: workshops, research groups, publishing seminars, final doctoral seminar, and research stay abroad. As described earlier, workshops with a PhD colleague (see Chapter 3.5.3) have been a central arena for peer-debriefing. In the created PhD fellowship, we supported and played devil's advocate for each other's research. We challenged the preconceptions, concept descriptions, theoretical and philosophical backgrounds, and choice of method and analyses. Furthermore, we have read and commented on each other's interview guides, information guides, conference papers, and manuscript drafts. Critical questions and comments in the workshops have contributed to better research quality. Another method of conducting peer-debriefing included active membership in two research groups at Nord University. The research groups have provided a space for presenting the thesis as a whole and critical comments on article drafts. I have also appreciated participation in publication seminars for young researchers. The seminars have been a joint project between Nord University, Namsos Hospital and Levanger Hospital, where Jonathan Tritter, professor in sociology and public policy at Aston University, has run the seminars. In these seminars, we critically analysed the participants' manuscripts. In the final phase of the doctoral period, the final seminar with Rob Bongaardt, professor of mental health, was of great value for getting feedback on the draft and for an opportunity to discuss the thesis strengths and weaknesses. Finally, a research stay at Yale University, has been my last peer-debrief arena. Through talks with leading international researchers in recovery, I received constructive feedback on articles and my own research. Being part of this research environment provided new experiences and perspectives that were enriching for the thesis.

3.8 Reflections on becoming a researcher

According to Finlay (2011), phenomenological research has the potential to be transformative for the researcher. During the four years in which this thesis took place, I experienced the transformative process from being a mental health therapist and a university lecturer to becoming a researcher with clinical experience. This transformative process has neither been streamlined nor reached the end station.

I found that the phenomenological research allowed me to stay focused and open to the new possibilities and to keep wondering about the world around me, as well as the topics that I had earlier taken for granted. The role as a researcher requires me to be reflective (Finlay, 2002, 2011). This has resulted in an exploratory position for me. When I started this PhD, I was keen to find the right way to conduct the research. I read a considerable amount of books and articles, hoping to receive an overview of the research field because I thought it was possible to find the right way to do the research. During this research process, I became less concerned about finding one way to do the research. To a greater extent, I have developed an understanding that there are many different ways to carry out the research but that I need to visualise what choices I have made and why these were taken.

In addition to choosing a research approach based on the research questions, it has been important to find approaches that reinforced my strengths and where I was allowed to use myself as a tool. Initially, I was very keen to make a strong distinction between being a researcher and a clinician. I was unsure if it was appropriate to use my previous experiences when I was to shape my role as a researcher. When I became more confident in the main differences between a researcher and a mental health therapist, it became easier to use my qualities as a person in the researcher role. I realised that I was the tool, regardless of whether I was the researcher or the therapist. Then I could begin to recognise my qualities and use these in the different phases of the research process.

4. Findings

This thesis is built upon three empirical articles. In this chapter, I briefly summarise the findings from these articles. As described in the methodology chapter, the three articles build on each other. This means, that the topics that emerged in the analyses of one article are more broadly and deeply explored in the next article. Therefore, instead of presenting each article's findings separately, I provided a more coherent summary of the three articles together in this chapter.

Participation in the MTW offered the participants perspectives on an existence different from the confines of the mental hospital, its daily routines, the health professionals, and their constricted gaze. The participants mirrored expectations from health professionals, which came in the wake of symptoms and diagnoses and they maintained a corresponding understanding of themselves and what they could achieve. Upon entering the MTW, the participants' way of being with themselves, relating to other people, and believing in their own possibilities might transform (Articles 2 and 3).

In the MTW, the participants met dedicated arts professionals who were flexible and solution- and person-oriented without therapeutic education or therapeutic intentions. Together they created a workshop setting featuring a non-judgmental attitude consisting of a genuine interest, an acceptance, and an ability to understand, as far as possible, the world seen from the perspective of the participants (Article 1).

MTW emerged to become a creative zone that belonged to the participants. Despite sharing a plethora of challenging personal life stories and existential questions, the participants experienced having access to a free zone in the mental hospital free from therapy and diagnosis. Through laborious creative work on these stories and questions both alone and together in the workshop setting, space was created for the diversity of perspectives that were discussed, used, merged, and given shape. In the creative process, the unique and distinctive features of the participants were embraced and flourished in full appreciation of the capabilities and limitations. The participants' capabilities, limitations, and diversities were transformed to resources for their creative performances. They were challenged to explore different facets of themselves to allow the character and the story to come to life for an audience. The participants evolved insight into new and diverse perspectives that made it possible to increase their role repertoire, as well as to create new narratives and a multitude of future scenarios, within and beyond the workshop setting (Articles 1 and 3).

The magic of MTW is the given free space that was allowed to be fragmented, dysfunctional, resourceful and creative at the same time. That MTW could accommodate participants' vulnerabilities and the capabilities increased the participants' interest in exploring who they were and what they could manage, which supported a feeling of becoming more genuine and whole as a person. By participating in MTW, the participants experienced glimpses of positive moments despite a challenging life situation. Such volatile moments of meaning, focus, joy, and achievement could be picked up as threads of a new life, woven into a new sense of self, and a transformed identity. For some participants, this new tapestry of meanings was solidified in a life beyond the workshop setting and the mental hospital. For other participants, however, continuity of the workshop was required to maintain the availability of a different, more expanded existence (Articles 2 and 3).

5. Discussion

The overall aim of this thesis is to explore how performing arts can support recovery processes among people with long-term mental health problems. In this chapter, I will discuss the findings in relation to the research questions of the thesis. The findings will be discussed in light of the theoretical perspective of the thesis and the research literature. To various degrees, all three articles describe participants' experiences with the MTW as a free zone. Therefore, I will discuss the meaning of the MTW as a free zone in relation to recovery processes. Furthermore, I will discuss the cornerstones of the free zone that appear to be of importance to supporting recovery processes and at the same time shed light on some challenges with offering arts activities in a mental hospital context. The chapter concludes with a discussion of the implications for policy and practice and questions for further research.

5.1 The MTW – a free zone that supports the recovery process

The MTW is described by the participants as a free zone. The findings from the empirical analyses of participants' stories illustrates that this free zone could support recovery processes in their lives. In this chapter, I consider how the MTW can be understood as a free zone. I will also identify prominent recovery processes through participation in the MTW. Based on the participants' accounts in articles 1 and 3, this free zone can be understood as a physical, as well as a psychological place, where the participants seek safety, belonging and creativity in an otherwise vulnerable situation. The participants described the free zone as a good place to be as they experienced unconditional care and acceptance, a sense of control and freedom without being limited by the hospital environment (Article 1). This free zone appears to be a parallel to Winnicott's (1971/2005) concept of *potential space*. According to Winnicott (1971/2005), living creatively is a healthy state and situated in the potential space between the person and the environment. He describes the potential space as an intermediate area of experiencing between fantasy and reality (Ogden, 1985; Winnicott, 1971/2005).

> In the potential space, in the encounter between inner and outer reality, the person, in his spontaneous movements and inclinations, encounters something, or pursue something in the external world and both transforms it and lets himself be transformed by it. (Jemstedt, 2000, p. 125)

This thesis shows that it is possible to create such a free zone, a kind of potential space, for people with long-term mental health problems in a mental hospital context. This possibility exists despite previous literature reviews pointing out that mental hospitals' physical and organizational structures are not designed to give patients space and access to privacy from health professionals during their hospital stays (Gwinner & Ward, 2013; Waldemar, Arnfred, Petersen, & Korsbek, 2016).

The understanding of recovery in this thesis is inspired by Deegan (2002), who claimed that recovery is a process of transformation. From my perspective and based on findings in this thesis (Articles 2 and 3), I argue that recovery is more than one process of transformation. Thus, I will describe recovery as a multidimensional process of various transformations through interacting with others to live a meaningful and valued life as equal citizens. I will distinguish between transformation and change: I see transformations as movement while change is intended to be longer lasting. The movements I have described in this thesis did not need to be powerful or enduring to be considered transformations. It could also be more momentary transformations that briefly allow participants to experience entering into another world, but to return to their normal states at the end of a rehearsal or performance. The transformations participants' experienced varied both in form and degree and will be further elucidated in this chapter. This thesis shows that the MTW as a free zone has the potential to facilitate a multitude of transformations and thus support central recovery processes for people with long-term mental health problems. The transformations described are multidimensional (personal, social, relational and structural) as people are not independent of the social world. Based on the empirical analysis of the data material, the participants described transformations in relation to (a) *identity*, (b) *hope and meaning*, (c) *coping and self-efficacy* and (d) *agency and liberation*. Although these transformations are most visible in the empirical findings, differences were observed among the participants in relation to which transformations are most evident and the magnitude of the impact on their lives. Some of the transformations were distinctive in a person's life, others were small, some were prolonged and others were brief snapshots.

5.1.1 Identity transformation

Article 3 shows that participants experienced various identity transformations through their participation in the MTW. The participants described processes where they came to know and reveal new aspects of themselves and gradually could “take of their masks”. This transformation permitted participants to create more healthier and more positive identities, balance multiple identities and collectively redefine themselves and together create counterstories. In the discussion in Article 3, I highlight that participation in the MTW transformed the participants’ experiences of identity at both an individual and a collective level. Earlier research on performing arts and recovery have elucidated the potential of arts activities to transform a negative or stigmatized identity of being mentally ill to a more positive artistic identity (Moran & Alon, 2011; Sapouna & Pamer, 2014; Torrissen & Stickley, 2018). Research has, to a limited extent, illuminated how the process of portraying characters influences the journey of self-discovery and how this process has a potential to create a sense of belonging to the world. What this thesis adds to this research is how working with a role repertoire triggers a self-discovery process. In the development of the participants’ roles, they actively draw on themselves. Participants sought within themselves to find traits that could be used to portray roles. Getting underneath the skin of a character was important; it created an image of a character’s thoughts and feelings, and thus experiencing these. Sometimes it was enough for participants to remember thoughts and feelings from their own lived experience, other times make-up, costumes and scenery where needed to enter a role. As I discussed in Article 3, this is consistent with Tust-Gunn (1995), who highlights that self-consciousness is both important and necessary to create new characters onstage. At the same time, Tust-Gunn (1995) emphasizes that the work of developing new characters can simultaneously build an actor’s self-consciousness (Tust-Gunn, 1995). Through an increased self-consciousness, the participants in the MTW could use more of themselves in the roles they created. The MTW could be understood as a free zone in which to act out characters whose characteristics and traits resembled their own, but ones participants had not fully developed or dared display in real life.

This thesis makes visible how the MTW has the potential to positively influence participants getting to know themselves, restoring positive identities and becoming a person; all elements that are considered central to the recovery process (Davidson, 2003; Davidson & White, 2007; Deegan, 2002). Participation in a MTW can support participants’ explorations of themselves and the process of becoming a person. This aligns with Rogers (1989) *process of becoming*. Rogers’ (1989) argued that through the interaction with the environment, and specifically through contact with a therapist, the structure of the patient’s self could be formed. Among the participants in this thesis, there was a significant variation in how far the participants had come in their process of becoming. The differences varied from those who were unsure if they were even someone at all, to those who worked on removing their masks when meeting their surroundings; others felt they knew themselves well, but still struggled when trying to be authentic. The participants reported that through the MTW, they had become more concerned with themselves, because having too large of a gap between their "inner" and "outer" selves felt like an energy drain (Article 3). When the participants were not capable of acting in accordance with their selves, it was experienced as problematic, and they described a feeling of alienation. This is in line with Rogers (1989), who emphasizes the importance of being authentic, meaning being oneself. In the MTW, the participants were accepted as human beings. This meant it was simultaneously possible to be fragmented, dysfunctional, resourceful and creative. In other words, there was room for a person's complexity and contradictions to be acknowledged (Rogers, 1989). Participants could be themselves, with all the richness and complexity this entailed, without having to hide or fear anything, either from themselves or from others; they could experience becoming a person.

5.1.2 Hope and meaning as transformation

Finding hope and meaning are central goals in recovery (Leamy et al., 2011). Article 2 shows that the participants have had difficulties finding a sense of hope and meaning in their lives due to long-term mental health problems. The participants described suicidal thoughts, plans and attempts as common occurrences. In Article 2, I demonstrate that the participants had been given pessimistic prognoses by health professionals. Since these prognoses for the future were given by "experts" during treatment, they had a significant influence on any goals, dreams and visons of the future. As Deegan (1996) claimed: "when the future has been closed off in this way the present loses its orientation and becomes nothing but a succession of unrelated moments" (p. 92). Such experiences of hopelessness and pessimism hinder recovery (Onken, Dumont, Ridgway, Dornan, & Ralph, 2002). For some, participating in the MTW became an activity that provided moments of meaning in a life otherwise in existential vacuum (Article 2). Experiences in the MTW seemed to give some of the participants glimpses of meaning, while others described these experiences as turning points in their lives; transformations that created a prolonged or more permanent change in making their lives worth living. In line with Davidson, Shahar, Lawless, Sells, and Tondora (2006), who emphasize that play, pleasure and positive life events can play a central role in recovery, this thesis suggests that participants could gain purpose, meaning and hope in their lives and a belief in a better future.

According to Stickley and Hui (2012), there is a lack of meaningful activities in mental health services. Creating the potential of having an everyday life is seen as central to supporting people with mental health problems (Borg & Davidson, 2008). Being in the MTW helped participants to create and add structure to their everyday life. The participants were given something to go to on a regular basis adding substance to their days and a reason to get up in the morning. When they were given a point of reference in their lives, transformations of hope and meaning took place. Previous research highlights the importance of people with mental health problems participating in meaningful activities that link health services to the local community (Stickley & Hui, 2012) and preferably activities that not solely occur in psychiatric settings (Borg & Davidson, 2008). This thesis emphasis, that participation in the MTW can give participants similar experiences and simultaneously facilitate transformation processes of hope and meaning, despite the activity taking place within the hospital rather the local community.

5.1.3 Coping and self-efficacy as transformation

Participation in the MTW contributed to transformative processes associated with coping and self-efficacy. Participation in MTW was allowed regardless of previous interests, experience or skills within performing arts (Article 1). The theatre director invested time to get to know each participants and their interests and experience within the arts and to gain insight into the goals, motivation and expectations. This important process allowed the theatre director to rapidly give new participants manageable tasks to experience satisfaction and joy of accomplishment. Article 1, in this thesis, documents how arts professionals could adapt activities appropriately to meet the ability of participants. This did not mean giving the participants tasks with little difficulty. Rather tasks were set to be challenging and slightly above participants' level of coping. This approach seems to be in line with Csikzentmihalyi (1996) concept *flow* (i.e. when the activity's challenges aligns with the preconditions to master the challenges, a person can experience a mental state in harmony with the activity, where one`s sense of space and time fades away*).* Through participation in the MTW, participants described flow experiences (Article 2) and increasingly flourishing arts skills (Articles 1 and 3). Most participants had low self-efficacy when they started in MTW, but this changed considerably through their participation and their experience of successfully coping with new and increasingly challenging tasks. These changes seem related to the arts professional's ability to adapt skills to the level of the participants and see resources within the participants that they could not see themselves; this process transformed symptoms and challenges into becoming personal resources.

In this thesis, I emphasize that participants and arts professionals joined a collective collaboration. In this collaboration, the participants described exercising considerable influence on the creative process and in finding appropriate solutions based on their own resources and challenges (Article 1). Although each person's performance was important, the main focus was on creating good stories and experiences for the audience (Article 2). To meet this goal, participants had to work together and see each other as collaborative contributors. The art professionals were not merely teachers who gave participants music and theatre training, but rather true collaborators in a creative expression. Working together this way meant sharing power; sometimes the participants would be considered the expert and sometimes the professional would be. This collaboration resembles Slade's (2009) description of partnership relationships. According to Slade (2009), part of the core of recovery-oriented work is supporting such partnership relationships as opposed to traditional detached relationships where the professionals have the real power. In the MTW, the participants experienced genuine collaboration in which their competence, life experience and perspectives were considered as interesting and important as those of the professionals for the development of a creative product. In this collaboration between participants and arts professionals in the MTW, the participants' competence of the participants was recognized and they were given greater responsibility, which resulted in increased faith in their own competence and self-efficacy.

Article 1 highlights that participants were challenged with tasks and activities they had never tried before or were unsure they would be able to do. The participants reported tension or anxiety linked to being on stage, remembering lines, telling a story and portraying new characters. According to Slade (2009), all human beings must take risks to grow, develop and experience change. Slade (2009) claims that people with mental health problems must be given more exposure to positive risk taking, getting involved in activities that are challenging and lead to personal growth and development. As shown in article 1, the health professionals were sceptical toward participation, fearing that such activities participation would trigger the illness or otherwise deteriorate the person's mental condition. Slade (2009) reports that health professionals have traditionally taken too much responsibility for people with mental health problems, thus keeping these people from exposing themselves to positive risks. By continuously reducing risk, health professionals remove the possibility of choice and growth for people with mental health problems (Slade, 2009). This thesis emphasises that the participants in the MTW were given the opportunity to try various ways of expressing their creativity, increasing their coping and self-efficacy. Participants anxiety when trying new tasks was communicated as a normal reaction rather than a symptom of a new illness course. However, the MTW was emphasised as a space in which they could try and succeed, or they could fail without fear or ridicule (Article 1). This is consistent with Deegan (1988), who says: “To recover, psychiatrically disabled persons must be willing to try and fail, and try again” (p. 16). The fact that the participants were exposed to positive risk taking in the MTW resulted in increased competence in arts activities. Additionally, the participants experienced self-efficacy as a result of their achievement. Sometimes such experiences could be a turning point in what they thought was possible and how they could build their future life. Thus, this thesis highlights that increased coping and self-efficacy influence how participants approach new creative tasks and their implication for tasks and situations outside the MTW.

5.1.4 Agency and liberation as transformation

Long-term mental health problems and enduring contact with mental health services can undermine people’s agency and sense of freedom (Goffman, 1968; Slade, 2009). In the MTW, participants could draw on their lived experience, positive and negative, and transform these experiences into various expressions of art. As primarily described in article 3, these themes were linked to existentialism, identity, stigma, mental health problems and interaction with health services. Participants could find these themes challenging to talk about, but they became easier to engage with through the arts. In line with Gadamer (1960/2010), who claims that the true experience of theatre is being drawn into the play, the participants experienced the MTW as liberating because there was room to be drawn in. When acting, they exercised greater freedom to be creative (Winnicott, 1971/2005). Article 2 revealed that acting offered participants a break from normal social rules and demands, and article 3 showed that this allowed participants to see problems or situations in a different way. The participants experienced freedom from their usual roles, and found abandoning the conventions surrounding mental health services particularly liberating. Through acting in the MTW, participants could challenge established structures and truths, and they could play with the roles of patients and health professionals: what it means to be ill and classified as a mental patient and how to deliver treatment. The participants knew how to give in to the mental hospital's many demands, standards and ways of thinking, but through the arts, they had the opportunity to reflect upon, criticize and challenge the mental hospitals' established practices. This is consistent with Varkøy (2012b) who claims that the arts can challenge established truths. The arts can give people an opportunity to stop and reflect upon being-in-the-world (Varkøy, 2012b). The MTW participants developed a different perspective on the world. Through the arts, they realized that the world did not necessarily have to remain as it is. In this research, this realization seemed to trigger new thought processes and an awareness of how they as individuals and as a group, could be understood and should be treated. In line with Nicholson (2014), arts gave participants an opportunity to travel into a fictional world, that provided them with new ways of seeing and different ways of looking at established truth. When the participants had the opportunity to enter fictional worlds over a longer period of time, they appeared to get a break from normal life and access another existence where they could gain power to transform their lives. They could start a process of getting control and responsibility in their own life. The MTW participants were also empowered as a group. Together, they were able to question established mental health practice and contribute to real change and liberation. This research highlights how artistic tools could be used to question, highlight and criticize the established system without individuals suffering any negative consequences. This is consistent with Faigin and Stein (2015), who emphasise that theatre can be a softer form of activism, one where humour can disarm the audience and strengthen the actors' message. Thus the MTW appeared to help participants achieve a visibility and raise a valued voice in public debate, which is considered an important step to recovery.

5.2 The cornerstones of the free zone

Based on the empirical analysis, some cornerstones of a free zone are identified. These cornerstones are important for supporting recovery processes in the MTW. In this section, I emphasise three cornerstones for creating a free zone with transformative potential: (a) a high degree of accessibility and flexibility, (b) a person-centred approach and (c) belonging and constructing a safe haven

5.2.1 A high degree of accessibility and flexibility

Article 1 shows that participants had previously been in programs or activities that had clear guidelines on access, duration of activity and expected outcomes. If they failed or had challenges in meeting the requirements, they were no longer welcome. Over the years, they came to feel that they had trouble joining or completing these activities. Although, the participants had been in beneficial activities they had to terminate their participation because they were discharged from the hospital or the course programme ended. This challenge of flexible access and entry reinforces findings from Deegan (2002), claiming that numerous activities within health services actually work against the process of recovery. As shown in article 1, the MTW chose a more dynamic and nonlinear approach in relation to access and entry. The sole criterion for participation was that people were in treatment or had previously received treatment at the mental hospital. The participants embraced the freedom of personally determining the frequency and duration of their participation according to their own needs. With no frequency restrictions, the participants felt less stress if frequency varied. Without duration limitations, most chose to stay involved in the activity for extended periods. As described in article 3, the MTW became an anchor where they could manage and were they were allowed to attend for years. According to Deegan (1988, p. 16), to nurture recovery, the activities within the service must be structured to embrace the fact that the recovery process is long-lasting and relies on a series of small beginnings and very small steps. The fact that the MTW had taken seriously the recovery process's long-lasting course and the ups and downs experienced by participants, the high degree of accessibility and flexibility contributed to this approach's success. Furthermore, by recognizing recovery as an nonlinear process (Deegan, 1988, 2002) with waxing and waning symptoms and functioning over time (Davidson et al., 2010), the participants highlighted the importance of being allowed to participate in all phases of the recovery process. In the MTW, arts professionals allowed them to participate regardless of their symptoms, functionality or contact with the hospital (Article 1). As emphasised in this thesis, despite being positively oriented towards participation, health professionals can be sceptical that people with mental health problems should participate during a phase of full symptom bloom. However, an understanding that each person is unique, makes it difficult to judge, when a person should actually take pause from an activity. Based on the participants' descriptions, however, it seems that activities with a long duration, are flexible with regard to access and entry and follow the person rather than the system.

Allowing participants to choose when to attend provides a great foundation for recovery processes.

5.2.2 A person-centred approach

The approach and the paradigm professionals adopt to engage with the person with mental health problems appear to be important in supporting recovery processes. Article 1 reports that the participants experienced the MTW as being guided by a different paradigm than other hospital activities. It seems that the MTW was framed by a humanistic instead of a biomedical paradigm. This can be seen in the emphasis on strengths, resources and potential. This humanistic paradigm is also seen in a focus on finding solutions and a belief that the participants seek value, meaning and creativity in the things they do. These elements are strongly connected to humanistic psychology and the theories of Carl Rogers and Abraham Maslow (Ivey, Ivey, & D'Andrea, 2012; Rogers, 1989).

As illustrated by Eldal et al. (2019), being recognised as a "whole person" by professionals in mental health institutions fosters recovery. The MTW participants were met with interest, respect, acceptance, and understanding, elements that recognised them as human being (Schibbye, 1996, 2004a, 2004b). To be met as subjects was essential for perceiving the MTW as a free zone that supported recovery processes. According to Ekeland (2014), this means that people are regarded as competent to make their own choices, take responsibility and to have desires, intentions and judgment in relation to their own actions. This approach recognized participants as fully fledged individuals and human beings with equal rights. Although participants perceived their relationships with health professionals as important, these relationships were rarely described as equal. Health professionals act on diagnostic-based guidelines and approaches, with a strong focus on procedures, documentation and "proper treatment" that influence how they engage with people who use health services (Ekeland, 2014; Lauveng, 2017). Participants described health professionals who were over-focused on their diagnoses, problems or deficiencies (Articles 1 and 3). They were reduced to a diagnosis or a patient, which resulted in interactions characterized by being measured, assessed, described and predicted. Although this has a benevolent goal of providing the right diagnoses and finding the most appropriate treatment, this approach could distract health professionals from seeing the participants as human beings. Meetings characterized by an attentive subject-subject orientation in the MTW created an openness and facilitated a space for wondering. These meetings could be seen as a counterweight to the other meetings in the mental hospital, that were greatly characterized by a subject-object orientation. Meetings with a subject - subject orientation provided a fellowship with space for openness without needing to find one truth (Schibbye, 2004b). A fellowship focused on exploring the person rather than explaining them allowed recovery processes to develop.

5.2.3 Belonging and constructing a safe haven

In this section, I focus on the importance of belonging and ownership in the free zone for promoting recovery processes. Human beings have a basic need to be affiliated (Winnicott, 1971/2005). Schön et al. (2009) declare that recovery is made possible in social arenas because people can redefine themselves via social relations. The participants in this research described living relatively isolated lives. In article 2, I emphasize that long-lasting mental health problems affected the participants' opportunities to complete their education, take up work or pursue leisure activities. These activities influenced access to social arenas that could be important for developing relations and gaining a sense of belonging (Karlsson & Borg, 2017). Hagerty, Lynch-Sauer, Patusky, Bouwsema, and Collier (1992) describe belonging as a feeling and sense of fitting in and being an accepted part of a larger whole. Based on the empirical findings in article 1, an open and inclusive environment seems essential so the participants can be themselves, get to know each other and build safe social ties within the group. Not defining how individual participant should fit in to the group ensured an accommodation of diversity. Tangvald-Pedersen and Bongaardt (2011) emphasise the need for an open, inclusive and generous context to be able to accommodate extremes of behaviour and identity. Welcoming diversity in the MTW became important for allowing transformations to take place. This seems to support Deegan (1996) who emphasises the importance of embracing diversity in recovery processes. She says:

> The goal is to embrace our human vocation of becoming more deeply, more fully human. The goal is not normalization. The goal is to become the unique, awesome, never to be repeated human being that we are called to be. (p. 92)

Others in the MTW understood diversity as a resource, provided an opportunity for developing social relations and a sense of belonging for all within the MTW.

As described in article 1, the MTW was experienced as a place that belonged to the participants, not to the mental hospital. Access was reserved for people who had an active role in the MTW, which seemed to create this ownership. Participants who felt a sense of ownership to the MTW, appeared able to take more responsibility and shape both it and their lives. This aligns with a recovery-oriented practice that strives to support people with mental health problems in taking an active role and simultaneously ensuring that security nets exists when needed. This is important for providing sufficient safety to explore life outside the mental hospital. Inspired by Lauveng (2017) who postulates that adults with mental health problems need a *safe base* to explore the world, but also a *safe haven* to return to after exploration, and the MTW seemed to function as such a safe base and a safe haven for the participants. In MTW, the participants had a safe base through relations with others who could meet their needs and whom the participants could return to as a safe haven, when experiencing personal challenges. After the participants gained sufficient trust in these relations, their anxiety could be reduced, and they recovered enough to explore and enjoy the world, safe in knowledge that it was possible to return to this base if help was needed.

5.3 The challenges of a free zone in a mental hospital

This thesis highlights that the MTW can be viewed as a free zone with the transformative potential to support recovery processes. In this section, I illuminate some challenges that creating such a free zone in a mental hospital could have at organizational, structural and human levels.

MTW was located in the hospital, making it possible for participants who needed to be accompanied to the rehearsals (Article 1). Most participants were less dependent on public transportation and mostly did not need health professionals to attend. Hodgson, Lloyd, and Schmid (2001) claim that practical challenges such as transportation limit participation in leisure activities for people with drug, alcohol or mental health problems. This was also highlighted by the participants in this thesis. In periods where they were not admitted, challenges like public transportation and anxiety problems could cause problems with attendance.

The MTW was located at a mental hospital and presented as an arts activity for people with mental health problems, which can create obstacles for participation due to stigmatization. Several participants spent months or even years, before choosing to participate in the MTW. As described in article 3, this was about their fear of being branded as mentally ill and the danger of being stigmatized and therefore being further alienated as a group if the arts activities were ridiculed. Fieldhouse (2012) claims that mainstream activities in the local communities are preferred, as these are neither segregated nor stigmatizing. The MTW can thus be criticized as being a segregated activity that may prevent participation in the local community and increase the stigma for participants. Although integrating people with mental health problems in their local community is an accepted goal (WHO, 2013), several participants in the MTW appreciated that the art activity was solely for people with mental health problems. This seems to relate to their uncertainty in seeking out a mainstream activity, due to their fluctuating mental health. As shown in article 1, some participants had already experienced an inability to participate in mainstream activities because of lack of flexibility and individual adjustments. However, mainstream activities are preferred as a way to support recovery. Parr (2006) underlines that people might experience mainstream activities as challenging, as these might increase their feeling of *otherness.* People with mental health problems are not a homogeneous group (Karlsson & Borg, 2017), and some may prefer mainstream activities, but this thesis shows there is a need to offer activities in institutional settings.

In modernity, an increasing number of our activities will be subject to technical rationality (Øverenget, 2008). In Norway, technical rationality is prevalent within health contexts. According to Varkøy (2012a), the arts are at great risk of being subordinated to health and that the artistic experience being reduced to promote health and "useful" results. This thesis emphasises that MTW can generate a free zone with transformative potential and enable a process of recovery. It is important to defend this arena, however, because it seems at risk of being dismantled in the name of instrumentalism. Instrumentalism is about the tendency to consider everything and everyone as a means to the end (Varkøy, 2012a). The MTW was potentially at risk as the hospital management and health professionals did not consider it a goal in itself, but rather a tool to lessen symptoms, increase the participants functionality and/or improve quality of life. This application of technical rationality could restrict participants' freedom. As shown in article 1, when participants highlighted the therapeutic effects of from unfolding themselves creatively, health professionals and hospital management considered this as therapy and attempted to change the activity. The participants themselves were sceptical of such changes as the MTW might no longer function as a free zone. The challenge of redefining the leisure activity as therapy, replaces the intrinsic value of the art experience with one of the usefulness. It might then become necessary to show who benefits from such an activity. In technical rationality, a demand will probably arise to measure improvement rates and health effects in MTW participants. The challenge then becomes who gets to decide who can participate in the activity, what the results of the activity should be, at what point a result must surface for the person to keep participating and when outcomes should be measured.

The MTW participants are not a homogeneous group and their reasons joining and outcomes varied greatly. However, none of the participants explicitly stated that they participated in the MTW for the possible health benefits. Instead, they emphasised that their participation related to the MTW experience as being meaningful in itself, but it resulted in positive side effects on their life. Therefore, it is important to note that measuring the therapeutic effects of the MTW, could limit the liberating potential because acting, belonging and freedom of choice would be seen as less valuable. This is consistent with Sapouna and Pamer (2014), who emphasize that treating arts activities in mental health institutions as primarily clinical rather than as psychosocial interventions limits their potential. The MTW's intrinsic value, not the art activity that generated improvement and created room for personal transformations. Such outcomes are difficult to argue for based on technical rationality as only human activities that result in a concrete product are considered important and useful (Øverenget, 2008). Thus, those who facilitate and participate in the MTW may have to legitimize the activity through a more instrumental way of thinking; by pointing to the health benefits from the art experience. However, the art experience is important exactly because it is "useless" (Øverenget, 2012). As the participants themselves explained, having a free zone inside the mental hospital where they were allowed to be who they were without any expectations of health improvement was important.

5.4 Implications

5.4.1 Implications for policy and practice

The knowledge in this thesis is relevant to the understanding of performing arts and recovery in the field of mental health. This research contributes to practical knowledge within mental health services. Based on this thesis, practitioners, management and policy makers can exploit to a greater extent the potential of arts in the development of mental health services and recovery.

The United Nations Special Rapporteur on the right to health, Dainius Pūras (2017) claims that the world needs a revolution in mental health care. Both the desire and the need to change the mental health services from a biomedical to a more humanistic understanding of the human being has been justified in policy documents and guidelines nationally as well as internationally over years. Recovery-oriented practice is often highlighted as a humanistic mental health approach that could meet the requirements of this new practice. However, it is to be difficult to transfer political ideas and guidelines into action in the field of mental health (Karlsson & Borg, 2017). This thesis contributes an example of how to create activities that are based on humanistic understanding and values in a mental hospital. It is also a response to Waldemar et al. (2016) which question whether it would be realistic to integrate recovery-oriented practice within in-patient mental health clinics. Although the MTW was not considered a part of a treatment program, the evidence from this research shows that it is possible to create activities within a mental hospital that place the person at the centre, offer a high degree of freedom and primarily focus on participant's strengths and potential instead of on stabilization and symptom relief. In addition, in developing a recovery-oriented treatment programs in a mental hospital context, the findings from this thesis may have value. In particular, the research shows that recognising that recovery is a long journey and affective treatment programs should incorporate flexibility and accessibility, a person-oriented focus and embrace belonging and participants ownership of the treatment program.

A system that aims to make patients healthy but instead chooses to focus on what is considered ill is quite a paradox. As underlined in the WHO`s Mental Health Action Plan 2013-2020 (WHO, 2013) and the Human Rights Council`s (2017) report on everyone's right to the highest attainable standard of physical and mental health, mental health services should be focusing in patients' strengths, rights, aspirations and goals. This is unfortunately a subordinate medical and problem-oriented focus in mental hospitals. Having arts professionals run performing arts programmes inside mental hospitals could contribute to an increased focus on a patient's strengths and resources because the main focus will be on the person rather than his or her illness. In addition, Solli (2014) claimed that music experiences are related to the healthy parts of a person and reflect a salutogenic understanding (i.e., relying on human health and well-being rather than the disease, as seen in pathogenesis). Increased efforts should be made ensure that professionals in mental hospitals manage to balance their focus on the person and on the illness. There is limited focus in mental hospitals to create free zones where patients can take a break from their problems, diagnoses, and therapy. This thesis contributes to raising awareness of the creation of such free zones within mental hospitals. Psychiatric institutions have an untapped potential in supporting recovery processes, and creating access to free zones where people's strengths and resources are the focus could be one way to support recovery. This thesis emphasises that a free zone can be of great importance in the hospital context as a therapeutic break for patients, but perhaps even more important, the free zone can allow for a variety of transformation processes among people with long-term mental health problems. These processes, which include transformations of identity, hope, meaning, coping, self-efficacy, agency and liberation are seen as important in recovery but are undervalued in today's mental health. This is related to the challenges of measuring transformative processes that are seen to be unique and need to be seen through a long-term perspective. Nevertheless, there is a necessity to raise awareness of these transformation processes and contributions practitioners can make to supporting the person in his or her long-term recovery (Deegan, 2002).

In future mental health services, activities that underpin the person's strengths and resources should be developed and expanded. To do so, collaborations with sectors and professionals with non-health-related backgrounds would be particular useful. The combinations of arts and health will most likely be explored in the years to come. How such activities should be organized will be one of the questions that need to be further explored in practice. Given the difficulty of providing something that suit's everyone's expectation, interests, and needs, this thesis recommends offering a wide and varied selection of arts activities that vary in degree of creativity, as well as human facilitation, and that offer patients the opportunity to choose their desired activity. Some art activities can be developed in mainstream society. Some will be closely linked to health, social, or art services, and yet others can be collaborative projects involving mainstream society, health or social services and art services. This is in accordance with Deegan (1988) who claimed that every person's recovery is unique and that determining the best solution for the individual should be a priority. Furthermore, more attention should be placed on creating transitions between the activities. This involves developing arts activities that follows the person rather than the service he or she uses. There is also a need for a smoother transition from activities organised in the health services to arts activities that already exist in the local community so that people who want to participate in mainstream activities or have developed the necessary creative and social skills can seek out new challenges in their local communities.

It is important to point out that arts activities are rarely a substitute for therapy. However, questions have been raised regarding doing art as a natural topic within therapy. Therefore, it is understandable for some people to find it liberating to use art as arena for therapy. This is particularly relevant if the person is limited in expressing his or her experiences and feelings through his or her available verbal language skills and instead conveys the message through body language. For most people in arts activities, art will probably not be seen as an arena intended to replace therapy but rather as a supplement. Although this is elaborated in limited degree in this thesis, there is possibility that art could improve people's work with therapy efficacy. The fact that the participants in this thesis shared topics they worked on in MTW with their therapists and vice versa was, in any case, not uncommon.

5.4.2 Questions for further research

Although the present thesis addresses a comprehensive description of the recovery process that can take place through performing arts in a mental hospital, future research could expand on this in several ways. First, more research is needed that explores arts activities in mental hospitals. Different arts activities and programs that already exist could be investigated to consider their similarities, but also varieties of target audience, purpose of activity, collaborators, outcomes and challenges. Such research would be helpful to identify the best ways to organize these activities in mental hospitals. Secondly, as this thesis shows that arts in mental hospital have the potential to support the recovery processes, it would be interesting to investigate how these recovery processes actually happen. Further research could adopt a longitudinal design to investigate arts participation over time. Thirdly, more research is needed on whether arts activities contribute to further stigmatization and exclusion from mainstream society, or whether they can be a way for people with mental health problems to re-enter society. Fourthly, additional research is needed to investigate collaborations between the arts and health services to create and further develop arts activities for people with mental health problems. Fifthly, this thesis has developed knowledge about how performing arts can create a free zone in a mental hospital context, but there is still a need to explore further how such free zones can be created and developed to support recovery processes. Finally, future research should have a greater emphasis on the mundane experiences rather than focusing on the major goals and rehabilitation outcomes for people with mental health problems. There is a need to increase knowledge on how to support everyday life for people with mental health problems. Small positive moments could be one such topic that future research could explore in more detail. More participatory action research projects in mental hospitals involving people with mental health problems, relatives and professionals might contribute to new and interesting studies on mundane topics.

6. Concluding remarks

The overall research question in this thesis explored how performing arts can support recovery processes for people with long-term mental health problems. This thesis provides evidence about creating a space where participants can perform recovery. The participants experienced the MTW as a free zone in a mental hospital. This free zone had the potential to create transformations that supported the recovery processes in the lives of the participants. Having access to such a free zone provided both a break from challenges in life and offered the participants new experiences, perspectives and skills that were considered important for living a life in recovery. However, it was not enough to only offer performing arts to promote recovery processes. Rather, additional corner stones were needed for the MTW to become a free zone with transformative potential to support recovery processes for participants.

This thesis contributes to knowledge on the use and potential of performing arts in mental hospitals. The fact that performing arts is more concerned with making use of the personal resources, creativity and exploring the mystery of the human being, rather than searching for weaknesses, constraints and problems, makes it highly compatible with a recovery perspective. By filling leisure time with performing arts, participants experienced a new perspective on a different existence, a new way of being with themselves and others and an increased belief in their own possibilities. Performing arts provided the participants moments that had value in themselves and some of these moments could also be used and transformed as part of a process of performing recovery.

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APPENDICES

APPENDIX 1: ARTICLE 1

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Acting Out: Enabling Meaningful Participation Among People With Long-Term Mental Health Problems in a Music and Theater Workshop

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Abstract

In this article, we explore what enables meaningful participation in a music and theater workshop from a first person's perspective of people with mental health problems. The study uses a hermeneutical-phenomenological approach. Data were collected from qualitative in-depth interviews with 12 participants in a music and theater workshop located in a Norwegian mental health hospital. Data were analyzed through thematic analysis. Two overarching themes were identified: (a) *room for dignity* and (b) *a creative arena*. This study indicates that to enable participation for people with long-term mental health problems, it is important to facilitate activities that are flexible, person centered, and resource oriented, in which participants have the possibility to participate regardless of symptoms, functional ability, or whether they are hospitalized. In addition, having professionals who believe in creative growth and offer an illness-free zone that belongs to the participants in a hospital setting is of great importance.

Keywords

recovery; mental health and illness; lived experience; social participation; social support; users` experiences; qualitative research; hermeneutical phenomenolocigal; thematic analysis; Norway

Introduction

People with long-term mental health problems participate in cultural activities less often (Bergem & Ekeland, 2006; Whiteford, 2000, 2004) and have greater difficulties addressing their concerns in terms of their rights and participating in organizations (Lindquist & Sèpulchre, 2015). Leisure activities are important parts of life for every individual, especially for people with limited employment prospects (Lloyd, King, Lampe, & McDougall, 2001). The aspirations for participation among people with mental health problems are similar to those of the wider community (Thornicroft, Rose, Huxley, Dale, & Wykes, 2002). The fact that people with long-term mental health problems sometimes are hospitalized complicates their ability to participate and enable continuity in their participation in their community. Their mental health conditions, the costs, and their need for transportation, either for themselves or through hospital staff, are barriers to their participation in leisure activities (Hodgson, Loyd, & Schmid, 2001).

Cultural activities have a long connection with mental health (Lloyd, Wong, & Petchkovsky, 2007). Internationally, mental health hospitals have offered and seen the value of cultural activities since as early as the 1940s and 1950s (Pratt, 2004). Traditionally, these cultural activities are considered as treatments, such as music therapy and art therapy. In this study, we aim to shed light on the use of music and theater activities in a mental health hospital setting as a nontherapeutic offering for people with long-term mental health problems.

Increasing attention has been paid to the user perspectives of people experiencing mental health problems in health care politics, practice, and research (Thornicroft & Tansella, 2005). Mental health recovery is a critical and user-oriented paradigm that arose from the civil rights movement in the United States (Davidson, 2006; Davidson, Strauss, & Rakfeldt, 2010), which contributed first-person perspectives from people with mental health problems regarding their lived experiences of the phenomena of mental health problems (Deegan, Anthony, &

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Rutman, 1996). Increased knowledge from first-person perspectives of mental health led to radical changes in the understanding of mental health and illness (Slade, 2009). The traditional focus on treating illness to produce clinical recovery (Liberman, Kopelowicz, Ventura, & Gutkind, 2002) is shifting toward living a meaningful life despite symptoms (Borg & Davidson, 2008; Davidson, Tondora, & Ridgway, 2010). Thus, mental health recovery is no longer as much about clinical outcome as it is about recapturing one's role as a healthy and contributing citizen of one's community, which is a shift from a traditional medical model to a civil rights model of recovery (Borg, Karlsson, & Stenhammer, 2013; Davidson, Strauss, & Rakfeldt, 2010). Recovery literature frequently uses the terms *clinical recovery* (Liberman et al., 2002), *personal recovery* (Anthony, 1993; Slade, 2009), and *social recovery* (Best, Bird, & Hunton, 2015; Repper & Perkins, 2003; Tew et al., 2012; Topor, Borg, Di Girolamo, & Davidson, 2011) to discuss recovery.

A valid understanding of recovery must be grounded in lived experiences (Slade, Williams, Bird, Leamy, & Le Boutillier, 2012). We understand recovery as a journey that can be experienced differently from one person to another and as a process. Slade, Leamy, et al. (2012) stated that a recovery process consists of connectedness, hope, identity, meaning in life, and empowerment (CHIME). Having a meaningful everyday life filled with activities is important to people's recovery processes. Although the importance of having a meaningful everyday life is well established in theories and research regarding recovery processes (Davidson, Tondora, & Ridgway, 2010; Salzmann-Erikson, 2013; Slade, Leamy, et al., 2012), there is a growing interest to explore first-person perspectives related to participation in meaningful activities (Davidson, Shahar, Lawless, Sells, & Tondora, 2006; Deegan, 2005; Ness et al., 2013). In addition, less attention has been paid in the research literature to first-person perspectives related to participation in cultural leisure activities within mental health hospitals. In addition, people with mental health problems have stated that the development of mental health services should include prioritizing something meaningful for patients to do during the day and ranking future research on art in mental health highly (Thornicroft et al., 2002). Stickley and Duncan (2007) reported a growing awareness of the relationships between cultural activities and health.

Internationally, the number of projects involving cultural activities in community-based mental health care is rapidly increasing. Existing research studies on recovery containing cultural activities have been conducted either in hospitals providing music therapy (Chhina, 2004; McCaffrey, Edwards, & Fannon, 2011; Rolvsjord, 2009; Solli, 2012; Solli & Rolvsjord, 2015; Solli, Rolvsjord, & Borg, 2013) or in local communities through community-based art (Faigin & Stein, 2010; Lloyd et al., 2007; Lund & Haugstad, 2013; Ness et al., 2013; Stacey & Stickley, 2010; Stickley, 2010; Stickley & Duncan, 2007; Stickley, Hui, Morgan, & Bertram, 2007). In Norway, despite hospital settings offering different kinds of cultural activities, there has been a lack of research literature on the use of cultural activities (Knudtsen, Holmen, & Håpnes, 2005). Little attention has been paid to leisure activities in relation to people with mental health problems and enhancing their ability to participate.

Therefore, the purpose of this study is to explore first-person perspectives regarding enabling the participation of people with mental health problems in cultural activities. The specific research question for this study is as follows: What enables meaningful participation in a music and theater workshop, located in a mental health hospital, from a first-persons perspective of people with long-term mental health problems?

Method

A hermeneutical-phenomenological approach guided the research. Hermeneutical phenomenology attempts to find, describe, and understand the participants' subjective experiences by systematically determining the common and unchanging themes, or *essence*, of participation as a phenomenon (Starks & Trinidad, 2007; Van Manen, 1997). To this end, we conducted qualitative, in-depth interviews with 12 participants in a music and theater workshop. We combined a thematic analysis inspired by Braun and Clarke (2006); Clarke, Braun, and Hayfield (2015); and Van Manen's (1997) phenomenology of practice to analyze and interpret the data. Following Finlay (2002, 2012) and Malterud (2011), we stressed a reflexive perspective, exploring how our intentions and preconceptions as researchers might have influenced the present study.

Music and Theater Workshop as a Research Context

The research samples were drawn from a music and theater workshop affiliated with a mental health hospital in Norway. It was primarily a leisure activity for people with long-term mental health problems who were or had been hospitalized at district psychiatric centers or mental health hospitals in Norway. Second, the workshop functioned as a job-training facility in collaboration with the Norwegian Labor and Welfare Service (NAV). The music and theater workshop was open for participation with no exclusion criteria and regardless of diagnoses or previous experience with cultural activities. A theater director had been employed full-time since the initiation of the music and theater workshop in 2003. Initially, the theater director went to all hospital departments to recruit patients. Later on, the participants entered in different ways. Some contacted the theater director directly, while others were recommended for participation by mental health professionals. However, most were invited by other participants.

Participants in the music and theater workshop had weekly rehearsals in which they read and acted out their own written scripts. In addition, each participant had the opportunity to make formal or informal appointments with the theater director or musicians to create or further develop their own lyrics and musical expressions. The music and theater workshop's philosophy was that creative processes and participation were possible for all but must occur on the participants' own terms. A basic working principle was to make people with mental health problems co-creators. Developing participants' strengths and using the challenging phases of their health problems were central in the music and theater workshop. Participants were involved in all levels of the production process and collaborated with professional actors and musicians, both individually and in groups.

Ethical Considerations

The Regional Committee for Medical and Health Research Ethics (REK) in Norway (2015/476/REK-Midt) approved this study. Participation was voluntary. Informed written consent was obtained prior to the interview, and the participants were informed that they could withdraw from the project at any stage, no questions asked. REK considered the participants as a vulnerable group and required a special consideration for the group's interest during the research process (National Committee for Research Ethics in the Social Sciences and the Humanities, 2006). The first author, Ørjasæter, had a clinical background but was not working with treatment in mental health care at the time. All participants were offered the opportunity to speak with a physician specialist from an outpatient clinic. The specialist's name, phone number, and email address were given to the participants in an information sheet about the study. This person had the responsibility to clarify informants' situations and assess any needs. However, most of the interviewees already had, if required, a contact in the mental health system whom they could talk to after the research interview.

Recruitment

To explore experiences regarding enabling participation, we recruited participants who had lived experiences from a music and theater workshop in a mental hospital in Norway. The inclusion criteria were experiences of long-term mental health problems and current or former participation in the music and theater workshop. The theater director distributed postage request for participation and consent to all 14 current participants and six of the former participants. Including the current participants, approximately 60 people with mental health problems have participated in the music and theater workshop since its initiation. The theater director selected former participants who had experiences from workshop`s initiation and participants who have had roles or functions in the music and theater workshop that the current participants could not represent, including as teleprompters. Those who were willing to participate could contact Ørjasæter via email, phone, or preaddressed envelope. Before the study was initiated, potential participants were invited to an informational meeting about the study.

Sampling

Twelve people agreed to participate in the study. There were eight women and four men, ranging in age from 22 to 48 years. Their participation in the music and theater workshop ranged from 9 months to 10 years. Their contact with the mental health system ranged from 3 to almost 30 years. All participants claimed that they had mental health problems that were classified as more than one diagnosis in diagnostic manuals like *International Classification of Diseases and Related Health Problems–10th Revision* (ICD-10; World Health Organization, 1992) and *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*; American Psychiatric Association, 2013). Some did not know how many psychiatric diagnoses they had, while most identified three to six concurrent diagnoses. The participants described experiences of psychotic symptoms, attention-deficit/hyperactivity disorder (ADHD), bipolar diagnosis, different types of personality disorders, complex posttraumatic stress disorder (PTSD), dissociative disorders, anxiety, and symptoms of depression, in addition to the use of legal and/or illegal substances to varying degrees. All of them had received, or still received, various services related to their mental health problems from the municipality and/or hospital. The participants were given the pseudonyms Anna, Benjamin, Carina, Dina, Emelin, Frida, Gabriel, Hermine, Isak, Jenny, Karoline, and Ludvik to ensure their anonymity.

Data Collection

The qualitative, in-depth interview was chosen as the method to gain insight into the experiences of the phenomenon of participation in the music and theater workshop (Kvale & Brinkmann, 2009). According to Kvale and Brinkmann (2009), the qualitative interview aims to obtain descriptions of the interviewee's lifeworld to interpret the described phenomenon. The descriptions referring to the lifeworld belonged within a phenomenological approach, while interpretation of the described phenomena belonged within a hermeneutical research tradition. Ørjasæter, a social worker with clinical therapeutic experience in the mental health field, conducted the interviews. Each participant was interviewed once. To become familiar with the music and theater workshop, Ørjasæter examined the location of the group and was present at a dress rehearsal, the performances, and rehearsals; during video editing; and when one participant planned and conducted a workday at the music and theater workshop together with the theater director.

An interview guide with open-ended questions shaped the interview (e.g., "Can you tell me about your participation in the music and theater workshop?"). Prompt follow-up questions were asked when considered fruitful. The issues explored in the interviews included the participants' descriptions, and their contributions in the music and theater workshop, and their experiences of how their participation had affected their health and life in general. All interviews were conducted at locations suggested by the participants, most often in an office to which Ørjasæter had access, located in the same building in which the music and theater workshop had its sessions. One interview was conducted in a participant's office, a second in a participant's home, a third in a district psychiatric center which the participant was hospitalized, and a fourth in a forensic hospital. The interviews ranged from 46 to 138 minutes (M = 88 minutes) and were carried out between June and October 2015. All of the interviews were audio-recorded and transcribed verbatim.

Data Analysis

Following a hermeneutical-phenomenological approach, the aim of the analysis was to capture, in detail, the participants' personal experience of participation and the researchers' interpretations of the participants' lived experience (Heidegger, 1927/2007; Kvale & Brinkmann, 2009; Van Manen, 1997, 2014). However, the meaning or essence of a phenomenon is never one dimensional but rather complex and manifold (Van Manen, 1997). All phenomena are both knowable and mysterious (Saevi, 2005). We tried to embrace the mystery of participation as a phenomenon rather than reduce the phenomenon into clearly defined concepts and theories to disclose its mystery (Marcel, 1950). Hermeneutical phenomenology opened up the diversity and uniqueness of participation as a phenomenon, rather than simplifying and generalizing it. By striving toward the richest and most manifold understanding of the phenomenon under investigation, we hoped to approach its essence (Saevi, 2005).

In qualitative studies, the researchers are the analytic tools and play an important role in the research process (Kvale & Brinkmann, 2009). Therefore, it was essential to clarify preunderstanding and knowledge at the beginning of the study (Malterud, 2011). We tried to have a phenomenological attitude of wonder—to make it possible to see the unknown in the known—and openness, which presupposes a critical self-awareness of our preunderstanding (Van Manen, 2014). Our pre-established ways of understanding were challenged and transformed through a reflexive dialogue with the data, colleagues, and co-authors throughout the research process (Finlay, 2012; Malterud, 2011). We combined a thematic analysis inspired by Van Manen (1997), Braun and Clarke (2006), and Clarke et al. (2015). Thematic analysis is a method identifying, analyzing, and reporting themes within the data and helping interpret research topics (Clarke et al., 2015). According to Van Manen (1997), themes are the stars that make up the universes of meaning we live through. Themes are not necessarily dependent quantitative measures that are focused on what is captured in relation to the research question (Braun & Clarke, 2006). This study's central themes captured key elements of what the participants experienced as meaningful participation in the music and theater workshop. Analysis proceeded through the following steps.

Become immersed in the data: Nàive reading. To become familiar with and get an overall impression of the data, Ørjasæter spent time with the data in the beginning by undertaking the transcription, reading and rereading transcripts, listening to audio recordings, and making notes and reflections. Initially, the author's notes pertained to obvious meanings, but greater depth of insight was achieved after reading through the transcripts several times with curiosity and questioning.

Generating units of meaning. This step required identifying and labeling anything of interest about participation in the music and theater workshop. The authors shared and discussed generating units of meaning as a part of the analysis.

Developing emerging themes. We created a plausible and coherent thematic map of the data and reflected on the relationships between the themes. The most prominent, in terms of illuminating the research question, were chosen as central themes. We compared different themes and merged themes that represented similar meanings.

Reviewing, defining, and naming themes. Earlier themes were reconsidered. We asked whether the themes were good enough compared with what we wanted to describe. A review of each topic was used to consider whether a clear and distinct essence existed. Each interview and all speaking quotations were reviewed again. By questioning the data, new insights and perspectives emerged.

We created a thematic overview of the data. Based on selected quotations and reviews of the themes, Ørjasæter wrote “interpretative condensed synopses” for each subtheme. Finally, we selected sensible names (Braun & Clarke, 2006; Clarke et al., 2015), such as *room for dignity* and *a creative arena*, for overarching themes.

Writing up an understanding. Writing is an integral part of the analysis (Van Manen, 1997). Writing exercises the ability to see, and, according to Van Manen (1997), writing is the method. Writing is not a straightforward process. To justify the richness and ambiguity of experience in the informants’ lifeworld, the authors submitted to a complex process of rewriting (i.e., rethinking, re-reflecting, and recognizing). We stressed writing a coherent story. To ensure quality, Ørjasæter held a meeting with the participants to discuss the findings and presented the findings at a national research conference held by the Norwegian Network of Disability Research.

NVivo Qualitative–data-analysis software Version 11 (Qualitative Solution and Research International, 2015) aided the data. NVivo was used to organize notes, reflections, and audio files; to transcribe interviews; and in developing emerging themes. The analysis was performed in Norwegian. In the final step, concepts and quotes were transcribed into English.

Findings

We identified two central themes in what the participants in the music and theater workshop experienced related to enabling participation: room for dignity and a creative arena. Room for dignity explored what the participants experienced as meaningful in their meeting with professional musicians, actors, the theater director, and the other amateurs. Meanwhile, a creative arena pointed out the importance of the arena’s design and focus to meaningful content for the participants.

A Room for Dignity

The majority of the participants spontaneously described human dignity as a key element to enable participation.

Being allowed to be themselves was crucial and meant feeling accepted as themselves without having to try to be someone else. In the hospital setting, many participants acted out roles as they thought the mental health institutions and professionals expected or roles that gave them more benefits in the mental health system. Several participants experienced playing roles as challenging and time-consuming. However, in the music and theater workshop, they felt taken seriously, no matter who they were or how they behaved. Hermine felt no need to spend energy trying to cover up who she was: “You don’t have to wear a fake smile to go to the music and theater workshop.”

When participating in the music and theater workshop, there was room for people to experience symptoms, such as inattention, hyperactivity, impulsivity, panic attacks, lack of energy, flight of ideas, and dissociative symptoms. The participants knew that others understood and accepted symptoms. Many had the impression that they had to be symptom-free to participate in leisure activities or different kinds of work. Frida had an earlier experience of being thrown out of a work-training project because of her symptoms:

> I was thrown out of a work-training project focusing on nature, culture and health. They thought I had too much symptoms to continue. When I got in touch with the theater director, I was frustrated. However, the first meeting with the music and theater workshop. . . . It was nice, the way I was greeted—no problem or focus on my symptoms.

The fact that the participant had an opportunity to participate without question and with no need to explain themselves made it easier for the participants to be themselves. After being greeted with respect when participating while experiencing symptoms, Carina realized that she did not have to cover up her problems:

> People come in different shapes, colors, and sizes here. You have seen people become manic or psychotic or whatever; you are used to it, so if someone comes who becomes psychotic or manic . . . I mean, of course it affects you, because you cannot help but notice it, but there is still so much respect. It’s alright; no one throws you out because “now you are being manic, so you have to go.”

To be seen, met, and understood as whole humans. Many participants reported being stigmatized by mental health services. Stigmas included a feeling of not being seen, heard, or understood by professionals. Instead, patients’ diagnoses and medical journals dictated how professionals met them. This led to a feeling that the mental health services only saw them as patients who were ill. While participating in the music and theater workshop, the participants described how none of the professionals evaluated them as patients. They felt that the theater director, the musicians, and their colleagues enjoyed the time they spent with them, respectfully, as human beings. The way the participants were treated, made them feel seen, met, and understood as whole human beings that contrasted with their experience with professionals in mental health services. Karoline highlighted the respectfully meeting with the professional musicians when they worked with her songs: “That someone had faith in you . . . the musicians . . . I did not experience that anybody had the attitude; ‘Poor you—you are ill and we are healthy.’” Nonjudgmental attitudes and open questions provided a feeling of being taken seriously and carefully listened to when talking, even though they were considered ill. Anna underlined the importance of nonjudgmental reception:

> The people at the psychiatric unit only see problems. I feel I disappear behind problems in their eyes. I am there because I am ill, so that is all they see. A lot of me disappears. But the theater director didn't seem to care what was wrong with me or how long I had been in the system. . . . He did not care about problems and diagnoses, but rather what I wanted to do and what I found funny; other stuff. . . . He did not try to define you in every way or put you in a box. . . . I felt he saw the real me, more than most others.

Participation in the music and theater workshop was demanding because the participants needed to be physically and mentally present, interact with others, try to tell a story, perform on stage, and use both body and voice at the same time when acting out a role. However, the fact that someone was interested in them as people and explored how much stress and how many tasks and new experiences they could manage gave them a feeling of being allowed to be a human being. As Ludvik pointed out,

> I can't think of anything with which I could compare the accommodation of humans to such a degree, as in the close context we are talking about now, in the theater . . . you are kind of stretched pretty well. . . . It shows how strong human beings are when they are allowed to be human.

To be allowed to use their voices to communicate with the outside world. Despite the focus on patient involvement in mental health services in Norway, participants had negative experiences when it came to being heard as patients because they felt that the health professionals did not take them seriously due to their mental health problems. Some of the participants felt that their voices were barely audible compared with the voices of mental health professionals when talking about treatment, hospitalization, and use of medications. Participation in the music and theater workshop gave the patients an audible voice. Participation actually allowed the participants to have an opinion and disagree with professionals. Carina highlighted that not everything she said or did related to her mental health problems: "There is actually room for me to have an opinion. I am allowed to not agree with everything. I am allowed to have my own ideas; not everything has to be the sickness." Patients were allowed to voice their questions about human dignity in the mental health system strongly and could challenge a system in which the professional's voice traditionally had been the strongest. Carina continued,

> I can say what I want and people listen to me. It's not like when I say what I want and then someone sits there and judges me, or disagrees, or just says that "people like you. . . . " But on stage, no one interrupts me. No one says "You can't say that!" . . . I actually have a voice. I actually get to speak up. That has actually been more important than I thought.

A Creative Arena

The participants described the music and theater workshop as a creative arena that was open to everyone with mental health problems, regardless of any previous experience with cultural activities. The participants had different levels of experience when it came to music, theater, and scriptwriting. A few of them had formal drama or musical education. However, several had previous experience with various forms of music, theater, and writing for their own amusement and had varying degrees of ambition. The diversity in roles and functions that were needed to create music and theater productions gave all participants the opportunity to find something for themselves and provided a sense of mastery.

Having the opportunity to explore and develop skills. The participants' healthy sides were in focus in the music and theater workshop. The participants' inherent capabilities were adopted, so searching for resources to stimulate their capabilities was important. Participants spent time with the theater director to explore what they wanted to bring into the music and theater workshop. Jenny remembered that the theater director had wondered how he was supposed to use her in the music and theater workshop. In the end, he came up with a job that matched her perfectly.

> Suddenly, one day, he says: "I know what you should do; prompter!" "So nice, I said." "Does it involve acting on a scene?" "No." "Then it is probably okay!" He neither explained nor let me see any videos about a teleprompter`s work. He wanted to build and shape me from the beginning and he really did. He quickly saw, that I had a gut feeling he possibly could use in that role.

The theater director tried to connect the participants with professional musicians and actors with whom to cooperate. These connections with professionals who had different artistic expressions and personalities provided variation in the patients' manuscripts, songwriting, and musical expressions and encouraged the participants' potential for development. The professionalism among the musicians and actors was important for the participants' artistic development. Isak emphasized that it would not have been a good idea to have a health professional do the theater director's work: "I don't think it is a good idea to give the job as theater director to a social worker or a nurse. . . . It would have to be someone who has expertise in theater."

Behavior change and symptom reduction are critical in therapy. However, in the music and theater workshop, negative symptoms and behaviors were harnessed positively. As the participants saw it, the theater director tried in collaboration with them to figure out how "the disturbing element" could be turned into a resource. Redefining symptoms and behaviors gave participants the opportunity to participate in symptom remission while providing a sense of mastery. Isak described an opportunity to use his extreme mood swings when interpreting roles. He got to experience his illness as a strength in creative processes. Through participation, he learned how to provoke different moods when performing.

> I think that, my experience as bipolar, makes me a better actor. I try to be myself as much as possible in all roles. In acting, I have an opportunity to use my experiences . . . I had already experienced the fullest possible sense registry: from a world of darkness in which I thought about committing suicide to the feeling of being the coolest and toughest man in the world.

Benjamin noted that creativity, great capacity for work, and rambling ideas showed up in his manic phases. The theater director helped him sort out which ideas he could continue to work on. He had written several scripts, which subsequently were used in performances with brilliant results. Prior to his participation in the music and theater workshop, both he and his network had rejected his ideas originating from his manic phases because they appeared rambling and useless.

> There were maybe 10 ideas, but only one or two of these were usable. . . . Where someone else might see only noise, chaos and illness, and go: "Let's just calm down and take some more meds." Then he'll just go in and "there it is!" He has found something worth building on amidst all the chaos.

Having flexible solutions. The music and theater workshop was a solution-oriented arena because all participants experienced how flexible the activities were. Together with the theater director, the participants created an arena in which attendance during the rehearsal and play was flexible. The focus on alternative solutions gave the participants' courage to participate despite their challenges. All participants experienced some days or periods with greater difficulty regarding their own mental health condition. A culture developed in which the participants could inform the theater director of such days or periods ahead of rehearsals. Carina highlighted the importance of having their individual situations considered and the rehearsal adjusted to comply with their mental states, often with more continuity and fewer breaks to avoid long conversations between the participants.

> The theater director get [*sic*] straight to the reading. He makes sure there's continuity, so there aren't too many breaks during which you have time to think. If I'm having a bad day, the breaks . . . you totally lose your concentration and get upset and stuff.

The music and theater workshop was different from other theater workshops because the participants felt that they had considerable influence and dared to ask the theater director and professional musicians to find alternative solutions. They made something out of a situation that others would have considered impossible. If an actor could not learn something by heart, the participants were convinced that other theaters would have said that the person was not supposed to be an actor. The fact that several participants considered being physically close to and keeping a close distance with others challenging could have caused major difficulties in a theatrical production in which there is a lot of close contact between actors. Carina continued to describe how the theater director managed to find solutions that worked both for her and the production in general:

> I dislike having people physically close to me. I prefer that people keep a distance. Then, when you're acting, you have to figure out the proximity you can handle, how close you're able to let them. . . . So I can start thinking that I am ruining everything by not wanting to stand close to that person, because it feels too close for me, but then the theater director can say: "It works just as well if he or she is over there," and then, strangely, it works out anyway.

All participants mentioned that alternative solutions were common in the music and theater workshop. During the interview, the number of alternative solutions the theater director and the participants had come up with surprised Carina:

> So many alternatives that have been thought up here; it's amazing! When you sum it up like that, I'm thinking: "Oh my God, the number of solutions we are able to find!" . . . I've never realized that before. Oh my God, how much we manage to come up with whenever issues arise, and we make it work as if there weren't any issues to begin with! That's an accomplishment on its own.

Having access to an illness-free zone. Many of the participants had been in touch with mental health services for a long time due to their mental health problems and talked in different ways about feeling as though they had lost their freedom. Most of them had several long-term admissions during which the focus had been to map out deficiencies, abnormalities, and the negative impact these aspects had on their quality of life. These admissions contributed to a feeling of loss of freedom. They had submitted to a treatment regime and taken on the role identity of an ill patient. They experienced losing the ability to make their own decisions and needing professional helpers to set their agendas. They were reminded constantly of their role as patients with locked doors, escorted exits, compulsory interventions, and day plans according to the hospitals' routines regarding meals, activities, and conversations. The music and theater workshop became an arena in which they no longer were considered ill but rather were singers, musicians, or actors. They were given an arena in the hospital that belonged to them rather than the system. The music and theater workshop was theirs alone, and neither therapists nor personnel were welcome unless they were invited or participated artistically or practically. Ludvik highlighted the fact that mental health professionals not being allowed to attend rehearsals had an effect on the participants' identities:

> The gorilla in the hallway! That's the guards! . . . They have to wait outside, because we do not have guards with us in the theater. We do not use diagnoses on the actors. . . . Yeah, the guards had to remain in the hallway. . . You leave escorted exits and compulsory interventions behind. You're by definition deprived of your freedom indefinitely, and your freedom of movement has been restricted; then, you come to a door and you leave the psychiatric patient with compulsory interventions and escorted exits behind. You leave that behind, and become a human being, and an actor; then, you close the door behind you.

Several participants emphasized that participating in a music and theater workshop located in a mental health hospital was challenging. At first, there was inner resistance: The mental health services expressed skepticism about patients' participation in the music and theater workshop. Health professionals thought that patients from compulsory admission could not participate in the music and theater workshop on their own. They presumed that the patients were too sick to participate and could not see beyond their labeled roles as patients. Isak had been discharged and was no longer entitled to treatment. For him, canceling his performances was not an option. A cancellation, in addition to his mental health problems, would have made everything worse for him. He felt that the health professionals should have understood that, but they did not:

> The hospital said: No, that does not make sense. You cannot be admitted to an intensive care unit and act in a theater! That is not possible! . . . They said that made no sense, so I could no longer be that ill.

However, after a while, the hospital and health professionals shifted positively in support of patient participation in the music and theater workshop, so much so that they wanted to characterize it as a therapeutic service. The participants did not care for this at all, because as Ludvik and the others saw it, doing so would make the workshop part of the system and not a service only for the participants:

> One professional group after another came and tried to claim that this was therapy. That pissed us all off. The music and theater workshop is a therapy-free zone. If there is one thing we are sick of, it's therapy, diagnoses, and psychiatry. Can't we just be free of it for 5 minutes, right? Don't you dare come and steal this by calling it therapy, because it's theater! Forget it! I think that has destroyed the entire sense of freedom . . . As soon you call it therapy, it belongs to the system. Then it's no longer a free space.

Discussion

In our analysis, we highlight two central themes in what the participants in the music and theater workshop experienced regarding enabling meaningful participation: room for dignity and a creative arena. We will present our discussion around three overarching themes based on our findings. First, we will discuss the importance of continuity in leisure activities regardless of symptoms, functionality, or the participants' hospitalization status. Second, we will discuss the importance of having access to an illness-free zone in a hospital setting. Third, we will discuss the importance of having a resource-oriented focus in cultural leisure activities.

The overall impression of our findings is that participation in the music and theater workshop was highly appreciated among the participants. Interestingly, when the participants shared their experiences of participation in the music and theater workshop, they used their experiences from the mental health system as a contrast. Even though the music and theater workshop was organized in a mental health hospital, participants experienced the cultural leisure activity as something separate from it. In a way, two different paradigms (Slade & Longden, 2015) met when patients participated in the music and theater workshop.

Having Continuity in Leisure Activities Regardless of Symptoms, Functionality, or Hospitalization

Traditionally, mental health systems are concerned with how to reduce or remove symptoms (Davidson et al., 2006; Slade, 2009). To reduce daily stress, people with mental health problems still meet with health professionals who advise them not to attend leisure activities or work until they are free of symptoms or have achieved a sort of stability (Davidson, Tondora, & Ridgway, 2010).

Interestingly, attending the music and theater workshop was experienced as liberating, despite being emotionally and creatively challenging and requiring participants to handle uncertainty and changes in the music and theater production. For several of the participants in our study, symptoms increased during participation. However, symptom exacerbation could represent, or be a consequence of, movement throughout life rather than being understood as a relapse (Davidson, Tondora, & Ridgway, 2010). We should not underestimate the importance of being challenged by activities that are experienced as meaningful (Davidson et al., 2006), even if symptoms increase for a while. This study suggested that health professionals not wait until people with mental health problems are free of symptoms to participate in leisure activities and work, which has been a common strategy in mental health care (Davidson, Tondora, & Ridgway, 2010). Thus, it is important that practitioners encourage participation in such activities and address barriers within the system for participation.

Traditionally, people with mental health problems are not allowed to continue leisure activities at the hospital after they are discharged, meaning they have to find activities in their local communities. Frequently switching between staying home and being hospitalized is a barrier to committing to leisure activities, which is why many of the participants had not experienced continuity in activities earlier and felt that continuous participation was impossible. The music and theater workshop filled this gap because it was open to all participants, regardless of hospitalization. Finally, patients could continue a cultural activity, even when experiencing symptoms, low functionality, and periods in which the symptoms were minimal or absent. In accordance with Ness et al. (2013) and Solli (2012), continuity in cultural activities is important for people with long-term mental health problems and should be strived for. This also is in line with mental health recovery, since people are likely to live with their mental health problems for a long time (Davidson, Tondora, & Ridgway, 2010) and need developing activities that are flexible enough to allow them to commit to the same activity regardless of their mental condition or where they are staying.

Access to an Illness Free Zone That Belongs to the Participants

A number of participants had experienced stigmatization from health professionals in mental health care (Andersen & Larsen, 2012; Rao et al., 2009). The participants played roles (i.e., "wore a mask") in almost every context, including their meetings with health professionals. They felt that participation in the music and theater workshop was so safe that they could remove the mask, which is in line with Stickley and Hui's (2012) study in which participants experienced participation in an art project as a safe place where they could be creative with others who shared similar experiences. Using sociologist Ervin Goffman's (1959/1992) concept of front- and backstage, performing gave the participants an opportunity to escape reality and wear a mask (i.e., frontstage). However, backstage, during rehearsal and when interacting with other participants and professionals in the music and theater workshop, they felt free rather than stigmatized. They had created a room together with the other participants in which they could be their authentic selves (Ness et al., 2013) and be accepted as such. Because many of them spent so much time wearing masks in their daily lives, being backstage together with the others felt just as liberating as being alone. We argue that participation in the music and theater workshop was just as much about unmasking oneself as it was about putting on the mask of a role.

It was liberating that the music and theater workshop was not part of a therapy service. No records (e.g., journals) were written about the rehearsals, and no discussions about their participation occurred in the hospital wards' treatment meetings. The music and theater workshop contrasted to music therapy, in which a traditional biomedical discourse/paradigm is adopted (Solli, 2012). Participation in the music and theater workshop was a nontherapeutic service in which the participants felt free from illness, treatment, and their status as mentally ill. This is concurrent with the findings from Solli and Rolvsjord (2015), who showed that many participants felt that they did not have many illness-free zones in their lives and highlighted the importance of having a free zone in a hospital setting. For that reason, there was opposition to mixing the music and theater workshop with therapy. There was also a strong fear that another arena in their life, which they until now had experienced as resource orientated, felt ownership of, and found to be a place in which they could unmask, would become "pathologized" by health professionals or would be destroyed (Rolvsjord, 2009). This is also in line with Stickley and Duncan (2007) who argued that having a distance from the medicalizing tendency may be required, if cultural activities are supposed to promote social inclusion, social capital, and reintegration. Facilitating a non-threatening environment in cultural activities is of great importance (Stacey & Stickley, 2010). However, there is a discussion within the arts and health field about the distinction between the specific practices of art therapy (Stickley & Duncan, 2007) and music therapy (Solli, 2012; Solli & Rolvsjord, 2015) and the therapeutic benefits of cultural activities in health contexts (Stacey & Stickley, 2010; Stickley & Hui, 2012).

The participants in our study argued that outside of mental health institutions, music and theater were seen as leisure activities or work, and they questioned why participation by people with mental health problems in a music and theater workshop should automatically be perceived as therapy. We should not underestimate the importance of offering nontherapeutic cultural activities besides treatment led by people other than health professionals. These findings suggest that the mental health system should strive to offer more cultural leisure activities in which people with mental health problems may keep or develop illness-free zones, which will ultimately encourage participation.

Importance of Having a Resource-Oriented Focus

The participants stressed the importance of meeting people who treated them as though they already were somebody (Davidson, 2003). The participants in Davidson and Johnson's (2013) study highlighted the small things that counted to them. We argue that the participants in our study supported these findings, when focusing on the importance of being asked questions about what they preferred doing creatively, feeling seen or heard, and experiencing being met in a respectful and nonjudgmental way. This is in line with Anderson (2012), who highlighted that how one begins to meet people creates the kind of conversations and relationship one can have with them. Similarly, Lund and Haugstad (2013) stressed the importance of people with mental health problems having experiences of being seen, heard, and understood, which enables meaningful participation in leisure activities.

An underlying philosophy in the music and theater workshop was that people generally are creative if given the chance (Levine, 1997). Having art professionals who believed in growth during illness and creating a person-centered (Rogers, 1967) and individualized approach (Brown & Kandirikirira, 2007) were important to make room for participation. This is consistent with the view of Stickley and Hui (2012) who argued that the theoretical foundation for the health benefits of the arts is located in the humanistic psychology literature, in which person-centered and humanistic values (as expressed by Maslow and Rogers) are important.

The music and theater workshop was a kind of trial arena in which the participants could play with different creative expressions. They were allowed the opportunity to try and succeed or to fail without fear. This environment gave the participants an opportunity to develop creative skills. Lloyd et al. (2007) expressed similar findings and pointed out the importance of having supportive relationships and a supportive physical environment to make participants feel safe enough to take risks and to be vulnerable in their creative journey. In our study, the fact that the participants felt safe when participating gave the art professionals the opportunity to challenge the participants with new tasks. The balance between completing the tasks they managed and the tasks they felt were challenging gave the participants the potential for creative growth, regardless of their earlier experiences with music and theater. Positive mastery experiences were critical and nurtured the participants' self-efficacy. The art professionals strove to frame these mastery experiences to the participants as being for actors and musicians, rather than for mentally ill patients, despite the fact that the material (songs, poetry, and scripts) came from experiences of living with mental health problems.

Many joined the music and theater workshop to have something to do during the week. However, after a while, the participants felt that it was liberating and inspiring to use their voices. According to Stacey and Stickley (2010), creative processes give people with mental health problems an opportunity to express themselves and communicate to an audience. In our study, the participants redefined their symptoms and experiences through their participation. Their symptoms were used as resources, inspirations, or interpretations. Our findings show that cooperating with art professionals who likely saw their potential instead of their limitations gave the participants access to a full range of opportunities (Hammel et al., 2008). Similarly, Lloyd et al. (2007) argued that participation in cultural activities may lead to a new lifestyle when individuals identify themselves apart from their mental health problem. We argue that the focus on redefining symptoms gave the participants an opportunity to show and convince both the people surrounding them and themselves that they did not have to see their symptoms as a problem. By looking at symptoms in a new way, the participants could find strategies to live with and accept them. The participants' challenges decreased because they no longer needed to hide their symptoms or dedicate so much of their cognitive capacity to the symptoms' negative side effects.

Interestingly, the concept of normality seems to be wider in art than in mental health contexts. In art, there is more room for diversity, and "madness" is appreciated. Innovation in art requires people to go outside the box. In mental health contexts, being or doing something outside the box is seen as abnormal. Slade (2009) characterized the mental health system's tendency to use dichotomous scales to explore people in terms of normal–abnormal, sick–healthy, us–them, and patients as nonexperts–health professionals as experts. As a result, both health professionals and people with long-term mental health problems may internalize a narrow normality, and there are high chances that someone will end up outside the box. In a way, it is a paradox that a system that is supposed to help people has such small limits regarding what is normal, especially when few participants have the goal of becoming mainstream and would rather be unique yet still be treated like human beings, rather than as "a mental illness" (Deegan et al., 1996; Slade, 2009).

Limitations and Strengths

We recognized some strengths and limitations in this study. The participants gave rich descriptions of their experiences in ways that we did not expect before the study began. People with long-term mental health problems were considered vulnerable informants by REK, but their contributions of their experiences and openness were extraordinary. They showed us the importance of bringing their voices into research because of their rich experiences and user-oriented perspectives. The understanding of participation generated by this study cannot claim to capture the full complexity of what people with mental health problems experience as meaningful participation. Our understanding was based on 12 interviews and can be explored and modified further through research and practice. Participants' observations could be an important supplement to provide complementary understandings and insight regarding what is important for enabling participation.

Other researchers may have viewed the data from a different angle. As in any qualitative study, subjectivity and the authors' backgrounds have influenced both the study design and analysis. Ørjasæter's background was shaped by her experiences as a therapist in in- and outpatient clinics in the mental health field. The second author, Ness has had extensive experience with social and psychological research, especially in family therapy, recovery from addiction, and mental health.

Mental health support is moving more toward community based rather than institutional settings in Western countries (Davidson, Strauss, Rakfeldt, 2010). Even though our findings are from an institutional setting, the principles enabling meaningful participation, as we have discussed in this article, may have a wider interest and probably are experienced centrally even by people with mental health problems who live and are supposed to participate in their local community.

Conclusion

In this article, we explore what people with mental health problems experience as meaningful participation in a music and theater workshop located in a mental health hospital in Norway. The findings highlighted that the mental health system should facilitate cultural leisure activities for people with mental health problems to a greater extent than they do currently. We have argued in support of the importance of having access to a music and theater workshop in close proximity to mental health hospitals, regardless of admission status. Despite being located in the hospital, cultural leisure activities should remain independent from therapy and be run by people with professional artistic backgrounds. This will give the participants greater chances to be treated as musicians and actors, not patients. A resource-oriented focus is important to enable participation. We need professionals who believe in creative growth despite mental health problems and who facilitate a flexible and person-centered approach. Because the participants had few illness-free zones in their everyday lives, having access to a nontherapeutic zone—free from diagnoses, therapy, and stigmas of the mentally ill—was paramount. This cultural free zone should contain opportunities for participants to try different creative expressions and encourage trial and error and trying again. Participation in the music and theater workshop could function as a starting point or springboard to participation in activities in the local community and strengthen patients' positivity regarding becoming a citizen (Horghagen, 2014; Sayce, 2016).

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APPENDIX 2: ARTICLE 2

RESEARCH ARTICLE

“I now have a life!” Lived experiences of participation in music and theater in a mental health hospital

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Data Availability Statement: Excerpts of the interview transcripts relevant to the study are included in the paper. The Regional Committees for Medical and Health Research Ethics (REK) in Norway has concluded that a full, anonymized data set cannot be shared publicly. They emphasize three main points for this assessment: (1) The participants have not given their consent to this. (2) The participants are or have been in a vulnerable situation. (3) The dataset consists of individual interviews with a small cohort. If other researchers seek access to the data, REK would require a new

Abstract

Participation in activities perceived to be meaningful is of importance in recovery processes among people with mental illness. This qualitative study explored experiences of participation in music and theater among people with long-term mental illness. Data were collected through in-depth interviews with 11 participants in a music and theater workshop carried out in a Norwegian mental health hospital context. Through a hermeneutical-phenomenological analysis, three central themes emerged: (a) engaging in the moment, (b) reclaiming everyday life, and (c) dreaming of a future. The findings indicate that participation in music and theater provided an opportunity to focus on enjoyable mundane activities and demonstrate how arts have the potential to bring meaning and more specifically small positive moments into participants’ lives. Despite seeming to be small in nature, these moments appeared to be able to add pleasure and meaning to the lives of those experiencing them. Consequently, there is a need to raise professionals’ awareness of these small positive moments of meaning, the power these experiences carry, and how to facilitate arenas which can provide such moments for people with long-term mental illness.

Introduction

People with long-term mental illness may often experience existential frustration, wonder whether life is worth living, and strive to find meaning in their lives [1]. When struggling with mental illness, finding meaning in life is considered a central process in mental health recovery

consent from the participants. For more information regarding data, please either contact REK at rek-midt@mh.ntnu.no, or the corresponding author at kristin.b.orjasater@nord.no.

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[2]. There is a hope in practice and policy considerations that participation in arts projects might have therapeutic benefits for people with mental illness [3–5] and potential to facilitate key elements in mental health recovery [6–11]. For years, mental health recovery has been seen as a unique, personal process [12], which means that each individual needs to take control of his or her life [13] and is considered the central actor in the recovery process [14–16]. But in recent years, there has been a growing understanding that recovery is more than an individual and personal process [17]. It is also seen as a social and relational process that occurs in people's everyday lives [18, 19], in an environment imbued with meaning, in relationships with other people, and through access to meaningful activities and valued social roles [17, 20]. According to this understanding, mental health recovery is about recapturing one's role as a healthy and contributing citizen [21, 22], with mundane everyday experiences potentially serving as building blocks in the recovery process [18, 23, 24].

It is well established that having a meaningful everyday life is important for mental health recovery [2, 25–27]. According to Thornicroft and colleagues [28], people with experiences of mental illness have stated that mental health services should place priority on meaningful activities during the day and have highly recommended future research on arts in mental health. Despite a growing interest in exploring first-person experiences related to participation in meaningful activities [23, 28–30], less attention has been paid to non-therapeutic creative activities and art programs inside the context of a mental health hospital.

In this study, we have analyzed data from a qualitative research project focusing on recovery processes among people with long-term mental illness [31]. In two previous published articles from the same study, we have focused on what enables meaningful arts participation in a mental hospital setting [31] and explored how arts participation may transform identities among people with mental illness [10]. The first article showed that continuity and flexibility in arts activities, guided by arts professionals with a non-judgment attitude, enabled participation [31]. In the second article, we found that having access to an illness-free zone where the emphasis was on the creative processes created a sense of belonging, skills-development and self-discovery which made it possible to transform previous identities [10]. In the current article, we take a broader view on arts participation and explore what experiences of participation in a music and theater workshop add to the lives of people with long-term mental illness. More specifically, we ask the following research question: What do the experiences of participating in a music and theater workshop bring to the lives of persons with long-term mental illness?

The music and theater workshop as a research context

The music and theater workshop (MTW) is located at a Norwegian mental health hospital. It is a leisure activity not intended for therapeutic purposes. The target group is people with long-term mental illness who are in treatment or have been treated at the mental hospital as inpatients or outpatients. For some participants, the MTW also functions as a work training facility in collaboration with the Norwegian Labor and Welfare Service (NAV). A theater director works full time to run the MTW. Participation is open to all participants regardless of their psychiatric diagnosis or previous experiences with the arts.

In the MTW, participants are seen as co-creators: they are involved in all aspects of the production process, based on their interests and skills. They can participate through script writing, singing, playing instruments, creating costumes, acting, technical support, and other tasks. Further, participants are encouraged to bring their own poems, written drafts, and diary notes to the theater director. Some of these writings are transformed into dialogues or songs that become part of the MTW.

The participants in this study were offered the opportunity to collaborate with the theater director, professional actors, and musicians, both individually and in groups. Participants have weekly theater rehearsals, where they read and portray characters based on their written scripts. Through reading scripts in the rehearsals, both the theater director and the participants get ideas about how new and old scripts could function together in a play. A large music and theater production is offered annually to the public. In addition, small-scale productions take place several times a year. The MTW collaborates with the leisure center staff at the hospital, who facilitate technical, practical, and personal support, stage work, transport, and catering and have informal conversations with the participants when needed.

Method

In this qualitative study, a hermeneutical phenomenological approach guided the research. The phenomenon *arts participation* was explored and illuminated through a phenomenological analysis inspired by Van Manen [32, 33]. Following Finlay [34, 35] and Malterud [36], we used a reflexive perspective. Through discussions among the researchers and communication of preliminary findings to involved participants, at public events, and at international research conferences, we both explored and were challenged about how our intentions and preconceptions as researchers influenced the study.

Research ethics

The Regional Committee for Medical and Health Research (REK) in Norway approved this study (approval number: REK, 2015/476). Participants received oral and written information about the aims of the study prior to the individual qualitative interviews. An informed consent process was a requirement for participation. In the beginning of each interview the first author put a special emphasis on the right of the participants to withdraw their consent and leave the research project without having a reason or fear of negative consequences. All participants gave permission to tape-record the interviews. Because the participants were considered a vulnerable population, they had the opportunity, if needed, to speak with a psychiatrist after the research interview. The psychiatrist's name, phone number, and email address were given to the participants in an information sheet about the study.

The consent procedures were approved by REK. All participants were considered able to consent at the time they conducted the interview, bearing in mind participants' symptom load and general health condition [37, 38]. The first author who carried out the interview explored whether the participant understood the information provided about the study and showed the ability to understand the consequences of their own participation. In addition, the first author considered the participant‘s capability to reflect on the pros and cons with participation considering own state and whether the participant had the ability to express a choice. Based on our extensive clinical and research experience in the mental health field, we were committed to the view that people with mental illness in most cases can assess themselves whether an interview is feasible [37]. However, in one case both the first author and the participant had doubt. We entered a dialogue if it would be justifiable to conduct the interview, which resulted in an agreed three months postponement of the interview.

Participants

Participants recruited for this study had to meet the following criteria: First, they had experiences of long-term mental illness and had been an inpatient and/or outpatient in a mental health hospital. Second, participants had current or previous experiences with participation in the MTW. Third, they had been participants in the MTW for more than three months. The theater director distributed flyers to 20 current and former participants of the MTW and invited them to be part of the research project. Those who wanted to participate were encouraged to contact the first author by email, phone, or using a preaddressed envelope. Before the study started, invited participants got an opportunity to participate at an information meeting about the study, where the first author informed them about the study's purpose and aims. In total, 11 persons participated in the study: seven women and four men, age 22 to 48 years. They had participated in the MTW from nine months to 10 years, and their contact with the mental health system ranged from three to almost 30 years. The participants themselves self-reported their health status, including self-reported diagnosis. They described experiences of psychotic symptoms, bipolar disorder, personality disorder, attention-deficit/ hyperactivity disorder (ADHD), dissociative disorder, complex post-traumatic stress disorder (PTSD), anxiety, and symptoms of depression, in addition to the use of legal and/or illegal substances to varying degrees.

Data collection

We used in-depth interviews to collect data from participants [39, 40]. The interviews were conducted in a conversational form, based on an interview guide using open-ended questions [40] beginning with "Can you tell my about the MTW? Can you tell me about your participation in the MTW? What has participation in the MTW meant for you and your mental health?" Participants were invited to tell their stories with a minimum of interruption [41].

The majority of participants chose to be interviewed in an office located in the same building where they had their MTW rehearsals. Three participants preferred other locations for interviews: at home, in a district psychiatric center, or in a forensic hospital. Each participant was interviewed once, and the duration of the interviews ranged from 46 to 138 minutes. All interviews were carried out between June and October 2015 and were transcribed verbatim. To ensure anonymity, the participants were given pseudonyms: Anna, Benjamin, Carina, Emelin, Frida, Gabriel, Hermine, Isak, Jenny, Karoline, and Ludvik.

Data analysis

Van Manen's [32, 33] phenomenology of practice was used to analyze the transcribed data. According to Van Manen [33], the aim of phenomenological reflection is to grasp the essential meaning of the lived experiences of a phenomenon. In this article, we want to explore what lived experiences of the phenomenon *arts participation* brings to the lives of people with long-term mental illness. To understand how this phenomenon is experienced, with its many layers and dimensions, the thematic aspects of the lived experiences are analyzed and used as the basis for formulation of thematic phrases [33]. However, a thematic phrase will never be able to capture the full richness of the lived experience, but rather represents an aspect of the phenomenon [33, 42].

Data analysis was mainly led by the first author. To support the analysis, NVivo 11 [43] and MindManager 2017 [44] were used. These software programs were used to organize audio files and mind maps, transcribe the interviews, code the data material and write reflexive memos throughout the study. The analysis proceeded through the following steps, and will be explained below:

1. Naïve reading
2. Extracting descriptions of the lived experiences with the phenomenon from each interview transcript
3. Developing emerging themes based on all interview transcripts

4. Creating short "interpretive condensed synopses"
5. Reviewing, defining and naming themes based on discussion with participants and researchers
6. Writing up an understanding through a phenomenological reflective writing

Shortly after the completion of each interview, oral reflexive memos of the interview context, interview content and technical conducting of the interview were audio-recorded [34]. The first author did a naïve reading of the transcripts and listened carefully to the audio recordings [34, 35] to get acquainted with the data in order to get an overall impression. After the first analysis of the overall impression, the data were interpreted asking questions from the text in a curious, inquiring manner [45]. Notes on discoveries that might lead to looking at the data again were recorded. During this process, it was noted that the data contained both interesting elements related to what enabled participation [31] and what participation provided in light of the participants' experiences. The first author went back to the audio recordings, reflexive memos, and transcripts looking for the "essence" of each interview and reflected on quotations that seemed to describe different aspects of what participation brings. Again, the analysis revealed information about participants' experiences of arts participation in various and diverse ways. These experiences refer to both longer identity narratives [10] and shorter, more expressive descriptions showing the complexity and variety of what arts participation bring to their lives. To formulate overarching themes requires an intensive analytical process [33]. Based on analysis of all interview transcripts, three emerging themes were organized in mind maps. These were then discussed with the co-authors and used as the foundation for the further analytic process. The first author wrote short "interpretive condensed synopses" for each of the themes and discussed the findings further with the co-authors. All authors then posed questions to the proposed themes in different ways, in order to critically examine it they captured the answer to the research question in a systematic way. In addition, to critically examine the initial interpretation of the data, member checking and dialogue with other researchers about preliminary findings were used. During this process, themes were reviewed, defined and renamed. Writing is at the core of hermeneutical phenomenological analysis, where it is required that the researchers develop an ability to be sensitive to how the text "speaks about" the research phenomenon [42]. Consequently, writing has been an integral part of the ability to see and analyze the phenomenon [33]. After finalizing the analysis, the quotations used in this paper were translated from Norwegian into English.

Findings

Three central themes emerged from the hermeneutical phenomenological analysis: (a) engaging in the moment, (b) reclaiming everyday life, and (c) dreaming of a future. However, these themes can be considered independent of each other, not always as subsequent stages.

Engaging in the moment

The theme *engaging in the moment* suggests that having long-term mental illness can be experienced as demanding and, thus, lead to great suffering. The participants described how their mental illness took over control of their lives for longer or shorter periods of time. Some felt that it was unrealistic to completely regain control over their lives. However, they experienced the MTW as offering some respite from these problems or a space for coping, which again was central to their efforts of sustaining and fighting for a meaningful life.

Within this context, participants expressed in diverse ways how they were at one with the activity in the MTW. Jenny described how participation gave her an opportunity to focus.

> "The prompter job is so wonderful. It allows me to concentrate. (. . .) I just shut everyone out. I exist only in my own little bubble. That bubble is only about me and what is happening onstage and who has the next line. (. . .) I shut everything out and become very focused on what I am doing at that point; when the lights go out, not otherwise." (Jenny)

In line with Jenny's experience as a prompter, Ludvik described how acting provided a mental presence of mind. Being present onstage provided a setting where he could distance himself from his problems outside the MTW. The more he immersed himself in the music or the role, the less space was available to reflect on the troublesome aspects of his life. His role demanded Ludvik to engage solely in the moment:

> "It is about focusing on the present moment. (. . .) Here and now. Here and now. Here and now! It is about standing there, remembering lines, and not thinking, 'Damn, I hate that I am in a mental health institution.' Your focus is on the text. There are others onstage you need to look at. You need to go over there and wait for the heat from the light. Then you time the line over there. It is all about focusing on moments. (. . .) Every moment is filled with what you are doing and experiencing; that is the magic of the MTW." (Ludvik)

Several participants described previous situations in which their mental health issues had gotten out of hand or taken over control of them. Carina expressed a powerful desire for things to be different, so she could function on a higher level. She felt trapped. Her self-destructive thoughts and actions in relation to eating and self-harm absorbed all her energy and directly affected her quality of life. Her destructiveness took up most of her time, energy, and mental space. For Carina, participation in the MTW provided a break from her self-destructive thoughts and actions. She managed to make an active choice to put her difficult life aside for a moment:

> "I spend all day every day being self-destructive, except when I am here [at the MTW] Here, I am not self-destructive. The rest of the time, I am self-destructive—from morning to midnight." (Carina)

While participation in the MTW offered a freezone, not everyone could have this experience all of the time. Some participants reported that life could be so tough at times that not even participation in music and theater gave them a break. Karoline had made a conscious decision to protect the music and theater workshop as something positive in her life. In order to maintain the positive function of the MTW, she decided to take a break from participation when things got too difficult, even though this was a hard choice to make:

> "I have to take a break because it is too much right now. (. . .) I couldn't even remember anything from the performance. Felt like it turned out really bad. (. . .) It is so important that it [participation in the MTW] remains something positive, because that is what it has been for me so far. Right now, I am too tired and stressed out." (Karoline)

Several participants also suggested that engaging in the MTW provided moments filled with a sense of achievement that they truly enjoyed. These moments were powerful experiences in both the present and as recalled later and provided them with energy whenever their mental illness caught up with them again. Even when Karoline took a break from the MTW, she could bring with her the positive moments she had experienced there before. She deliberately returned to these moments by watching a recording of one of her performances. For her, watching these recordings was important both for recalling the positive moments and for holding on to them.

> "The sense of achievement and the joy that I felt that spring! It was one of those amazing experiences. To hold on to and enjoy each moment. It strengthened me so much. (. . .) I need for it to feel like it did back then." (Karoline)

The participants entered a free zone, a place where their negative/sad thoughts or destructive behaviors received less attention. Through arts activities, energy was concentrated on other facets of their life than mental illness. They experienced that arts activities require a mental presence. If the participants could not manage this presence, they could decide to take a break. They seemed to have a reflective awareness of their own participation, even in periods when they had challenges in taking part. In these periods, they could reflect on what they had been part of and what they had managed through their participation.

Reclaiming everyday life

Participants emphasized that engagement in the MTW initiated a process through which they could reclaim everyday life. They described how long-term mental illness affected their ability to structure daily life. They stressed the importance of hanging on to everyday life routines that were meaningful. Participation in the MTW enabled the participants to regain meaningful everyday life activities.

> "It makes sense for me to experience normal days. For many years, I only had special days. Days where I was either up or down, where normal everyday life was not even a possibility. (. . .) It is important not to fall out of everyday life. (. . .) It has become a sort of everyday life, too, coming here to the MTW." (Benjamin)

Due to mental illness, several participants found it difficult to hold on to their ordinary everyday life tasks. Their mental health issues created challenges to completing their education, keeping a job, or engaging in leisure activities. Participants described a daily life in which they were inactive, either at home or in an institution. Through participation in the MTW, they experienced more active days than before. In addition, the arts activities gave them an opportunity to add meaning to everyday life activities. Gabriel underlined this point by describing how important it was to make music, not only to stare at the wall of a long-term facility: "*There is no point in just sitting there and sleeping and eating, and sleeping and eating, you know. That's not a life*! *To create something—that's fun"* (Gabriel).

Having a daily or weekly activity was of great importance to gaining a reference point in participants' everyday lives. Participants described engagement in the MTW as a kind of lifeline. Through music and theater, they added structure to an otherwise chaotic life. As Frida stated "*The MTW became an anchor for me."* Although some participants stressed the importance of having something to hold on to in their daily life, the MTW not only allowed them to take part in an activity that structured their days. They also experienced that having a meaningful activity awoke their desire to start the day, even in periods when their mental conditions became challenging. For Benjamin, participating in the workshop was important in helping him out of severe depressive episodes. In periods when he had difficulties doing anything on his own, he highlighted the importance of attending a consistent social fellowship, such as the MTW, to share his interest with others:

> "Yeah, especially for the first few years, MTW held me up. It was the only thing I could do except from lying in bed unable to do anything. (. . .) I remember it lifting me up, lifting me

> up from Wednesday to Wednesday, and then to more and more practices. Then I remember how I finally got out of the mud. It lifted me out of my depression through the hours I spent practicing every week." (Benjamin)

Experiencing mental illness for long periods of time left participants struggling to find a sense of meaning in life: *"I feel so helpless. It is too much. (. . .) My entire situation feels stuck after 20 years in psychiatry" (Anna)*. Participants appreciated what the MTW added to their lives. Isak highlighted the importance of having a meaningful activity to get a sense of meaning in life: *"That's what the MTW provides*: *meaning*! *Something to do that gives meaning."* Participants considered this sense of meaning in life as a necessity for surviving long-term mental illness. Suicidal thoughts, plans, and attempts were common among the participants. Several experienced the MTW as one of the most important anchors in life, which thus represented a change from feeling unmoored. They described their participation as being crucial for their existence. Isak expressed this point the following way:

> "I have felt suicidal several times, and I might have actually done something about it had it not been for my participation in the MTW. I believe, hand to my heart, I can say that without the MTW, I don't know if I would have been alive today." (Isak)

Dreaming of a future

The theme *dreaming of a future* capture how a clear sense of purpose and direction in life affected the participants' motivation to both live and discover life outside of the institution. When MTW took up more space in their lives, the participants experienced increased belief in building a meaningful life outside the mental healthcare system.

Participants described having low prospects, ambivalence, or uncertainty about what they could expect of their lives before their participation in the MTW. The limitations of what they believed possible were both external and internal: in the mental health system and inside themselves. Further, participants found these limitations to be interlinked. When health professionals did not expect them to recover, it reinforced their lack of expectations for their own future. Karoline shared one example:

> "In my medical journal from when I was 21 years old, it said that I was chronically ill and treatment resistant and would have to be on anti-psychotic meds for the rest of my life. I had a long list of medications. It was considered impossible to get well from schizophrenia. That was how it was put. Of course, that is not good. It makes you think, 'What is the point of all this?' (Karoline)

Karoline experienced a great change in what she considered possible in life after she attended the MTW. She learned to maintain hope for a better future. She reported feeling more self-assured after experiences of achievement from standing onstage performing. Karoline made a clear distinction between her plans and her dreams. Through her participation in MTW, she dared to make room for some concrete plans. However, she still found it hard to dream outside the context of the mental healthcare system:

> "Of course, you never know what the future might bring, but my plan is to give lectures, publish a book, and continue with the music and theater bit. (. . .) I think, MTW, but maybe: I have a dream about singing, but that is more of a dream than a plan." (Karoline)

Several participants described the MTW as opening up the possibility for them to dream more freely. Before participating in the MTW, their dreams had mainly been framed by what the mental healthcare system deemed possible for them. Through their participation in the MTW, their dreams changed. Several participants expanded their dreams from being discharged or being less dependent on using health services to living meaningful lives in their local community independent from care from the mental healthcare system. They highlighted the importance of having people around who helped them to set short- and long-term goals in areas in life other than therapy. For Jenny, the combination of setting goals both in therapy and in the MTW, which represent different areas in life, gave her a sense of psychological flexibility. A strong focus on the MTW not only fulfilled her goals, but helped her to go beyond the dreams she used to have.

> "There is no doubt that the MTW has done a lot for us and for me. I never dreamt that I could be sitting here with millions in debt, own a bus, a car, and have three children. That was so far beyond my dream, beyond what I thought was possible. My psychiatrist told me a few years back that my best-case scenario would be to live at an institutional dorm that was not manned 24 hours. That was my biggest dream. I surpassed those limits miles ago." (Jenny)

Participation in the MTW also contributed to a new pattern of behavior among the participants. In line with increased involvement, the frequency and number of readmissions they experienced went down considerably:

> "I have been admitted for three weeks in the last two years. I used to be admitted for months every year. (. . .) There has of course been other factors than the MTW, but the way the MTW has helped me and how much less of a burden I am to the system compared to before I started participating in the MTW. (. . .) It costs a little to have an activity like this. But it gives you so much more in return, both in terms of quality of life and in terms of costs." (Benjamin)

When admissions declined and quality of life increased, participants shifted their orientation toward a life outside the mental healthcare system. They gradually started to believe that they could contribute to society. Despite the fact that they had been out of work for a very long time, participants developed the skills necessary to return to the labor market or enter it for the first time. When Gabriel developed skills in music production, he started to envision a future job in the music industry and to believe that he could give something back to society.

> "I want to be a part of the MTW and work professionally with music, as a sound technician or in the studio; or sit in the studio and act as a guide for others who are in psychiatry. To sit in front of the computer, create beats, run everything, you know. I have been doing this for so many years now, so I know all the programs." (Gabriel)

Several participants described their participation in the MTW as leading to job opportunities. For Ludvik, participation worked as a stepping-stone to the labor market after years spent in the mental healthcare system. Ludvik reported that the MTW had also given him the qualifications needed to get back to work after being in a mental health hospital. Before participating in the MTW, Isak felt that his mental illness stood in the way of his chances to gain skills as an actor. In the MTW, he found that he could use his knowledge and experience of having mental illness in his performance as an actor. Through his years acting in the MTW, Isak said he built competencies that made him a sought-after actor beyond the borders of Norway. He stressed that it was important to hold on to such opportunities when possible, because no one knows what is waiting around the next corner:

> "Therefore, being an actor has given me so incredibly much. (. . .) It is possible to be very ill and get better and have amazing experiences. Sure, I can get ill again. I never know. Statistically, according to my diagnosis, I will get ill again, but then again, not necessarily! Think about it (. . .) to go from being strapped to a bed not many years ago and getting disability benefits because you'll never work again, to playing overseas! So, everything is possible!" (Isak)

Many of the participants in the MTW were people who expected to live out their lives within the confines of the mental healthcare system. However, experiences with the MTW enabled participants to see themselves differently and helped to initiate a process of recovery. In addition to reporting fewer and shorter periods of hospitalization, they had fewer symptoms and mental problems, and several were capable of establishing a life outside the hospital in a local community. After Jenny attended the MTW for years, she gradually created a life outside the mental healthcare system. She was not an active participant in the MTW at the time she was interviewed. However, she kept on dropping by the MTW to keep in touch. During her many years of hospitalization, the MTW worked as an umbilical cord for her. She reported that the MTW helped her to believe in a life outside the institution and at a certain point, it became natural to detach herself. At the same time, she pointed to the fact that establishing a new life outside the MTW had been a demanding process:

> "I now have a life! I can see that life has so much to offer. Still, I must admit that I do miss life in the institution. I really do. It scared me to begin with. Now, I understand that it is part of the process. (. . .) I had to leave MTW. I had to leave the safety and security because I wanted to live my own life. However, I have to go back now and again to seek some comfort and predictability. This is considered absurd in psychiatry. Life is so unpredictable out there [in society]. Here [MTW], the only thing that can happen is that someone gets sicker, but it is still very predictable. (. . .) I have discovered that maybe we were the normal ones in here [MTW] and the rest of the world was crazy. However, I want to live where the craziness is; I like it out there." (Jenny)

Discussion

The main findings in this study provide descriptions of lived experiences of participatory arts in 11 adults with mental illness, recruited from a music and theater workshop in a Norwegian mental hospital. Through the arts, many participants experienced small, positive everyday moments. Further, participants highlighted that these moments had diverse impact. The small glimpses of positive moments experienced by the participants have sparked our curiosity. In our discussion, we have chosen to look closer at these moments in relation to mental health recovery.

Moments of flow and peak experiences

The participants described moments when their focus became sharp and experiences of a world that seemed to fade away—when nothing other than being in a creative process seemed to matter. The moments were powerful and could be related to flow experiences [46] similar to those experiences of professional artists [47, 48]. While these experiences of flow came when participants were doing arts, they reported rarely having such experiences in other life situations. They valued these moments greatly and described how they empowered them in everyday life as well as in their creative processes. Interestingly, for some of the participants, these moments lasted far beyond the actual situation they encountered. It seemed that the participants had found a way to take good care of and savior these moments. They used the moments to both pursue their artwork and as a reference point in life in general. Once the participants had experienced moments of being fully dedicated and present in a performance, they strived to experience such moments again. Some of the participants wanted to take a break from the MTW rather than perform if they failed to be present in the moment. In a way, they set an expectation for themselves, not necessarily for their performance, but for their own presence when performing.

Participants also described moments when they had exceptional experiences of joy or achievement. Some of these moments could be understood as peak experiences [49, 50]. Consistent with Maslow's findings [49, 51], participants talked about how some of their small positive moments had the potential to totally change their images of themselves and allow them to see their situations in a new way. These moments provided them with hope that they could manage situations in an otherwise chaotic life and also helped them to stake out a direction in life [52]. Their encounter with the arts challenged rigid beliefs about what they would be able to achieve despite long-term mental illness [5, 7, 9]. Some experienced these moments as guiding stars in their lives that were important for their recovery. That flow and peak experiences had impact on how they handled their mental conditions, reinforces the value of Moran and Nemec [53] suggestion of incorporating concepts and positive indicators of wellbeing (i.e., flow) from positive psychology to contribute to achieving the full vision of recovery.

Moments of meaning

Participants also reported that doing arts made their lives more meaningful. The arts gave them a reference point in their everyday lives. Consistent with findings from Borg and Davidson [18], participants claimed that even small reference points were of importance for them in experiencing a sense of meaning in everyday life. One rehearsal a week or some meeting points a week at the MTW could be enough. They got little glimpses of being able to hold an everyday routine if they attended an activity that they experienced as meaningful. In line with Frankl [1], participants described spontaneously experiencing meaning while performing arts—some just for a few moments and others for longer periods. We posit that some of the participants moved from living in an existential vacuum to experiencing a sense of meaning in life. The creative process became a form of "personal medicine" [30] for recovery. Being among others, performing arts brought forward an awareness of what could bring meaning in life and that they could develop skills that helped to achieve this.

Consistent with previous studies [6, 8, 9], participatory arts were also found to have potential to provide participants with experiences of meaning despite suffering. This meaning was not universal, but rather an individual meaning-making that lay in each individual situation [1]. Participants emphasized the experience of meaning as the importance of feeling they were in a recovery process. They did not feel that life always had to have meaning but stated that they could build meaning in life through experiencing glimpses of meaning and fewer periods of meaninglessness. Therefore, we found it particularly interesting that music and theater enabled the participants to have more purpose and direction in the rest of their lives [6]. As noted by Moran and Alon [54], participatory arts, facilitated as a non-therapeutic activity, offer people with mental illness an opportunity to engage and develop as equal citizens in their community. Although participatory arts can facilitate meaning and initiate recovery for some, we cannot expect all people with mental illness to find a route to recovery through participatory arts [6]. On the other hand, this knowledge may have transfer value to other activities that are conducted in the mental health system and seen as leisure activities. Other avenues of creating recovery could also be pursued through other means (e.g., sport, nature).

Conclusion

This study suggests that people with long-term mental illness may experience participation in music and theater as an opportunity to focus on activities that have the potential to provide moments of meaning, flow and peak experiences. Although these moments appeared in glimpses, they added value and gave strength to the participants as they were able to transform these positive moments to "meaning-making" far beyond arts. They experienced arts participation as liberating. This might be of particular importance to people with long-term mental illness who otherwise live a life with severe challenges, extensive contact with mental health services, and limited access to non-therapeutic arenas that support development and growth. For the participants in the music and theater workshop, the small positive moments experienced through the arts provided hope for a better life and a belief that change could be possible, which seemed to motivate and made it possible to engage in the community in the same ways as others.

Implications

Although the field of mental health endorses a vision of recovery, people with mental illness still have limited access to arenas which support a meaningful everyday life. There is a need to increase knowledge of the importance to gain access to arenas which have a potential to provide small moments of meaning, flow and peak experiences. Since this study shows that participation in arts can provide potential for these experiences, it becomes important to discuss how professionals can facilitate arenas that provide such moments for more people with mental illness, even in periods when they are affected by increased symptoms. Simultaneously, it could be of great importance to raise professionals' awareness of the profound role of small moments of meaning, flow and peak experiences and further examine the power of these for people with long-term mental illness. That small positive moments may play an important role in people's lives can encourage professionals to focus beyond the big goals and rehabilitation outcomes to become more aware of the importance of mundane non-therapeutic activities [24, 55–57].

Supporting information

S1 Interview Guide. English version.
(DOCX)

S2 Interview Guide. Norwegian version.
(DOCX)

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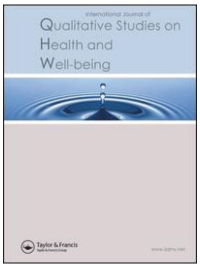
APPENDIX 3: ARTICLE 3



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Transforming identity through participation in music and theatre: exploring narratives of people with mental health problems

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ABSTRACT

Background: There is a growing understanding that mental health problems and prolonged contact with mental healthcare systems can affect people's identities. Working with identity is an important element in mental health recovery.

Purpose: In this article, we explore the significance of participation in a music and theatre workshop in terms of people`s experiences of identity.

Design and methods: This is a qualitative study based on a hermeneutical phenomenological epistemology. Data were collected from in-depth interviews with 11 participants at a music and theater workshop, analysed through a narrative analysis and presented in an ideographical "long" narrative form. The music and theater workshop is not overtly therapeutic although the activity takes place in a Norwegian mental health hospital for adults living with long-term mental health problems.

Results: We identified three crosscutting themes: (1) *becoming a whole person*, (2) *being allowed to hold multiple identities* and (3) *exploring diverse perspectives*.

Conclusion: Findings show that participation in the music and theatre workshop transformed the participants' experiences of identity on two levels: individually and collectively. The participants developed a broader picture of themselves through their creative work with others. When they developed new identities, the narratives of themselves expanded.

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Arts; identity; identities; mental health; music; narrative; recovery; theatre; workshop

Introduction

In her 2000 book, *From Psychiatric Patient to Citizen*, Liz Sayce envisaged a collective shift in identity for those who have been diagnosed with a mental illness. In 2016, she released a new edition and questioned, "to what extent have the rights of citizenship progressed in the 16 years gap between the books?" (Sayce, 2016). Whilst European countries may have seen an increase in media campaigns, and governments are more willing to discuss mental health, what is less clear is what progress has been made in the collective identity of those with a diagnosis of mental illness.

Throughout history, language regarding mental illness has described a collective and largely negative identity: lunatics, the insane, the mad, and so on. What each of the nouns has in common is its pejorative nature. Historically, the so-called mad were sent to an asylum, set apart from mainstream society, and the identity of the "outcast" or the "other" was established (Davidson, Strauss, & Rakfeldt, 2010). In many countries, the large asylums have been closed, but the stigma of people with mental health problems remains entrenched (Sayce, 2016). They can experience what Goffman (1992) called "spoiled identities." Goffman claimed that people with a spoiled identity feel inferior and discredited and almost inevitably become so. As Goffman pointed out, identity is not an unaltered concept, but socially defined. Consequently, identity is neither permanent nor static, but something that is dynamic and constantly under development (Erikson, 1968). For people who experience mental distress, identity issues stretch back to the formative years of life when self-worth was established (Rogers, 1967). Any change in a person's identity will inevitably take time, involve a processes of negotiation and reference to anchor points.

In this article, we employ a narrative inquiry methodology that has the concept of identity at its core. By analysing individual narratives of people who have lived with mental distress and resultant diagnosis, we seek to discover and understand people's identity claims and if and how participating in arts activities leads to new identity claims. Through narrative discourse, identity is "accomplished, disputed, ascribed, resisted, managed and negotiated" (Benwell & Stokoe, 2006, p. 4). This approach to research elicits individual stories of people's

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lives and their experiences and understanding of the meaning they ascribe to those stories; it is within this meaning that people locate their own identity and make sense of their lives (Denzin, 2000). People may "position" their identity in relation to greater social narratives or discourses (Phillips & Hardy, 2002) or master narratives (Nelson, 2001) to help make sense of their experiences. Identities are negotiated and renegotiated with and in relation to others in society (Goffman, 1992; Nelson, 2001; Rogers, 1967). As there is a need to negotiate identity, people also may renegotiate negative identities (Riddell & Watson, 2014). In modernity, according to Bauman (2001, p. 129), people are no longer "having an identity" as they are "belonging to their" fate or historical categorization of identity. Instead, Bauman (2001) argued that sociopolitical, cultural, professional, religious and sexual identities are undergoing a process of continual transformation. Accordingly, identities become more fluid in modern times, meaning that identity is not a settled category without alternatives, but something more blurry and interchangeable with social contexts. Such understandings are relevant to this study.

There is scant evidence in the literature of narrative accounts that describe how people may negotiate their identities whilst participating in arts activities in hospitals. This study can be a complement to previous studies (Sagan, 2014, 2015; Spandler, Secker, Kent, Hacking, & Shenton, 2007; Stickley, 2010; Stickley & Duncan, 2007; Stickley & Eades, 2013; Swan, 2013; Van Lith, Fenner, & Schofield, 2009), which have illustrated from a first-person perspective that participation in community arts activities mainly conducted in their local communities has the potential to transform people's identities. To our knowledge, few international studies (Sapouna & Pamer, 2014) and no Scandinavian studies have focused on participation in arts activities in hospitals in relation to mental health recovery and identity. This article provides a deeper understanding through long-ideographic data from people with long-term mental health problems participating in arts activities in a Norwegian mental health hospital. The research question for this study is: "What meaning does participation in a music and theatre workshop have for people's experience of their own identity?"

The music and theatre workshop as a research context

The research context was a music and theatre workshop (MTW) that was a leisure activity for people hospitalized in a Norwegian mental health hospital; the workshops were not therefore overtly therapeutic. Some participants used this as a work-training facility in collaboration with the Norwegian Labour and Welfare Service. Since its inception in 2003, approximately 60 people with mental health problems have participated in the MTW. The workshop uses a separate building located at the mental health hospital. A theatre director is employed full-time to run the MTW, which is open for participation regardless of diagnosis or previous experience with the arts.

Based on the participants' interests and skills, the MTW provides activities in various art forms. The participants collaborate with a theatre director and professional actors and musicians, individually and in groups. A central working principle in the MTW is to make participants cocreators, and as such, they are involved in all aspects of the production process: script writing, singing, playing instruments, creating costumes, acting, providing technical support and so on. People bring their own poems, written drafts, and diary notes to the theatre director. Some of the participants are encouraged to transform their material into dialogues or songs. In working with professional musicians, participants bring a whole or part of a song and create a melody together with the musicians. They can also try different musical interpretations of the lyrics or just improvize with different instruments and from that create music.

The MTW has weekly rehearsals. In these rehearsals, the participants read and portray characters based on their written scripts. Through reading scripts in rehearsals, both participants and the theatre director get ideas for how new and old scripts could function together in a play. Usually, a bigger music and theatre production is developed once a year as well as the small-scale performances that takes place. Linked to the performances, the MTW collaborates with the Leisure Centre staff at the hospital, who facilitate technical, practical and personal support; stage work, transport and catering; and have informal conversations with the participants.

Methods

For this article, we drew on data from a broader qualitative research study that explored recovery processes among people with long-term mental health problems. Situated within a hermeneutical phenomenological epistemological perspective (Van Manen, 1997, 2014), we used a narrative inquiry (Riessman, 2008) to explore and illuminate the phenomenon of participation. Van Manen (1997) argued that the meaning of any phenomenon is complex and manifold. For this reason, it is important to study the phenomenon in the complexity in which it exists. Following Finlay (2002, 2012) and Malterud (2011), we approached the data with reflexivity, exploring how our intentions and preconceptions as researchers influenced the study.

Ethics approval

The Regional Committee for Medical and Health Research Ethics in Norway (REK, 2015/476) approved this study. Participation was voluntary and the participants were informed that they could withdraw their consent at any time without suffering any consequences. The Regional Committee considered the participants as a vulnerable group and a special consideration for the group's interest during the research process was required (National Commitee for Research Ethics in the Social Sciences and the Humanities, 2006). In the study, a psychiatric specialist from an outpatient clinic near the music and theatre workshop was available to participants who wanted to speak to somebody after participating in the interviews. In the information sheet about the study, the specialist's name, phone number and email address were given to all participants.

Participants

In all, 11 participants from the MTW were recruited. Participants had to meet the following inclusion criteria: experiences of long-term mental health problems and current or former participation in the MTW. The theatre director distributed posters for participation to all 14 current participants and six of the former participants of the MTW. Those who were willing to participate could contact the first author via email, phone or pre-addressed envelope and were invited to a meeting about the study. All participants gave oral and written consent before their interview.

Seven women and four men agreed to participate, ranging in age from 22 to 48 years. They participated in the MTW from 9 months to 10 years. Their contact with the mental-health-care system ranged from 3 to almost 30 years. Health information was provided by the participants themselves, including their self-reported diagnosis. All but one participant still received various services related to their mental health problems from the municipality and/or the hospital.

Data collection

The first author collected data by conducting 11 qualitative, conversational in-depth interviews (Kvale & Brinkmann, 2009; Patton, 2015). The qualitative interviews aimed to obtain descriptions of the interviewees' lifeworld to interpret the described phenomenon (Kvale & Brinkmann, 2009). The interviews were deliberately conducted in conversational form, combined with an interview guide. The interviews were approached using open-ended questions (Patton, 2015), and the participants were invited to tell their stories with a minimum of interruptions (Bell, 1988), beginning with, "Could you tell me something about yourself, who you are? Can you tell me about your participation in the MTW?"

In the process of becoming familiar with the MTW, the first author observed the location and the group at rehearsals and performances. Then the first author conducted all interviews at locations selected by the participants. The majority chose to be interviewed in an office located in the same building where the MTW had its sessions. Three participants chose other locations: in their home, in a district psychiatric centre or at a forensic hospital. The participants were interviewed once. The interviews ranged from 46 to 138 minutes and were carried out between June and October 2015. All of the interviews were audio recorded and transcribed verbatim. To ensure anonymity, the participants' names have been altered.

Data analysis

Narrative analysis refers to a family of approaches to interpret texts that have a storied form in common (Riessman, 2005). Our analysis was inspired by Riessman's (1993, 2008) narrative thematic analysis. Here, the exclusive focus of the analysis was on the content of the analysed transcripts. Focusing on the stories told, we examined the lives of the participants, honouring the principle of lived experience as a source of knowledge and understanding when analysing data (Clandinin, Steeves, & Caine, 2013).

The authors' backgrounds have influenced the analysis and it is important for us to acknowledge that other researchers may have interpreted the data differently. However, the contributions of the four authors, which together reflect broad clinical and research experience in health science, may have increased rigour. The first author is trained as a clinical social worker and family therapist, while the second author is a mental health nurse. Both had long experiences as therapists in the mental-health-care system before becoming involved in qualitative interdisciplinary research in the field of arts and health. The third author is a medical sociologist and professor of health science. The fourth author is trained as a family therapist and professor of counselling with extensive research experience in mental health recovery.

The first author mainly conducted the data analysis. NVivo 11 (Qualitative Solution and Research International, 2015) and MindManager 2017 (Corel Corporation, 2017) were utilized as tools for analysing the data. Shortly after completion of each interview, oral memos of initial impressions of both the interview setting and the interview content were audio recorded. Inspired by Finlay (2012), the following questions were asked: What was the interview about? What stories did the participants tell? How was the interview climate experienced in the conversation? How did the analytic process affect the questions? Each interview was transcribed verbatim shortly after completion of the interview (Riessman, 1993). To become familiar with the data and gain insight into what stories the participants told, interview transcripts were read through several times. Then the first author wrote reflexive memos (Finlay, 2002, 2012) based on listening to the audio recordings and reading and re-reading the transcripts. Based on the reflexive memos, the first author summarized the essence of each story told. These summaries of "essence" in the stories were compared with the essences of stories from the other participants. The first author found and visualized motifs to create a map (Corel Corporation, 2017) with the following themes: (1) becoming a person, (2) moving away from a narrow identity and (3) developing a creative identity. To ensure trustworthiness, the authors met to discuss themes to check for alternative interpretations (Finlay, 2011; Lincoln, Lynham, & Guba, 2011; Schwandt, Lincoln, & Guba, 2007). In addition, themes and narratives were presented and critically discussed in different ways: at an open meeting with the participants and people involved in the MTW, with the participants who owned the narratives, on a dialogue forum for practice-oriented research in Norway, and at the Culture, Health and Well-Being International Conference in the UK. Based upon the feedback from these meetings, the first author went back to the data and added to the analysis; some themes were modified. Three cross-cutting themes emerged (Riessman, 1993, 2008): (1) becoming a whole person, (2) being allowed to hold multiple identities and (3) exploring diverse perspectives. From the 11 narratives, we chose three that broadly illustrated each of the cross-cutting themes to become the focus of this article. Therefore, the narratives should be seen as illustrations of the cross-cutting themes. All authors contributed to the writing process to create an expanded understanding of what the cross-cutting themes and narratives could tell us. Throughout the writing process, the analysis continued to be developed (Van Manen, 1997).

Methodological strengths and limitations

A strength of the study was the in-depth conversational style used in the interviews, which were sufficiently open to enable participants to share rich stories regarding their participation in the MTW. To present our findings, we have chosen descriptions close to the participants' accounts. Instead of using quotations from all participants, we chose to illustrate our cross-cutting themes with long-idiographical narratives from three of the participants. By illustrating the themes with these rich narratives, we were able to show the complexity, tension and contradiction within the participants. However, this could limit the reader's understanding of how the cross-cutting themes were observed in the other participants.

Findings

In the analysis process, we identified commonality amongst participants' accounts of their experiences of engagement with the MTW; each of these accounts is embedded within a personal history and context. We identified three cross-cutting themes: (1) becoming a whole person, (2) being allowed to hold multiple identities and (3) exploring diverse perspectives. We present the themes separately by giving a short presentation of the content of each theme, illustrating each theme with a narrative, and reflecting on the narrative by considering the findings in light of the research literature. It is important to note that the identity narratives of Mina, Nelly and Oliver were fragmented and disordered, not explicitly told within a temporal order. We have organized the different stories from each of the interviews in a structure that facilitates interpretation of meanings.

Theme 1: becoming a whole person

Theme 1 shows the different trajectories the participants shared about their experiences of becoming a whole person through participation in music and theatre. The participants described a wide range of processes that were important to them, as they allowed them to get to know themselves better and reveal new aspects of themselves without "wearing a mask." Through retelling some of Nelly's narrative, we illustrate some of the elements of this theme.

Nelly: the peeling of layers

> I feel like someone from another planet that has been thrown down here. All my life, I have desperately tried to find my place, while keeping up a facade for everyone around me. It has been important to camouflage my inner chaos by appearing resourceful and competent. I have had an inside and an outside that were never in harmony. A lot of my energy has been spent trying to make my inner chaos invisible to others, but I wish I could move in harmony with how I feel, because when the gap between the inside and the outside gets too wide, my entire life falls apart and the road to admission to hospital is short!
>
> When the MTW first started, I had spent a lot of time in mental healthcare, but never wanted to be associated with any of it, like the day care centres, any possible groups or outings like the organisation "Mental health" or the leisure centre at the hospital —none of it. I really wanted to participate in the MTW, but that meant possibly being identified by someone, and then they could say: "Oh, so she's one of those mentally ill people, then." But then, when I had completed my studies, I could not start working. After filling my days with studies, it was back to everyday life! The gap between inside and outside became too wide again and I was admitted for a longer period. I took a risk and decided to explore the MTW. The level of generosity and non-judgmental attitude I was met with at the MTW was unlike any other. I became a regular there, even though I was afraid that anyone could find out that this was a group for the mentally ill. I still don't always tell people what kind of group it is when I invited them

> to come and see it. I am afraid of the prejudice, even though I feel there is great quality to the work we do here as amateurs.
>
> I do not feel like mental healthcare ruins my identity, but in a way, it does. They keep defining me, and it becomes an enduring reality. Of course, some of my problems might fit the diagnoses, but it is still not all of me. It is what they see. That is why it is so important to have an arena like the MTW when admitted, especially when you experience such loss of identity after remaining there for a long time. If the mental healthcare system wants us to grow and become independent people with healthy identities, it should make room for us, for the entire person, not just for the part that is ill.
>
> After several years as an actor, I accepted the challenge of writing texts for the MTW, even though I was afraid that what I wrote was silly or not as good as what the others wrote. At the same time, I was terrified of exposing myself. My texts were about difficulties I had experienced myself, and existential questions I had that made it very personal. But I cannot keep avoiding everything; I need to show a little bit of the inside, or it will catch up with me again. I am working on accepting how things are and how things have become, that I am who I am as a person. I just want to be able to be a human being, to feel complete and whole.

Analysis

Nelly experienced a year-long struggle with her identity. During this period, she needed to find a place where she felt she could belong. A sense of belonging has been previously associated with participatory arts activities (Lagacé, Briand, Desrosiers, & Larivière, 2016; Stickley, 2010; Van Lith, Fenner, & Schofield, 2011). Her need for belonging included a need to feel psychologically contained as she was afraid that her inner chaos might be visible to others. By participating in the MTW, Nelly applied her energies to developing a new role in the group, which demonstrated her competence and resourcefulness, in spite of her vulnerabilities. The chaos Nelly experienced (she referred to it as the "gap" between her inner and outer self) could only be helped by others. Her experiences with mental health services, however, were that they focused upon her deficits and weaknesses; participating in the MTW meant that she could develop her strengths and abilities and additionally access help in a relatively nonstigmatising environment. As such, the MTW helped her to process her identity issues more than standard psychiatric treatment possibly could. The apparent success of her engagement with the MTW may be largely attributed to the fact that whilst she was encouraged to maximize her strengths and abilities, there was also room for her vulnerabilities. This was successfully facilitated by a nonjudgemental environment, which gave her the space to acknowledge and explore her "gap." As a result of this work, the gap narrowed and she experienced herself as a more complete person.

Nelly's participation in the MTW was not without challenges and not all her problems were solved. Nevertheless, through participatory arts she was given an opportunity to be defined as a creative person rather than as a person having mental health problems (Sagan, 2015; Spandler et al., 2007; Stickley & Eades, 2013). Because of the stigma associated with mental health problems, it is understandable that people are strongly reluctant to disclose and become labelled for fear of alienation (Riddell & Watson, 2014).

The fact that Nelly considered the performances to be of high quality made it easier for her to publicly perform in an MTW production even though it might be known that the group was solely for people with mental health problems. The psychological benefits of performing (higher self-esteem and confidence) outweighed the potential stigma.

Nelly told a story of a long and painful journey. Participation in the MTW did not immediately remove her challenges. In most areas of her life, things remained unchanged from before she started in the MTW. Her story showed that she is in a process of change; she made no claim of a transformed identity, and her identity remained fragmented. Nevertheless, Nelly's narrative illustrates that her participation in the MTW has been crucial for her to initiate the process of identity re-integration on her journey to becoming a whole person (Van Lith et al. (2009). An important discovery for her has been that participatory arts can give her the space needed to allow her to be herself and to become herself.

Theme 2: being allowed to hold multiple identities

Theme 2, being allowed to hold multiple identities (Erikson, 1968), presents the participants' struggle of having more than one dominant identity in society. The participants experienced that mental health patienthood often became a dominant identity in their lives and barred them from holding multiple, healthy and positive identities. They described that any other (more positive) identity could be neglected, overlooked or forgotten by themselves or others. We illustrate some of these experiences with an excerpt from Oliver's story.

Oliver: reclaiming life

> I had been asking to be admitted to the mental healthcare system for a long time. I broke a glass of water against my forehead when my MD yet again denied my request for admission. That turned into a police escort to the hospital. It was important,

> because my life was in fact hanging in the balance. I knew I would be dead without treatment.
>
> Life in the mental healthcare system gradually became like being in prison. I kept being reminded that I only had a status as a patient, and the need to have a different role than just that of a patient began to emerge. Thus, it was liberating to be treated as an actor instead of a patient in the MTW. The fact that nobody used diagnoses on the patients was important. Many of us had been in and out of the mental health-care system; in and out of the institution. Several among us had low self-esteem and institutionalized role-identities. As an actor, I am neither ill, nor healthy. Actors act, they don't self-harm, right? I got to develop a role identity as an actor and a self-image as a human being, not as a patient! The healthy part of the humanity kicked in, and I could start taking care of myself again.
>
> While I was an actor in the MTW, I was also a prominent person in politics. Being open in both contexts at the same time cost me a lot. After a while, even the MTW could not give me the sense of belonging I was looking for. Again, the need to redefine my life emerged. So, I had a potential for development within the framework of the MTW. Once I had filled that frame, a need for greater challenges outside those of the MTW emerged. I did so much creative work in society at large that I no longer associated myself with the mental healthcare system, and continuing as an actor in the MTW became gradually more difficult with regards to my reputation as a politician. The MTW had actually given me the tools I needed to handle a lot of things, especially within the creative field, work life and social settings.

Analysis

Oliver's narrative refers to a story of identity and of continuous development of identity at various stages of his life. The identity he sought and experienced as liberating in one stage of his life made him feel stigmatized and hampered his personal growth at another stage. This resulted in a form of crisis and an urge to redefine himself. Oliver has a need for multiple identities in the same phase of life, but struggles to accept the fluidity and inconsistencies sometimes experienced with the reality of multiple identities (Bauman, 2001).

Prior to being hospitalized, Oliver reached a point in his life where he was no longer able to take care of himself. He described a long battle to obtain the status as a patient and the extreme measures that he was forced to take to achieve admission. Although Oliver initially wanted to become a patient, he gradually came to see that status as being identified as metaphorically "straightjacketed." He was robbed of his sense of freedom due to the many demands and restrictions of the mental-health-care system. Furthermore, he experienced how difficult it made maintaining his roles and activities outside of the system (Goffman, 1968a). Oliver's need for help over a prolonged period caused an identity crisis for him and ultimately led to his becoming a "mental patient" and having to reluctantly accept an "illness identity" (Sayce, 2016). This enabled him to have respite from his identity as a politician. However, he soon needed to discard the illness identity and establish a more positive role. Participation in the MTW provided this new identity. Previous studies have also observed the phenomenon of transformation from "illness" to "artist" identities amongst participants of group-based arts activity workshops (Sagan, 2014, 2015; Spandler et al., 2007; Stickley, 2010; Stickley & Duncan, 2007; Stickley & Eades, 2013; Van Lith et al., 2009).

Apparently, being perceived and subsequently treated as an actor in the MTW enabled Oliver to assume greater responsibilities, be more independent and develop new coping mechanisms, which in turn enabled him to start taking better care of himself. After a few years in the MTW, however, Oliver felt the need for more creative challenges outside of the hospital context. It appears that he began to feel his participation in the MTW was standing in the way of his becoming a creative and fully functioning citizen. Again, Oliver described the story of struggling with re-integrating his identity. Personal identities can never be separated from the societal and stigmatized identities associated with mental patients (Bauman, 2001).

Despite Oliver's desire to combine his identities as an actor and a serious politician, he experienced these as incompatible. Although it seemed he could manage the transition from one identity to another, it appears that he believed he must choose one or the other. In the period when he spent most of his time outside the mental-health-care system, he felt the need to separate himself from the MTW in order to be taken seriously by others and not to chance being stigmatized as an actor with mental health problems. However, it is possible to see the liberation as a natural process in his recovery journey. Eventually, he sought more confirmation from his community outside the institution than from the hospital. Therefore, it may be natural to re-negotiate his identity and represent himself as a multicreative person, without simultaneously connecting this to his identity as being mentally ill.

Theme 3: exploring diverse perspectives

Theme 3 illustrates how participation in the MTW contributes to participants' exploration of diverse perspectives. In this process, the creative product of the group becomes more important than a single actor's performance. In terms of creative processes, the group creates a performance piece based upon their own scripts. They are directed to act out a situation in different ways to figure out the best way to reach the audience. It is through this creative process that participants challenge themselves creatively and discover new aspects of themselves. We illustrate this theme by presenting some of Mina's narrative.

Mina: from no one to someone

> The way I see things is probably very different from how many others see themselves, especially when it comes to my experience of being met by this mental healthcare system and not feeling like I have been reduced to just being a patient by it. I am, of course, a patient from time to time; this I can agree with, but I do not describe myself as ill, and I hate being labelled as such. I rather think of myself as having a low level of functionality.
>
> In fact, I was initially sceptical towards participating in the MTW; I figured my poetry and music skills were better left at home and lacked the quality needed in this arena. I had never intended for anyone to hear any of it, but then my skills flourished here. Suddenly, I felt that I could participate. It didn't matter whether it was good or bad, that was not where the focus was. The focus was on what it could do for others, what others could gain from it if I shared it. So, I have learned a lot about myself and my relationships with others through my participation in the MTW. I have gained confidence and grown as a person; from having a completely decimated self-worth to being confident enough to start searching, testing myself, trying and failing.
>
> I have always felt like something was wrong with me and like everyone else was so different from me. Well, in fact, I have thought of myself as being "no-one." One of my texts became a play in the MTW. It was based on my whole life, my entire sense of identity. It was about being "no-one," and feeling left out and fighting alone against the world.
>
> I had to think a little bigger than I normally do. I couldn't sit there all narrow-minded and think that I was no-one. I had to think differently and get "no-one" to interact with the others. That was when I realized a lot about myself, that I can interact with others, even if I am a "no-one." But that would mean that I wasn't so alone anyway? Maybe I was "someone!"

Analysis

Mina has always considered herself as a "no-one" and felt very much alone in the world. Through her descriptions, we see that there has been little room for self-exploration since being no one is such a constant. She narrates that there is no-one to explore. Her feeling of being different from others relates to her finding a place in society. Being a no-one is a strong self-critical voice. In the MTW, she benefitted from new experiences when she interacted with other people. For her it meant becoming part of a community and that focus was changed towards the product—the performance—instead of on her individual skills. In this way, her self-critical voice became diminished. Mina's experience of being a part of a creative process enabled her to narrate a coherent story to an audience (Thomson & Jaque, 2017). By doing so, she became part of something bigger. The musicians and actors collaborated in an effort to realize a performance that was compelling and meaningful for the musicians, actors, and their audience, as Thomson and Jaque (2017) acknowledged. The fact that the participants could freely choose how to tell their story challenged Mina to see various texts and portray characters from different perspectives. She learned to open up to new experiences and interpretations.

The MTW enabled Mina to adjust her perception of reality by challenging her to let go of some of her negative beliefs and ways of thinking. By experimenting with the creative activities, she was able to entertain and embrace new, more positive ways of being (Rogers, 1967). As an actor in the MTW, she accepted a range of roles; the similarities these roles had to her own life appear to have enabled her self-exploration. Being able to portray the character "no-one" had a crucial impact on her new way of seeing herself. However, what was significant was the opportunity to bring life to the character of "no-one" on stage where "no-one" could interact with the other characters in the play. She had to use herself as a tool to allow the character to genuinely come to life for an audience (Hagen, 1973). In this process of portraying the character, she went beyond her old perceptions of herself and through a self-discovery journey from being "no-one" to becoming "someone." Consistent with the findings from Tust-Gunn (1995), Mina experienced a dynamic interaction between understanding herself and exploring the character "no-one"; through this explorative process, Mina became familiar with undiscovered facets of her life and experienced a new understanding of herself. Mina experienced herself through becoming creative and the creative process enabled a deeper engagement with the self and the world around her (Nelson & Rawlings, 2009). Through participatory arts, she told the story of her self-exploration that went from a cognitive level to an emotional level. She increased her ability to challenge existing preconceived beliefs and she became open to new understandings about herself and others.

Discussion and concluding remarks

The analyses of the narratives show that participation in the MTW gave participants new experiences and possibilities to change previous identities. Participation also contributed to processes that reflected both internal individual and personal identities and collective and socially created identities. Participants described an extended picture of themselves, incorporating a change of identity, from their previous stigmatized identity as being mentally ill to a more positive, reconstructed identity. In the two-phase process of portraying the characters (Noice & Noice, 2002), they each experienced a journey of self-discovery. They were able to use themselves as tools when they explored the script, determined the intentions of the characters and rehearsed and performed their roles. Their perceived identities and self-knowledge were the main sources drawn from to portray the characters. This required actors and musicians who were curious and wanted to accept and understand the different facets of themselves (Hagen, 1973). In line with Hagen's understanding, the participants in the MTW learned more about themselves, which included the opportunity to explore their own sense of identity, to enlarge that sense of self and to see how they could utilize that knowledge when they portrayed a character (Hagen, 1973). As an alternative to therapy, the participants had the opportunity to work on themselves, exploring the questions "Who am I?" and "Who can I become?" In this explorative process, they were able to discover themselves in new ways, which could result in becoming familiar with undiscovered facets of their lives and sometimes new permanent understandings of themselves (Tust-Gunn, 1995).

The participants' engagement in the MTW had a direct impact on their identities in relation to others in the workshops. The one unifying factor the participants shared when they commenced the MTW was their common experience of being labelled as having long-term mental health problems. However, after a while, their focus on arts became more important as they began to identify with the group. In everyday life, experiencing psychological belonging to a social group has been challenging for the participants (Hagerty, Lynch-Sauer, Patusky, Bouwsema, & Collier, 1992). Engaging in a creative environment where they felt accepted and staying together with people who shared their interests in music, theatre and scriptwriting gave them a sense of belonging, and for some of the participants, for the first time. Creating arts together gave the participants the experience of being part of a social world (Van Lith et al., 2009), which made it possible to question narratives about themselves and narratives regarding how society may look upon them. Through sharing and weaving together stories, anecdotes and narrative fragments from their lives, they collectively created counterstories (Nelson, 2001), extending their and the audience's perspectives on mental health, the mental health system and being a human being. Consistent with findings from Stickley (2010), some of the participants experienced participation in music and theatre as an opportunity to collectively redefine themselves. It restored their identities as artists as a social response to their experience of having their identities spoiled by society.

For participants in this study, identity is not something solely within (Gergen, 2009); identities are fluid (Bauman, 2001) and dependent on others, their relations, and their contexts (Gergen, 2009). The participants recounted spending much time in mental health care, surrounded by other patients and health professionals. This engagement within the mental health discourse strongly influenced their personal and social identities. It is apparent that an illness identity endures; moreover, an identity as a mental health patient is doubly negative and is often internalized (spoiled) (Goffman (1968b). In this study, this spoiled identity is confronted by the possibility of identity transformation through experimental arts activities. Theatre and music facilitated different and new experiences contrary to the stigmatized or spoiled identities enforced by society and the mental health system. These findings can give insight into potential new understandings of the recovery processes. Bringing music and theatre in mental hospital contexts could help people to develop new, expanded and different narratives about themselves. Participants in this study formed new narratives, which in turn brought reflexivity in the way they understood and told stories about themselves. Neither the mental health problems, nor their identities of being an actor, musician or scriptwriter could provide the whole picture of them, just a part. They are in a process working on an identity narrative that they can live with and that tells themselves and the world around them about whom they are becoming as human beings. However, this does not imply that their previous identities are gone; their old identities remain and can be recalled in relation to themselves and others.

Deegan (1997) says, "recovery is a process, not an endpoint or a destination" (p. 20). Through the MTW, the hospital is working with identity as a key in people's recovery processes (Andresen, Oades, & Caputi, 2003; Davidson & White, 2007; Salzmann-Erikson, 2013; Slade et al., 2012). As recovery is a personal and a social process (Topor, Borg, Di Girolamo, & Davidson, 2011), with no endpoint (Deegan, 1997), identity transformation can be the same. Based on the participants' narratives, we can appreciate that identity work takes place not just internally and with the participants, but also in relation to others in other contexts. Understanding, redefining and accepting self; incorporating illness; and overcoming stigma are some of the essential building blocks of recovery (Davidson and White (2007). Participation in the MTW had the potential to influence all these elements of identity. We do not assert that participation in music and theatre necessarily changes people's identities. However, this study illustrates how people with long-term mental health problems could work with their own identities in creative ways in the hospital context. Through participatory arts, people with long-term mental health problems have the potential to develop new identities and anchor points, which could result in expanded narratives of themselves.

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APPENDIX 4: LETTER OF APPROVAL

REK
REGIONALE KOMITEER FOR MEDISINSK OG HELSEFAGLIG FORSKNINGSETIKK

Region:	Saksbehandler:	Telefon:	Vår dato:	Vår referanse:
REK midt	Ramunas Kazakauskas	73597510	24.04.2015	2015/476/REK midt
			Deres dato:	Deres referanse:
			24.02.2015	

Vår referanse må oppgis ved alle henvendelser

Marit Solbjør
NTNU

2015/476 Recovery og deltakelse i teaterverksted for personer med langvarige psykiske lidelser

Forskningsansvarlig: NTNU
Prosjektleder: Marit Solbjør

Vi viser til søknad om forhåndsgodkjenning av ovennevnte forskningsprosjekt. Søknaden ble behandlet av Regional komité for medisinsk og helsefaglig forskningsetikk (REK midt) i møtet 10.04.2015. Vurderingen er gjort med hjemmel i helseforskningsloven (hfl.) § 10, jf. forskningsetikkloven § 4.

Prosjektomtale
Formålet med prosjektet er å utforske og forstå hvordan deltakelse i musikk- og teaterverksted kan bidra til å fremme recoveryprosesser hos mennesker med langvarige psykiske lidelser. Musikk og teater brukes i mange sammenhenger innen psykisk helsevern. Publiserte studier er i hovedsak knyttet til behandlingseffekt. Denne studien vil undersøke brukernes erfaringer recovery gjennom kulturell aktivitet og deltakelse. Problemstillingene i studien er: Hvordan beskriver personer med langvarige psykiske lidelser sine erfaringer med å delta i musikk-og teaterverksted? På hvilken måte kan musikk og teaterverksted være en arena for å fremme personlige recoveryprosesser hos den enkelte deltaker? Dette er en kvalitativ intervjustudie hvor det vil gjennomføres individuelle intervju med nåværende og tidligere deltakere i et musikk- og teaterverksted. Intervjumetode gir mulighet for å få fram førstepersonperspektivet til deltakerne i teaterverkstedet. Studien er del av et PhD-prosjekt om recovery.

Vurdering
Representant for psykologi Tore Aune meldte seg inhabil i saken og deltok derfor ikke i vurderingen av prosjektet.

Komiteen har vurdert søknad, forskningsprotokoll, målsetting og plan for gjennomføring. Komiteen oppfatter prosjektet som en studie som dreier seg om deltakelse i musikk- og teaterverksted for mennesker med langvarige psykiske lidelser, og hvordan slik deltakelse kan bidra til å fremme recoveryprosesser. Det skal gjennomføres individuelle intervju med 10-15 tidligere og nåværende deltakere ved kulturtilbudet "Cabaret for øyeblikket" ved Blakstad sykehus. Rekruttering vil skje direkte på teaterstedet og gjennom utsending av informasjonsskriv i posten.

Under forutsetning av at vilkårene nedenfor tas til følge, framstår prosjektet som forsvarlig og hensynet til deltakernes velferd og integritet er ivaretatt.

Vilkår for godkjenning

1. Komiteen ber om at det i informasjonsskrivet opplyses at man må ha hatt langvarig psykisk lidelse,

Besøksadresse:
Det medisinske fakultet
Medisinsk teknisk
forskningssenter 7489
Trondheim

Telefon: 73597511
E-post: rek-midt@medisin.ntnu.no
Web: http://helseforskning.etikkom.no/

All post og e-post som inngår i saksbehandlingen, bes adressert til REK midt og ikke til enkelte personer

Kindly address all mail and e-mails to the Regional Ethics Committee, REK midt, not to individual staff

samt vært deltaker ved "Cabaret for øyeblikket" i tre måneder. Komiteen vurderer at dette er nødvendig for å gjenspeile inklusjonskriteriene.

2. Komiteen ber om at kontaktinformasjonen for psykologen som har ansvaret for beredskapen oppføres i informasjonsskrivet. Dette gjelder både telefonnummer og e-post adresse.
3. Komiteen ber om at det må opplyses i informasjonskrivet at studien er godkjent av Regional komité for medisinsk og helsefaglig forskningsetikk.
4. Revidert informasjonsskriv skal sendes komiteen til orientering. Vennligst benytt e-postadressen post@helseforskning.etikkom.no og "REK midt 2015/476" i emnefeltet. Det reviderte informasjonsskrivet skal sendes komiteen for studien igangsettes.
5. Godkjenningen er gitt under forutsetning av at prosjektet gjennomføres slik det er beskrevet i søknaden og protokollen. Prosjektet må også gjennomføres i henhold til REKs vilkår i saken og de bestemmelser som følger av helseforskningsloven (hfl.) med forskrifter.
6. Komiteen forutsetter at ingen personidentifiserbare opplysninger kan framkomme ved publisering eller annen offentliggjøring.
7. Prosjektleder skal sende sluttmelding til REK midt på eget skjema senest seks måneder etter prosjektslutt, jf. hfl. § 12.
8. Forskningsprosjektets data skal oppbevares forsvarlig, se personopplysningsforskriften kapittel 2, og Helsedirektoratets veileder for «Personvern og informasjonssikkerhet i forskningsprosjekter innenfor helse- og omsorgssektoren». Av kontrollhensyn skal prosjektdata oppbevares i 5 år etter sluttmelding er sendt REK. Data skal derfor oppbevares til denne datoen, for deretter å slettes eller anonymiseres, jf. hfl. § 38.

Vedtak
Regional komité for medisinsk og helsefaglig forskningsetikk Midt-Norge godkjenner prosjektet med de vilkår som er gitt.

Komiteens beslutning var enstemmig.

Sluttmelding og søknad om prosjektendring
Prosjektleder skal sende sluttmelding til REK midt på eget skjema senest 30.06.2019, jf. hfl. § 12. Prosjektleder skal sende søknad om prosjektendring til REK midt dersom det skal gjøres vesentlige endringer i forhold til de opplysninger som er gitt i søknaden, jf. hfl. § 11.

Klageadgang
Du kan klage på komiteens vedtak, jf. forvaltningsloven § 28 flg. Klagen sendes til REK midt. Klagefristen er tre uker fra du mottar dette brevet. Dersom vedtaket opprettholdes av REK midt, sendes klagen videre til Den nasjonale forskningsetiske komité for medisin og helsefag for endelig vurdering.

Med vennlig hilsen

Sven Erik Gisvold
Dr.med.
Leder, REK midt

Ramunas Kazakauskas
Førstekonsulent

Kopi til:postmottak@svt.ntnu.no

APPENDIX 5: INFORMATION LETTER ABOUT THE STUDY

NTNU
Kunnskap for en bedre verden

HINT

Forespørsel om deltakelse i forskningsprosjektet

"Recovery og deltakelse i musikk- og teaterverksted for personer med langvarige psykiske lidelser"

Bakgrunn og hensikt

Denne forespørselen gjelder deltakelse i en forskningsstudie. Målsetningen er å utforske erfaringer med musikk- og teaterverksted for mennesker med langvarige psykiske lidelser. Hensikten med studien er å få frem deltakernes erfaringer med bruk av kulturell aktivitet og om erfaringene bidrar til å fremme bedring. Informasjon som innhentes i studien vil inngå i en doktoravhandling ved NTNU.

Hva innebærer studien?

Du inviteres til å delta i studien fordi du har en langvarig psykisk lidelse og er / har vært deltaker i musikk- og teaterverkstedet "Cabaret for øyeblikket" i minst 3 måneder. Deltakelsen innebærer gjennomføring av intervju med en varighet på 1 – 1,5 time. Intervjuet vil bli gjennomført av stipendiat Kristin Berre Ørjasæter. Intervjuet avholdes ved Vestre Viken. avd. Blakstad, eller du kan foreslå et sted som passer deg.

Hva skjer med informasjonen om deg

Informasjonen som registreres om deg skal kun brukes slik som beskrevet i hensikten med studien. Det er kun forskere knyttet til prosjektet som har tilgang til datamateriale. Intervjuene tas opp på lydfil. Intervjuene vil bli skrevet ut som anonymisert tekst. Alle data vil bli behandlet konfidensielt og på en forsvarlig måte. Det vil si at opplysninger ikke vil kunne føres tilbake til deg som person. Du bestemmer selv hvilke opplysninger du vil gi i intervjuet og hvor detaljert disse skal være. Du velger selv om du vil svare på spørsmålene. Jamfør § 38 i helseforskningsloven vil dataene bli oppbevart 5 år etter studiens avslutning. Forskningsprosjektet forventes avsluttet våren 2019. Resultatene i studien vil publiseres i nasjonale og internasjonale vitenskapelige tidsskrifter, konferanser og populærvitenskapelige kanaler. Det vil ikke være mulig å identifisere deg i resultatene av studien når disse publiseres.

Studien er godkjent av Regional komite` for medisinsk og helsefaglig forskningsetikk (REK).

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. Dette vil ikke få konsekvenser for din kontakt med musikk -og teaterverkstedet, videre behandling eller kontakt med hjelpeapparat. Opplysningene du gir i intervjuet vil ikke bli kjent for behandlere eller andre hjelpere. Du vil få dekt reisekostnader for å delta i studien.

Dersom du ønsker å delta, undertegner du samtykkeerklæringen på siste side. Du kan sende samtykkeskjema i den frankerte svarkonvolutten til Høgskolen i Nord-Trøndelag. avd. helsefag, Kristin Berre Ørjasæter, Postboks 474, 7800 Namsos eller lever samtykkeskjema på informasjonsmøte. Dersom du senere ønsker å trekke deg eller har spørsmål til studien, kan du kontakte Kristin Berre Ørjasæter, på tlf; 742 12337 / 90 14 15 86 eller e-post; kristin.b.orjasater@hint.no. Det er også mulighet til å ta kontakt med prosjektleder, Marit Solbjør, Institutt for sosialt arbeid og helsevitenskap, NTNU, på tlf; 735 90220 eller e-post; marit.solbjor@svt.ntnu.no.

Informasjonsmøte avholdes på Vestre Viken. Avd. Blakstad, 17.juni kl 12.00 i «Cabaret for øyeblikket» sine lokaler.

Hvis du i etterkant av forskningsintervjuet har behov for å snakke med psykiater, kan overlege og spesialist i psykiatri, Åse Lyngstad kontaktes på tlf; 91153731 eller e-post; aase.lyngstad@vestreviken.no.

Rett til innsyn og sletting av opplysninger om deg

Hvis du deltar i studien har du rett til å få innsyn i hvilke opplysninger som er registrert om deg. Du har videre rett til å få korrigert eventuelle feil i de opplysninger som er registrert. Dersom du trekker deg fra studien kan du kreve å få slettet opplysninger, med mindre opplysningene allerede er inngått i analyser eller brukt i vitenskapelige publikasjoner.

Informasjon om utfallet av studien

Du har rett til informasjon om resultatene fra studien. Alle deltakere som ønsker det vil etter prosjektavslutning få tilsendt en oppsummering av forskningsresultatene i eget skriv, og få en oversikt over hvor disse er publisert.

Namsos, 04.05.2015

Kristin Berre Ørjasæter	Marit Solbjør
Stipendiat HINT/NTNU	Førsteamanuensis, NTNU

APPENDIX 6: INFORMED CONSENT FOR PARTICIPATION

NTNU
Kunnskap for en bedre verden

HINT

Samtykke til deltakelse i studien

Jeg har mottatt informasjon om forskningsstudien, og samtykker til å delta i studien;
"Recovery og deltakelse i musikk- og teaterverksted for personer med langvarige psykiske lidelser"

Navn: ....
BRUK BLOKKBOKSTAVER

Jeg ønsker å bli kontaktet på følgende måte for avtale om intervju:

☐ Telefon: ....

☐ E-post: ....

....
(Dato, signatur av prosjektdeltaker)

APPENDIX 7: INTERVIEW GUIDE

Interview guide

Note: The guide was used as a way to prepare for the interviews. It consist of the thoughts and questions I was interested in exploring going into the study. The themes in the guide were touched upon during the interviews, but the conversations did not follow a strict structure, rather they were led by the informants stories.

Initial Question:

1. Can you tell me a bit about yourself?
    - Age, relational status, children, work, education.

Participation in the music & theater workshop

2. Can you tell me about the music and theater workshop?

3. Can you tell me about your participation in the music and theater workshop?
    - What has been your contribution?
    - Why did you become a participant?

4. What has participating in the music and theater workshop meant for you and your mental health?

Contact with the mental health services

5. Can you describe what kind of mental illness(es) you experience?
    - What age were you when the mental illness(es) / mental health problems started?
    - Diagnosis

6. What kind of support do you receive now?

7. When did you come in touch with the health services and which services have you received?
    - How have you experienced the contact with the health services?

8. How is it to live with a mental illness /diagnosis?
    - What term do you use for what therapist call mental illness?

Recovery

9. What promotes and hinders recovery for you?

10. Would you say that you are in recovery?

11. What has been important for your recovery process or what will be important to experience a recovery process?
    - Which of your characteristics has been important in your recovery process?
    - Which external characteristics or factors has been important in your recovery process?
    - What kind of role has everyday life, family, network, professionals or others had in your recovery process?

<u>*If the person experiences a recovery process:*</u>

12. Which parts of your life have changed through your recovery process?

    - Social networks and relations: How will you describe your social network: (Family, friends, others)
    - Leisure and everyday life: How do you spend your spare time?
    - Relief from symptoms: Mood, impulsivity, suicidal thoughts / plans, self-harm etc.
    - Hospitalization and medicine: extent and duration

13. Have participation in the music and theater workshop had impact on your recovery process?

    - If so, in what way?
    - Or why not?

14. Is there something you could have done differently or have wished other could have contributed with on your way to recovery?

<u>*If the person not yet experience being in recovery*</u>

15. From your perspective, what would be important for people with mental illness to enable an experience of recovery?

16. Is there anything you could have done differently or wished that others could have done for you to experience recovery?

<u>Concluding questions:</u>

19. How would you describe the support and treatment you have received?

20. Do you have any suggestions or experiences of services or treatments that has been useful, and that you would want more of?

21. Is there any topics we have not talked about that you consider of importance in terms of mental health, arts participation or mental health recovery?