In Defence of a Humanistic approach to Mental Health Care –
Recovery processes investigated with the help of clients' narratives on turning points and processes of gradual change

Abstract

Several studies in recent years have shown that recovery factors as experienced by clients are not always compatible with professional approaches. For example, clients often emphasise the importance of relationships and the satisfaction of universal human needs. The aim of the study has been to explore clients' descriptions of beneficial factors and to discuss the implications of those factors for the delivery of mental health services. Method has been qualitative content analysis of 347 user narratives. The study confirms findings in earlier recovery studies, but also demonstrates that the investigation of clients' stories leads to a range of existential dilemmas. Fundamental beliefs about what constitutes effective and necessary treatment are challenged. Recovery is a fundamentally personal process that involves finding a new sense of self and feeling of hope. Furthermore it is not only an internal process; it also requires external conditions that facilitate a positive culture of healing.

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Introduction

The fact that people are able to recover from serious mental illness has been established through numerous studies (Adams & Partee 1998, Glass & Arnkoff 2000, Mead & Copeland 2000, Spaniol et al. 2002, Topor 2004, Davidson et al. 2005, Hopper et al. 2007, Borg 2007, Till 2007, Brown & Kandirikirira 2007, Helm 2009, Schön et al. 2009, Song 2009) and has resulted in an increased focus on recovery as a focus in mental health care. However definitions of recovery have remained diverse (Anthony 2000, Kristiansen 2003, Onken et al. 2007); The implications for practice as well as professional understanding are therefore still unclear. For example, recovery research conducted by the WHO (International Pilot Study of Schizophrenia, launched in 1966, reported in Hopper et al. 2007) has mainly focused on the amelioration of symptoms, while the perspective held by mental health users' movements has been far broader. This latter perspective involves people overcoming the effects of having a mental health issue – such as stigmatisation, poverty, isolation and unemployment - and resuming control over their own lives. From this perspective, people may consider themselves as being in recovery even if they continue to be affected by mental illness (Davidson et al. 2005). In this article we will argue that a recovery perspective ought to imply an epistemological acknowledgement of the users' subjectivity as relevant to build knowledge, and that *the person* more than the diagnosis

1

should be the orientation both for research and practical mental health care. Accordingly, there is a need for more knowledge based on users' experiences.

The content of recovery

Several attempts have been made to sum up effective recovery factors and propose a definition of recovery. The National Consensus Conference on Mental Health Recovery (2006), resulted in a statement that identified ten fundamental components of recovery: self-direction; person-centred planning and care models; self-management and empowerment by shared decision-making; a holistic approach to the tragic early mortality rates of mental health users; recovery seen as a non-linear process; the promotion of peer-support by trained peer specialists; the countering of stigmatising media portrayals; respectful approaches to people; the right to feel responsible; and hope that change is possible (Del Vecchio & Fricks 2007). Davidson & Strauss (1992) have added factors such as redefining self; incorporating illness (accepting limitations and discovering talents and gifts); being involved in meaningful activities; and exercising citizenship. Onken et al. (2007) have with reference to Freire (1990) pointed to the re-authoring elements of recovery; the right to define the world, reclaim one's life and contextualise one's experiences – which is perhaps the primary mechanism of personal growth. This is an organic perspective, incorporating both the individual and the environment; seeing recovery as a unique process for each individual and addressing poverty, coercion and social marginalisation.

To sum up, researchers agree upon certain core elements of recovery. All are related to the satisfaction of universal material and emotional human needs and to individuals' ability to fulfil social roles after periods of distress and illness.

The recovery approach attempting to encompass complexity in human lives, needs, desires and existential meaning seems to go beyond attempts to construct models for recovery-oriented practices. In psychiatric mental health care it may be that such models are at odds with the recovery concept itself. Glover (2002) has stated that a desire to 'model' recovery will be one of the major threats to creating an authentic recovery-based framework. Other researchers hold open the possibility that one day we may arrive at a shared meaning of recovery, with room for various combinations of

dimensions (Davidson et al. 2005, Spaniol et al. 2002). However, as a result of biomedical orthodoxy also influencing psychiatric nursing, for example during recommendations about comprehensive assessment systems and the development of differential diagnoses (Barker et al. 1998), it is a possibility that a positivist research approach, studying recovery independent of the subject, could lead to the development of an evidence based recovery manual.

Including recovery research in professional knowledge

Strauss (2005) has questioned the resistance towards including recovery research in the field of psychiatry, a field that "continues often to teach and to act as though patients with schizophrenia can't improve in spite of all (literally all) the data to the contrary" (p.54). His challenge to professionals is about developing capacity for thinking in complex terms and dealing more appropriately with the complexity of the real world of persons suffering from mental disorders. Frankly he asks: "How can we make the mental health field a human science?" (p. 53).

A recovery orientation emphasising the resolving of existential dilemmas challenges reductionist and symptom oriented views. It also means to change the traditional instrumental way of thinking about treatment to an approach where cooperation and communication is the basis for theory and practice. An instrumental rationality reflected in standardised routines and rule-governed practice, which is implicit in the evidence-based paradigm, is hardly compatible with user-oriented approaches. User-focused approaches build on a communicative rationality where the ability to practise holistic assessments in cooperation with the client is core practice (Ekeland 2007). One important implication of this orientation is a need to transform users' experiences into relevant knowledge. This empirical study based on users' own experiences is motivated by this need.

Aim

The aim of this study is to improve the mental health nurses' and other professionals' understanding of different elements in change processes that support recovery, as experienced by mental health clients in a variety of life circumstances.

Method and research questions

The study has a qualitative, explorative and descriptive design. To obtain a better understanding of clients' experiences of recovery processes and implications of these experiences for professional theory and practice, 347 client narratives concerning meetings with the health service system have been analysed. Narratives were used because they can give the reader access to the lived experience of illness and healing (Richards 2008). The open question was: "Would you like to tell a story from a special meeting with a helper or a health service system that constituted a turning point in your life?" The term turning point was open for exploration and the majority responded by describing gradual processes of change, while some people also described special moments experienced as distinguished turning points. Our research question was about understanding some essential features of the recovery process from the perspective of the person engaging professional help..

The qualitative content analysis used is inspired by social and human sciences where texts are treated as windows into human experiences (Silverman 2000) and analysed in order to disclose central properties. Asking for clients' stories means that clients' experiences – expressed in their own words – are seen as a most valuable source for understanding how mental health services work and how these services can be improved. Furthermore, this approach underscores that reciprocal dialogues are necessary for creating effective service systems.

In the narrative tradition, extracts from stories unfold and communicate on their own merits (Spiggle 1994). Nuances in the material are communicated through the citations from several stories which illustrate further the variation and richness in each category. It is essential in these kinds of studies that the reader comes away with a better understanding of what it was really like for someone to experience what the study describes (Polkinhorne 1988).

Respondents

The data in this study were selected from a larger study carried out in cooperation with the national user organisation in Norway, Mental Health Norway (MHN). MHN was chosen because it is the largest user organisation in Norway. The organisation has a good relationship with the government as well as an administration that was able to facilitate the collection of data. During the period of data

collection there were about 5000 members spread over the entire country. About 4000 of them, chosen randomly, were invited to take part in the study. The intention was to include every second person of the 5000 members and send a reminder to this sample, but when it came to the second round, the member-lists had been altered and the organisation could no longer identify every second from the first round. Therefore, in the second round, questionnaires were sent to the first 3000 members in the new member-list. Roughly estimated then, altogether 4000 members received the questionnaire and approximately 1500 of them received it twice.

The response rate was almost 20%. Of these about 492[1] (151 men, 341 women, aged 19-90 years) also answered one or both of the open questions at the end of the questionnaire[2]. There were 380 persons who answered the turning point-question. Of these 347 persons wrote stories that were seen as sufficiently informative to be included in this analysis, that is the stories were readable, meaningful and not too general. For example "I have received good help" would be excluded because it does not tell us anything about the factors involved.

The respondents had experiences from all parts of the mental health care system – traditional psychiatric institutions, outpatient clinics, day centres and individual therapy. Around 67% were recipients of a disability pension, 13% were employed and 20% combined a disability pension with work or studies. Forty eight percent lived alone, 40% lived with a partner and 12% lived together with other people. About 90% indicated that they felt connected to other people or networks. This wide distribution indicates that the sample is representative even though not in a statistical sense.

The narratives vary in length from one line to several pages. The long stories often give in-depth information about background and concrete elements in the recovery process. But quite brief reports also contained important information, such as the statement that: "It meant a lot to be taken seriously, I could then open up".

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[1] The number cannot be given more exactly because it is suspected that 5-10 persons answered the questionnaire twice.
[2] In addition to the question about turning points, there was also a question: "If you have had strong negative experiences, would you like to describe such an event?"

Analysis

The data were analysed by means of qualitative content analysis, that is a combination of empirically based and theoretical interpretations (Graneheim & Lundman 2004). This involved reading the stories several times in order to discover themes hidden in the texts and to obtain a sense of the whole. Manifest content in the texts was then presented in categories which may also be seen as expressions of the latent content. The presentation of meaning units in categories was based on the researchers' interpretations. To validate the categorisation process, extracts from all the stories were read through by one of the co-researchers, who agreed to the chosen categories.

To provide an overview of the material, the number of respondents in each category is included. These must be regarded as rough estimates, as the dimension in for example category 2 may also be implicit in stories grouped under category 3 (e.g. clients who wrote about achieving a new orientation could also have told about rediscovering oneself), which means that the categories may be seen as a continuum. The aim of the analysis has been to describe different dimensions with as much nuance and detail as possible.

In narrative terminology the plots considered in the analysis are about gradual change processes and significant turning points, and clients' explicit or implicit reactions to these. Even the brief quotation: "It meant a lot to be taken seriously, I could then open up", contains the three central, narrative elements (Hydén 1997): first event (to be taken seriously), second event (I could open up) and a causal link (then). Narrative theory is here used to illustrate the rational and common properties of the stories, even if the analysis itself is carried through by the help of qualitative content analysis.

Ethical issues

The project was registered at the Norwegian Social Science database (NSD), which has delegated authority from the Data Inspectorate of Norway to accept investigations where sensitive, personal information is involved. The collecting of data was organised in such a way that the researcher was unable to identify the informants. Letters were sent to the members of the user organisation (MHN) directly from the MHN's secretary, after the project had been discussed in the MHN's executive committee. In practice this means that the user organisation had ownership of the investigation and

invited its own members to participate. Answers were returned anonymously to the researcher. Because the questionnaires were sent by mail, and the right not to participate was underlined, informants' informed consent was ensured and the right to privacy and integrity were maintained. There were no cases in which informants told of any discomfort about being asked to fill in the questionnaire or to write about positive or negative experiences. But some informants stated that they were unwilling to write about bad experiences. Reasons given for this included for example that the re-telling of the story would open old wounds. By contrast, several informants also expressed that it was a relief to write about their stories.

Results

Different categorization structures were evaluated before it emerged that the stories could be grouped into three main categories: helped to live with the disability; rediscovering oneself; and getting through crises and achieving a new orientation (refer Table 1). For each category there are examples of both long-lasting processes and moments of special significance.

The results are presented in Table 1 with main and sub-categories. Under each sub-category supplementary key words are listed, describing what the informants expressed as essential factors behind their improved situation. Sub-categories under 'turning points' have much the same qualities as categories under 'gradual change', but cannot be exactly the same because turning points refers to moments of significant importance. An example could be a special meeting/special words which in a way opened the persons' eyes so it was possible to see that life was worth living. Conversely, building trust is a more long lasting process and not a category under 'turning points'.

Category 1, 'Helped to live with disability' illustrates processes or events that made the situation bearable and helped the person to function better even if he or she was still struggling with the disability. Category 2, 'Rediscovering oneself' is about 'getting on track' again after periods of mental problems and suffering. In category 3, 'Getting through crises and achieving a new orientation', the informants describe processes where they restore both health and good functioning and, because of the crisis they have been through, experience new dimensions and qualities in life.

Table 1: Three dimensions of gradual change processes and turning points

Gradual change processes	Turning points
Helped to live with disability	*Helped to live with disability*
Taken care of; long-lasting relationships, home care **Accessibility;** hospitalisation, someone to talk to, medicines **Manage alone;** peer support, ambulant team, own flat, talks	**Taken care of in short periods;** crisis beds, help line **Limited problem solved;** helped with voices, phobia etc **Good encounters;** memories of respect, love, talks **Life saved**; someone to talk to in a critical situation,
Rediscovering oneself	*Rediscovering oneself*
New insight; finding words, history discovered, explanations **Equality;** meeting genuine people, medicines reduced, respect **Dignity;** identity, self consciousness; acceptance **Mutuality;** supporting networks, mutual trust, friends **Being in process**; have started therapy, confidence in therapist	**New insight;** honesty, alternative perspectives **Dignity,** identity and self respect achieved by words and rituals **Mutuality;** a special meeting with an adviser **Process started**; people dared to intervene
Getting through crises and achieving a new orientation	*Getting through crisis and achieving a new orientation*
New meaning; new interpretations, new words, spirituality **Liberation and mastering**; working through trauma, training **Trust and hope;** openness, talks, caring relation, safety **Healing;** talks, psychomotor treatment, medicines removed **New life opened**; courage to confront old wounds	**New meaning;** new interpretations, new understanding **Healing;** effects of kinesiology and psychomotor treatment **New life opened;** realized not being alone with shame, holding hands

Since the stories were written in response to a question about meetings with helpers or health care systems, one could not expect stories about socio-economic factors or social networks. However, these factors are mentioned in several stories where people talk about the importance of having their own place to live, employment, education and leisure activities. The importance of such factors in the recovery process is indisputable, but this is not the focus of this article. Further, within the frame of this article, and based on the data gathered, there was no room for a problematisation of the use of medicines. However it was interesting to find that only 18 of the 347 informants mentioned that taking psychotropic drugs was a factor in their recovery, which raises some intriguing questions. The following provides a deeper illustration of the results.

Receiving help - living with disability

This is a very strong theme with many references to special persons who could be trusted and who played decisive roles in their change processes. Often these included a doctor or a nurse, but also friends, family members and other users of mental health services. Because of those special and

empathic persons they felt taken care of and this created a confidence that they would be supported in their daily life and in situations where they needed more help.

Woman, age 57:

My GP is a unique person, very warm. He has always shown interest and calls me to ask how I am doing, even during his free weekends. In addition, I see a psychiatric nurse for talks. She is fantastic. I also participate in a conversation group that I benefit from.

Woman, age 59:

I use medicines and have to use them the rest of my life. Got them 11 years ago and they function ok. Was in hospital 11 years ago, but have managed alone since then. I have children and grandchildren and they have accepted my 'nerves'.

The next story is about a special meeting that created good memories:

Woman, age 31:

I had taken an overdose of medicines and was an in-patient in a local hospital. I made very good contact with a nurse there. She sat down at my bedside and talked to me. Gave me a good lotion after I had cut my arms with a mirror and gave me the whole tube and a hug when I was sent on to the psychiatric division. I will never forget her!

Dialogue, respect, care, understanding and good encounters emerge as important conditions for being able to live with disability.

Rediscovering oneself

In this category all the informants speak about important relationships. Quite common are phrases such as: 'the psychiatrist took me seriously', 'reduced the medicines', 'had time to listen', 'did understand', 'psychologist helped me to express what I had experienced', 'he was patient', 'helped me to open up', 'gave me the feeling that I am valuable'. But also peer support is quite important and is often described in almost the same way as professional support: 'The user organization keeps me going', 'I got encouragement to change my situation', 'my positive sides were seen', 'I met people

who understood', 'we have a fellowship where we respect each other', 'I experience meaning in life as I can also help other people'. The following story illustrates a special meeting with a religious person:

 Man, age 43:

After having fought with all kinds of bureaucracy and systems I at last considered committing suicide as a last escape. In desperation and by accident I passed a house where Catholic monks lived. I am not a Catholic, but was met with incredible warmth and not least, respect. The father invited me inside and we talked until I felt able to walk home. Later we had several talks about thoughts I was struggling with. The father's genuine wish to help showed through and he offered to engage himself also beyond the conversations. Until this day I have never met a person with an equivalent capacity to look into the soul and meet another person on this person's premise. I could also contact him whenever I wanted. This caused me to restrict myself, but I still experienced the feeling of security.

Respect, security, time, understanding and a feeling of dignity are demonstrated to be central factors in recovery stories. A new feeling of dignity and self-respect was often linked to being alive and not considering suicide any more. The meaning of respect and dignity is further underlined by looking at the devastating effects of coercion, as exemplified in the following extract:

Man, aged 50:

Mortification 1980. I was empty physically and mentally and was in an economic crisis. I was locked up together with criminals and seriously ill persons. No one cared about my concerns. Under such mistreatment one is injured for the rest of one's life.

Getting through crisis and achieving a new orientation

The third category illustrates experiences which led to the regaining of former roles or exceeding former roles. Informants describe the experiences as 'turning negative experiences to something positive', 'a richer life', 'a new freedom', 'ability to trust in people', 'a feeling of not being alone with the burden of shame' and 'a sense of meaning'.

 Good relations and confident dialogues are the central ingredients in the processes described. Often there had been talk therapy over years, body oriented therapies, working through traumas and

different art therapies. The category is illustrated by two stories. In the last one a special moment is described as significant for the recovery process.

Woman, aged 63:

I was an in-patient because of anxiety and was filled up with medicines. I believed it when the doctor looked at me and said: "I think and I know that you will manage this". Then he took away all the medicines. After half a year in hell I was free. A new life started. I engaged in the user organisation and established a journal together with another person. I paint, write poems, use a PC and now I am waiting for my first collection of poetry to be published.

Man, aged 37:

I was in a locked acute ward for psychosis. I felt a need of contact and asked some nurses to hold my hands. For 1-2 days some people continuously held my hands until I was out of the psychosis. I felt like I then got a new start, based on more presence and authenticity than earlier. I have tried to develop more openness and authenticity before this, but never felt as naked and helpless as this time. I was so dependent on the nurses to experience relief I think I also was in my parent's hands like a child. Therefore I experienced a new start. All defence and attempts at being the cleverest person was pulled away. I had a long way to go after this, but now, after five years I am free of symptoms and ready for a full time job.

Discussion

An underlying assumption in the study is that truth – or contextual understanding – is constituted through dialogue (Kvale 1996). We all contribute to the social construction of reality through narratives and language in general (Mattingly & Garro 2000, Drevdahl 2002). Seen from this perspective, users' accounts are strongly valid when we are seeking to understand factors that support recovery.

The analysis of clients' narratives in this study confirms earlier findings that the satisfaction of universal human needs (material and emotional) is essential in order to recover (Davidson & Strauss 1992). Further the study illustrates that recovery takes place in several dimensions; from being able to function in spite of a disability, rediscovering oneself and to experience new qualities in life; and

meaning and growth beyond the traumas of mental illness (Anthony 1993, Davidson et al. 2005, Onken et al. 2007). For most users the journey of recovery was a gradual process, but some of them also mentioned significant turning points. This finding corresponds with findings in other studies (Song 2009). Good relationships are fundamental conditions for recovery to take place, and include the feeling of support, acceptance, respect, love, trust, talks, honesty, safety, reciprocity and understanding. Also this finding is confirmed in recent studies (Schön et al. 2009) where the authors state that "Recovery from mental illness is a social process in which the helping factors have to do with the quality of social relationships" (Schön et al. p. 346).

The core factor in the experience of recovery itself still seems to be the ability to regain a feeling of dignity. This was made explicit in several stories and implicit in others. Also, a link between the courage to live and having regained a feeling of dignity was made explicit in several stories. Such experiences clearly point to an existential dimension in recovery processes. Philosophically, an existential dimension means that human beings are free and make choices which also imply responsibility. Approaching human beings from this perspective, implies a focus on freedom, dignity and meaning and acknowledgement of the importance of individuality as well as relationships, environment and ideology (Hummelvoll & Granerud 2009). Eckhoff (2008) exemplifies an existential approach by proposing that resistance in the shape of mental illness, can trigger the long-lasting spiritual work that may be necessary for us to grow. If people who are troubled by mental illness are supported, understood and respected, then creative power and existential understanding, (i.e. a sense of meaning) may be realised. People walk along different paths and the acceptance of several dimensions in the recovery concept implies that different life paths are honoured.

The feeling of dignity as a main force in recovery processes overlaps with the right and ability to define one's own experiences and externalise negative dominant discourses – described by Onken et al. (2007) as the primary mechanism in recovery. The other key factors, such as trust, equality, identity, good relationships, authentic dialogues, meaning, coherence, hope, fellowship, insight, respect, freedom, responsibility and opportunities for realising one's potentials are all related to and contribute to human dignity, and illustrate that change processes in the field of mental health care can best be understood in humanistic and existential terms and contexts, that is, existentialism is seen as

humanism (Hummelvoll & Granerud 2009, Hummelvoll & de Silva 1994) In this tradition Yalom (1980) in his therapeutic practice, has focus on the importance of confronting oneself with existential challenges. Such challenges can be isolation, loss and death, experienced lack of meaning, and how to manage the freedom of choice and develop as a dynamic and authentic human being in a world of fragmentation. By contrast, treatment approaches involving coercion often affects both physical health and mental well-being and hinders the recovery process (Höyer 2000, Glass & Arnkoff 2000, Onken et.al 2007).

As recovery research brings forth more distinct conclusions, it also gains increased credibility and force. However, gaining credibility is not only about comprehensive documentation, but also about having the power to define the *relevant criteria* by which successful models and practices can be judged. In medicine and science the existential-humanistic dimensions such as meaning, hope or anxiety are often made invisible or deprived of internal significance in professional contexts (Wackerhausen 2002, p. 42) and may be seen as "a nice but not necessary humanistic phenomenon" (Borg & Kristiansen 2004, p. 502).

A recovery-oriented practice based on users' interests requires a humanistic oriented, communicative rationality as an underpinning philosophy. Meaning is created in dialogue and good communication depends on mutual trust which will be counteracted by manualised therapies and conversation techniques. Standardised and de-contextualised procedures reduce the complexity in the client's life world and are not compatible with user collaboration (Ekeland 1999, Ekeland 2007). The recovery approach also challenges the biomedical view of mental illness and treatment on a more fundamental level, and cannot be fully realized without a paradigmatic shift in rationality and professional views, where the idiographic data and the patient as person should form the basis for mental health care. According to Barker & Stevenson (1998) "It is proposed that nurses' primary attitude should be one of addressing people as human beings first, and patients with problems second" (p. 13), and further "Nurses needs to acknowledge that the phenomena dealt with by nurses are human responses to various life problems. Nurses do not deal with now, and have never dealt with, mental illness *per se*" (Barker & Stevenson 1998, p. 5).

Conclusion

The study has illustrated the impact and importance of good relationships – including an existential focus and the promotion of dignity or ability to define one's own experiences in order to recover. Distinguished turning points and processes of gradual change do not differ much in the ways they are experienced, but the different time aspects both illustrate the variety in recovery processes and the decisive impact of some significant moments and encounters.

The analysis of users' experiences in this study points to practices based on communicative, existential and humanistic approaches which will demand a paradigmatic shift in rationality and professional understanding. This shift is important because the humanistic approach is now under attack by the evidence-based movement. The idea in this latter kind of thinking is to develop treatment as technology as standard procedures for standard diagnostic diseases. As a consequence, the person as subject might be silenced. Hopefully the results from this study will support a person-centred approach to caring for people with mental health issues.

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