

First-person experiences of recovery in co-occurring mental health and substance use conditions

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Abstract

Purpose: The purpose of this paper is to explore and describe experiences of recovery among people with co-occurring mental health and substance use conditions (co-occurring conditions) in a rural community in Norway.

Design/methodology/approach: In-depth individual interviews with eight persons with co-occurring conditions were conducted, audiotaped, transcribed and analysed using a phenomenological approach. This study is part of a research project investigating recovery orientation of services in a Norwegian district.

Findings: The analysis yielded four dimensions of recovery: feeling useful and accepted; coming to love oneself; mastering life; and emerging as a person. Insecure and inadequate housing and limited solutions to financial problems were described as major obstacles to recovery.

Research limitations/implications: Further research into the facilitation of recovery as defined by persons with concurrent disorders is needed, particularly regarding the facilitation of community participation.

Practical implications: This study supports an increased focus on societal and community factors in promoting recovery for persons with co-occurring conditions, as well as service designs that allow for an integration of social services and health care, and for collaboration among services.

Social implications: The results suggest that the community can aid recovery by accepting persons with co-occurring conditions as fellow citizens and welcoming their contributions.

Originality/value: The paper provides an enhanced understanding of how persons with co-occurring conditions may experience recovery.

Keywords: Recovery, Dual diagnosis, First-person perspectives, Concurrent disorders

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Introduction

Substance use and mental health disorders show a high degree of co-occurrence (Landheim, Bakken, & Vaglum, 2006; Mueser et al., 2000). There is growing support for tailored and integrated treatment for co-occurring substance use and mental health conditions (co-occurring conditions) (Drake, Mueser, Brunette, & McHugo, 2004), but challenges to implementation remain. Recovery and recovery-oriented care have been suggested as organising principles for the integration of mental health and addiction services (Davidson & White, 2007).

Originating among persons with lived experience, an understanding of recovery as personal and social processes that go beyond symptom reduction has gained a foothold in clinical and research environments within the fields of mental health (Anthony, 1993; Mezzina et al., 2006; Slade, Adams, & O'Hagan, 2012) and substance use (Laudet, 2007; Neale et al., 2014). Recovery has been defined as *“a process of restoring a meaningful sense of belonging to one’s community and a positive sense of identity apart from one’s condition while rebuilding a life despite or within the limitations imposed by that condition”* (Davidson et al., 2007). Akin to such approaches as person-centred theory (McCormack & McCance, 2006), positive psychology (Slade, 2010) and emancipatory theory (Freire, 1970), this perspective adds to the traditional psychiatric understanding of recovery as clinical outcome. Systematising service user experiences through research validates a broader definition of recovery (Veseth, Binder, Borg, & Davidson, 2012), challenges dominant discourses (Neale et al., 2015) and allows for a deeper understanding of recovery processes among persons with co-occurring conditions (Hipolito, Carpenter-Song, & Whitley, 2011).

Underpinning this study is an understanding of recovery as a personal and social process. Viewing recovery as a personal process involves seeing the person as the central actor and decision-maker and paying attention to and respecting each person’s unique experiences. Seeing recovery as a social process involves recognising everyday life as the central arena for recovery (Borg & Davidson, 2008), while acknowledging contextual factors (Topor, Borg, Di Girolamo, & Davidson, 2011) and underlying social-psychological dynamics (Best et al., 2016).

Much of the recovery literature focuses on mental health and substance use problems separately, which is reflected in parallel visions of recovery in mental health services and drug and alcohol services (Roberts & Bell, 2013). A recent review of the limited literature on first-person experiences of recovery in concurrent disorders (Ness et al., 2014) found that a meaningful everyday life, a focus on strengths and future orientation, and re-establishing a social life and supportive relationships were experienced as facilitators of recovery. A lack of tailored help, complex systems and uncoordinated services were experienced as barriers to recovery. A report of first-person experiences with recovery-orientation of mental health and addiction services in a Norwegian city (Biong & Soggiu, 2015) indicates that recovery is related to collaboration with health care professionals about goals that are important to the

person, mainly concerning living conditions and everyday life. Living with co-occurring conditions may be both similar to and different from living with mental health problems or substance use problems. There is a need for accounts of first-person experiences of recovery in co-occurring conditions from varied contexts (Ness et al., 2014; Slade et al., 2012).

The aim of this paper is to explore and describe recovery as experienced by persons who live with co-occurring substance use and mental health conditions in a Norwegian local community.

Methods

Context

This study is part of a research project that investigates recovery orientation of services in a local authority area in Eastern Norway. Norwegian health care is organised into primary, secondary, and tertiary care. Primary care is run by local authorities, whereas hospital trusts are responsible for secondary and tertiary care. The results presented in this study will inform developments in the practices of local mental health and addiction services. The community consists of agricultural areas, forested areas, and two community centres (<6500 inhabitants).

Similar to the account in Sælør et al. (Sælør, Ness, & Semb, 2015), a group of six persons from the community has advised the authors throughout the process. They are two persons with lived experience of co-occurring conditions, one family member of a person with co-occurring conditions, and three health care professionals. The group has participated in developing the interview guide, inclusion criteria and recruitment strategy. They have been consulted in the data analysis as an arena for validation and for understanding the results in relation to the local context.

Recruitment

A sampling strategy that aimed for diversity in age, gender, duration of contact with services, substance use and mental health problems was applied. Flyers were handed out by the staff members of the local mental health and addictions team to all service users they met with for a period of two weeks. Flyers were also distributed at a peer support house, in the local narcotics anonymous group and at a low-threshold meeting place that provides harm-reduction health services for persons with substance use problems in the nearest town. Participants were able to refer themselves by contacting the first author by e-mail or SMS, or by agreeing that staff members forward their telephone number to study personnel.

Participants

The participants were four women and four men ranging from their early twenties to their seventies. All were in contact with the community health and social services at the time of the interview. They acknowledged that substance use and mental health problems seriously affected their everyday life, now or in the past. They reported having used or using the following substances (number of participants reporting this as their *main substance* in parenthesis): alcohol (3), amphetamines (2), benzodiazepines (2), opioids (1) and cannabis. Most participants reported having used several substances. Four persons reported not using substances at the moment, one was in maintenance treatment, and three persons were currently using substances at the time of the interview. The participants reported experiencing or having experienced affective disorder, anxiety, post-traumatic disorder, psychotic illness, and hyperactivity disorder. This information is based on the participants' understanding of their mental health condition and not on an objective diagnosis. Five participants received disability benefits, one received social welfare, one was a student, and one was a job-seeker. Five participants lived in rented flats, two persons owned their own home, and one person

had no fixed abode at the time of the interview. Four participants were single and four were in a relationship.

Data collection

Eight semi-structured, in-depth individual interviews (Kvale & Brinkmann, 2009) were carried out by the first author. Concrete and detailed descriptions of subjective experiences with recovery were sought. An interview guide consisting of open-ended questions about what recovery means and what might lead to recovery was developed in collaboration with the advisory group. Participants were asked to describe their own personal experiences of recovery. Follow-up questions were asked, such as: “What was that like for you?”, and “How did that feel?” Interviews lasted from 45 to 80 minutes.

Analysis

Interviews were audiotaped and transcribed verbatim by the first author. Data analysis was guided by systematic text condensation (Malterud, 2012) within a phenomenological approach (Giorgi, 2009). Selective bracketing of the researcher’s pre-understanding was sought in the analysis process. Initially, all transcripts were read as a whole in order to gain an overall impression, resulting in preliminary themes. Secondly, the transcripts were systematically reviewed line by line, identifying, classifying, and sorting meaning units into code groups. Thirdly, meaning units within each code group were sorted into subgroups. At this point, the advisory group was consulted, leading to an enhanced understanding of the material. At the fourth step, all meaning units within each subgroup were reduced into an artificial quotation (a condensate) maintaining, as far as possible, the original terminology used by the participants, and an authentic illustrative quotation was identified for each subgroup. Finally, analytic texts were developed, synthesising the contents of the condensates and developing descriptions. The analytic texts were validated by returning to the full transcripts and asking whether our synthesis still reflected the original context. The results section consists of analytic texts with supporting quotes from the participants in italics. The N-VIVO-10 software was used in the analysis.

Ethical considerations

The study was approved by the Norwegian Social Science Data Service (Case No. 42244). Informed consent was a requirement for participation. Debriefing was integrated in the interview situation. Participants were offered the opportunity to get in touch with the first author after the interview. Details that could identify participants were removed before the material was shown to the advisory group. The members of the advisory group signed a declaration of confidentiality.

Results

Participants described personal and social recovery as (a) feeling useful and accepted, (b) coming to love oneself, (c) mastering life, and (d) emerging as a person. Gaining control over substance use, coping with mental health problems, and unravelling painful life events were described as pathways to recovery. Insecure and inadequate housing and a lack of solutions to financial problems were described as major obstacles to recovery.

Feeling useful and accepted

Recovery was described as feeling useful and accepted. Experiences of contributing in the community and meaning something to others were associated with feeling valuable, light at heart, joyful, having a sense of goodness towards oneself and others, not having to deal with one's own difficulties, and feeling that one is not the only person with problems. Several participants suggested that they had something to offer, but felt that the community did not need, or want, their contribution. Some participants expressed an understanding of employers' reluctance towards hiring them, because of their unstable life situation and the fact that they had substance use and mental health problems. Participating in facilitated activities was appreciated, but described as different from contributing in a genuine way.

"I hope that one day the council will get to the point where I'll be allowed to join in and be of help somewhere. Because I mean we're not useless just because we have disabilities."

"You feel light at heart. Feel much more like doing other things as well. Almost no stomach problems. You feel a kind of goodness, in a way. Yes, you do. Satisfaction. So that... that was a good, pleasant time."

"The course I'm going to, well, it's for teaching you about coping in everyday life. So the goal is to get up in the morning and start coping. That's all very well, but it's a bit pointless, because I'd like to contribute and make some money. So it's kind of pleasant enough, but I want something more (out of life)."

Experiences of being accepted in the community were described as valuable, whereas being met with a lack of acceptance was described as hurtful. One woman had left a café in tears when others had visibly made a point of leaving the table when she sat down there. Several participants said that it was difficult to feel accepted when one used substances. Others reported that people in the community were nice to them. One person noted the important difference between being tolerated in the community as a substance user, and being accepted in the community on the same terms as everyone else. He had found charitable kindness to be convenient when he was using substances, but later wondered whether it had kept him from moving on. Experiences of social participation on society's premises were described as motivating milestones in feeling useful and accepted. Acceptance was described as unexpected and undeserved by some participants.

“Now I’ve started going to the café. I think that’s helped me a lot. You get the thoughts out of your head because you’re talking to other people. And it’s so nice there. (...) So when I leave on Friday, they say: “You’re coming back on Monday, aren’t you?” I think that’s nice. (...) It makes a big difference. Yes, it really does. Apart from them, I haven’t got anyone, you know.”

“... and then it’s really embarrassing that they like us so much, you know. People really trust us here, in the supermarket and so on. If I haven’t got enough money, they still let me have the groceries. And now at Christmas time I went to the supermarket, and they gave me flowers for Christmas too. It’s quite incredible that they’re so nice to me there.”

Coming to love oneself

Recovery was described as a feeling of self-respect and coming to love oneself, related to persisting through hard times. This feeling was the result of one’s own insights and struggle.

“I’ve come to love myself, that’s what I really value most of all. The fact that I’ve been in this pain for all these years and got through it and learned to value myself. So that I’ve got back my self-respect. It hasn’t been put there, nobody’s given it to me, I’ve fought for it myself.”

Spiritual experiences such as religious faith, experiences of nature, and spiritual growth were highlighted by several participants. Being part of something larger than oneself was described as offering a feeling of dignity. Faith was described as feeling hope and consolation. Several participants described a special tranquillity related to spiritual experiences, particularly concerning feelings of gratitude. One participant described having a sixth sense he thought of as a gift and an important part of life, but it was kept hidden from health care professionals for fear that it would be perceived as a symptom of severe mental illness.

“I’ve got another perspective, and that’s the spiritual perspective in life. Not the way it’s always been. It’s always been empty, you know. Understanding that maybe I’m part of a bigger context, and that being human is a much bigger thing than what I’ve thought... (...) It’s about getting in touch with this big thing on the inside, you know... (...) ...getting a spiritual dimension in life too. Or else it all becomes so meaningless.”

Mastering life

Recovery was described as mastering life. The value of actually practising and gaining experiences of mastering everyday life was highlighted by several participants. Having support from others was described as important, and peer support was mentioned as particularly helpful. One person described how he had learned to master life by exposing himself repeatedly to everyday life situations, like going to the supermarket. Having a close friend to talk to during that period had been crucial to analysing situations and his own reactions to them. The experience of mastering one’s life was associated with confidence, joy, pride, and motivation to face future challenges.

“Well, kind of, how can I put it, the more you learn to cope, the better you feel about yourself, in a way. (...) Learning how to master things, achieve things, trust yourself. Because your confidence can be really low. So... Well, you know, less confidence and maybe more alcohol. And more alcohol, maybe less confidence. So those things are really connected.”

“Like getting my driving licence, for example. And knowing what a brake pad is on a car. So I kind of had so little knowledge and insight in all those things. Like that, you see. For example, when I got my licence, it was a great sense of mastery. It’s been important always having those goals that make me more like other people. (...) Because all the time I was taking drugs, and before too, I felt like I had so little in common with other people. When people were talking about something, I didn’t have any experience about the subject.”

Being able to pay one’s debts was described as crucial in a recovery process, related to atonement, putting the past behind, and then moving forward. Financial difficulties were described as a barrier to mastering life, linked to feelings of hopelessness and despair, especially when solutions seemed unavailable. Difficulties with concentration and attention after a period of substance use were described as complicating the process of gaining an overview of one’s finances.

“What’s bothering me most right now is the money problem. (...) The thing is, my head isn’t really working yet. So when I sit down with a huge pile of bills, and I have to sort them out, I just switch off pretty soon, because it’s too much. So it’s hopeless. When I think I’ve done all of them, another seven sort of appear. It actually bothers me quite a lot.”

“I can walk tall a bit more now. That feels good. (...) Like before, I was never late for things, I paid my bills, did what I was supposed to... It feels really good to start getting back to that – and that others can see it.”

A good place to live was described as a house in an ordinary neighbourhood. Being able to keep one’s home cosy and clean was described as a sign of mastering life, related to feeling decent and normal. Inadequate housing was described as an obstacle to mastering life. Some participants reported feeling unsafe and constantly on the alert in their home. They described experiences of having people entering the house with a weapon at night, having a hammer thrown through the window, and having the flower pots they had just put in front of their house broken on purpose. Some did not dare to leave their home for more than a few hours. One person was constantly afraid that family heirlooms with sentimental value would be destroyed or stolen. Others stored valuables with friends or family. Visits from children or grandchildren were described as impossible by some participants due to the state of their home. Several participants had experienced neighbours offering drugs at their door shortly after they had been discharged from inpatient addiction treatment, which had made it difficult to maintain abstinence. Others had noticed that neighbours hid drugs on their property, which

made them nervous that the police would think they were involved. Some of the participants wanted to move, but did not think it was possible.

“I hope (...) that I can live safely again. So I can start living again, not just stay at home, feeling terrified. If I hear footsteps in the street outside, I’ll wake up. If I hear crunching on the gravel by my post box, I’m wide awake. And you’re not supposed to live like that.”

Emerging as a person

Recovery was described as emerging as a person. Acting in line with attributes that one values, improving cognitive abilities and health, or rediscovering skills, were described as part of emerging as a person. Participants described this phenomenon as involving experiences of appreciating oneself, relaxing one’s shoulders, daring to come forward, and having peace with one’s conscience. Several participants used the expression “becoming myself again”, describing how skills, attributes and abilities had been lost in the course of alcohol or drug use and mental health problems, and then regained, to the pleasant surprise of themselves and others. Understanding mental health problems in terms of a psychiatric diagnosis was described as part of emerging as a person by some participants. Others described that having a psychiatric diagnosis felt irrelevant or that it felt like being put in a pigeonhole.

“Recovery is... your health improves, you feel better inside, you feel good about yourself, especially. And you see things are going better with people around you, especially the closest ones. And that builds up your confidence, you can manage to join in things, you’re not afraid you’ve got to get drunk before you can do something. Your self-esteem is better. (...) And then there’s sort of a bit more point to your life. You can go on trips that you’d never have gone on otherwise, go to concerts sober... a lot of things. And it makes you feel better about yourself.”

“I wonder how they could give me that diagnosis. But you know I was just so dysfunctional at the time. So introvert, and kind of emotionally closed up. And on top of that I was terribly paranoid about everything. (...) It’s not true anymore, so it doesn’t bother me now. I really don’t mind.”

Gaining a distance from alcohol and drug use was described as a pathway to emerging as a person by several participants. Some described abstinence as a foundation for work, education, artistic creation, family life, and improvement of mental health. An explicit distinction was made between substance use problems and addiction. Living with addiction was described as all-consuming and associated with low self-esteem. Several participants said that they had needed someone else to make them aware of the seriousness of their situation, while at the same time emphasising that they themselves were responsible for their actions and their life. A strong sense of regret was described, particularly related to not being able to care for one’s children. Addiction treatment, such as adequate detoxification, peer support, increased knowledge and awareness of addiction, and maintenance treatment were all

described as useful in emerging as a person. Some participants suggested that gaining a distance from drug or alcohol use made them feel like a different person from the one they were before. Some described that mental health problems were easier to live with without substances. Others described using alcohol or drugs in order to manage symptoms of mental health problems in daily life.

“You feel really lonely and alone, like an alien. A bit strange, you know. You take drugs, and... (...) I thought there was something wrong with me, and everybody else thought so too.”

“My whole life was just shame and guilt and I just got drunk and... I wasn't very conscious then of why it was all happening, you know. I just blamed everybody else.”

“Distancing yourself from alcohol makes you feel more confident about yourself. You relax more. You kind of dare to come forward, and you gradually become yourself again. You feel it's easier to get things done, you don't push them away. And then you need to make your grey cells start working again.”

For some participants, painful experiences in childhood had limited the possibilities of a good life. One woman described how her schooldays had been ruined by domestic violence and bullying, so that she eventually could not handle going up to the blackboard or doing exams. Some described how unravelling painful life experiences in psychotherapy had enabled them to emerge as a person. Several participants reported wanting to talk to a therapist about past experiences, but their referral to therapy in the public health care system had been rejected.

“(My anxiety) holds me back a bit, but I've become good at dealing with it. Now I go to the supermarket and I do what I have to and I can get things done. So a lot has changed completely. But it's a matter of finding out about the main reason and dealing with it... What happened to me when I was at school affected me really deeply. Because I've put up a wall between me and other people.”

Valuing lived experience was mentioned as important in emerging as a person. One participant reported that he valued the insights he had acquired by “walking the road of life,” even though they came from difficult experiences. Several participants had experienced a special kind of support from peers, relating this to the insight these persons had acquired through their own lived experiences.

“Once you've kind of fallen flat on your face and then got back on your feet again, I think you're really, really careful not to slide back again. Because (...) once bitten, twice shy, you know. (...) That's why I think it's important that people who've been down that road are there when people fall down. Because we know how bloody awful it is, we know what you think, we know how people think.”

Discussion

In spite of living with substantial current or past mental health and substance use problems, participants had experienced positive changes in their lives. This is in line with follow-up studies of persons with co-occurring conditions that indicate a hopeful long-term perspective when recovery is viewed as defined by clients (Drake et al., 2006). Control over substance use and over symptoms of mental illness was described as pathways to recovery, but not its essence. This concurs with previous accounts of recovery in co-occurring conditions (Davidson et al., 2008), mental health (Borg & Davidson, 2008; Topor et al., 2011) and substance use problems (Laudet, 2007; Neale et al., 2015). Experiences of coming to love oneself and emerging as a person are consistent with recovery as a personal process, whereas feeling useful and accepted and mastering life resonate with recovery as a social process.

A main finding in this study is the importance of contributing to and being accepted by the community on equal terms; this has also been pointed out by others (Bellamy, Rowe, Benedict, & Davidson, 2012; Perkins & Repper, 2014). We suggest that facilitating genuine community participation might be a missing piece in the promotion of recovery for persons with co-occurring conditions. Services acting as a link into the community may facilitate genuine participation. Also, informing a more nuanced and hopeful public opinion of people with co-occurring conditions may lead to communities being more open to accepting their contribution. Best and colleagues (Best et al., 2016) and Best (Best, 2016) discuss how accessing new social identities and a pro-social community role may act as mechanisms in recovery from substance use. Carpenter-Song and colleagues (Carpenter-Song, Hipolito, & Whitley, 2012) describe how recovery oriented, supported independent housing for people with co-occurring conditions, “recovery communities”, contribute to recovery from the perspective of residents. Residents highlight the social environment of neighbours, which provides a sense of belonging, recovery support and a way out of loneliness.

Experiences of recovery in this study resemble components of well-being and flourishing within positive psychology (Diener, Lucas, Schimmack, & Helliwell, 2009; Keyes, 2002). This supports the assumption that health and well-being are the same - and just as diverse - for persons who live with concurrent disorders as for everybody else (Slade, 2010). What seems to differ in this study is the importance of improving aspects of an adverse life situation, such as unsolvable financial problems, unsafe living conditions, or a lack of access to working life.

Participants described adverse living conditions that are rare in contemporary Norwegian society. Living with co-occurring conditions is associated with having poorer life circumstances than the general population in Norway (Dyb & Johannessen, 2013; Langeland, Dokken, & Barstad, 2016). Within social psychology, the fundamental attribution error (Ross, 1977) indicates the tendency of attributing others' behaviour to stable personality traits rather than to situational forces. Maybe health care professionals attribute the adverse living conditions of persons with co-occurring conditions to stable traits such as weakness, ignoring

situational factors. The tendency of health care systems to provide separate, unchallenging activities for persons with co-occurring conditions may be an example of this.

Being excessively perceived as weak and helpless seems to be a potential barrier to recovery for persons with co-occurring conditions. In a study that explored experiences of identity and belonging among people with severe mental health problems in rural communities in Norway (Ekeland & Bergem, 2006), participants who accepted their role as a “mental health patient” found it easier to establish an identity and be part of a community than those who did not accept this role. While the former were integrated as part of a marginalised group, the latter felt marginalised as individuals. This resonates with accounts in the current study of the difference between being accepted as a substance user, and being accepted as an equal citizen. Having visible substance use problems seemed to elicit rejection, but also charity and kindness, which was highly appreciated by some participants. Others wondered if this had defined their identity as a substance user in the past. We suggest that kindness in itself is not the problem, so long as it is combined with recognition of resources and contributions.

Results from this study challenge the belief that co-occurring conditions need to be associated with having a difficult, hopeless life. This does not mean that co-occurring conditions are easy to live with, but rather that it is possible to live well. In a study of first-person experiences of hope in relation to dual recovery (Sælør et al., 2015), participants reported that being met with positive expectations from others influenced how they perceived their future. A Swedish study found that persons with mental illness who received a moderate amount of money each month in addition to treatment showed a significant improvement in symptoms, social networks and sense of self, as compared to a “treatment only” control group (Ljungqvist, Topor, Forssell, Svensson, & Davidson, 2015). ‘Recovery-nurturing environments’ (Glover, 2005) have been suggested as a description of how contextual factors facilitate recovery. Results from the present study suggest that recovery-nurturing environments should provide opportunities to solve adverse life circumstances, while at the same time recognising the person’s potential.

Recovery was described as an experience of emerging as a person. Unravelling traumatic events, discovering skills and positive attributes in oneself, and learning from experience all seemed to contribute to this process. Our findings resonate with former accounts of recovery in co-occurring conditions as a process of acknowledgement, present orientation and transformation and growth (Hipolito et al., 2011), and of understanding, accepting and redefining self (Davidson et al., 2008). The concept of ‘possible selves’ (Markus & Nurius, 1986) indicates how individuals’ ideas of what they might become, what they would like to become, and what they are afraid of becoming, function as incentives for behaviour.

In the present study, recovery seemed to differ depending on whether or not the person had a positive identity to return to. The difference between ‘emerging as a genuine person’ and ‘becoming my old self again’ seems to illustrate an important nuance in dual recovery. The latter seems to point to regaining lost virtues, *in spite of* life experience, whereas the former means coming forward as a person in a new way, *building on* life experience.

Spiritual experiences provided meaning, consolation, dignity, and connectedness for participants in this study. This is in line with a study that explored recovery among African-American women with co-occurring conditions (Hipolito et al., 2011), where spirituality was found to cross-cut all other dimensions of recovery. In the present study, spiritual experiences were kept secret for fear of negative judgment from others, and participants expressed a wish to talk more freely about these experiences without being judged. These findings suggest that health care professionals should be non-judgmental of spiritual experiences.

Abstinence from substance use was experienced as crucial in recovery by some persons. In recent studies, abstinence from substance use has been associated with increased quality of life (Vederhus, Birkeland, & Clausen, 2016) and flourishing (McGaffin, Deane, Kelly, & Ciarrochi, 2015). Others described how they used substances as a way of managing everyday life, which is in line with a study of self-reported reasons for substance use in persons with severe mental illness (Pettersen, Ruud, Ravndal, & Landheim, 2013). The results suggest that substance use should be addressed and that individualised treatment should be available.

Limitations and strengths

The influence from recovery theory is demonstrated in valuing first-person experiences and exploring recovery beyond symptom reduction. Asking about experiences of recovery will have generated other descriptions than inquiring about experiences of suffering. Descriptions have been developed bottom-up from lived experience.

A strength of this study is the diversity among participants regarding age, gender, and life situation. We argue that a low threshold recruitment strategy leads to a rich collection of descriptions, including voices that would otherwise not be heard. There is also an underlying emancipatory agenda of allowing people to speak their mind about issues of importance to them – particularly so since results from this study will inform developments in local practices.

Diagnostic interviews were not conducted, and the description of participants relied on self-report in reply to general questions about mental health, substance use, and life situation. This may be a limitation to the transferability of the results since the symptom load was not accessed. We believe that the descriptions by the participants are detailed enough to make judgments of relevance to other contexts, an important point being that all participants found that co-occurring conditions affected their everyday life to a large extent, either now or in the past.

The first author's background as a psychologist may have led to an influence of normative, psychological knowledge on the analysis. Selective bracketing of pre-understandings and explicit avoidance of diagnostic and theoretical terms was sought during analysis, although a complete bracketing is viewed as impossible. The advisory group offered an arena for

validation and reflexivity, by challenging professional terminology. Involving the advisory group in all steps of analysis and during interviews might have offered further possibilities to address this potential limitation (Ynnesdal Haugen et al., 2016).

Conclusion

This study provides an enhanced understanding of how people with co-occurring conditions may experience recovery. The findings support an increased focus on societal and community factors by health care practitioners, as well as service designs that allow for an integration of social services and health care, and a larger extent of collaboration and communication among services. Opportunities for genuine community participation and sustainable solutions to adverse life circumstances are needed, along with individualised substance use treatment, access to therapy, and recognition of existential-spiritual dimensions of life. The findings support an understanding of recovery as consisting of both personal and social processes. Further research into the facilitation of recovery for persons with co-occurring conditions is called for, particularly regarding the facilitation of genuine community participation.

Conflict of interest

On behalf of all authors, the corresponding author states that there is no conflict of interest.

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