The conditions of possibilities for recovery

A critical discourse analysis in a Danish psychiatric context

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Title page

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The conditions of possibilities for recovery: A critical discourse analysis in a Danish psychiatric context

- Few studies examine the possibilities for recovery of inpatients and outpatients in mental health centres from a nursing perspective.
- The findings show that how recovery is guided by a paternalistic power-structure, where biomedical and evidence-based knowledge is ranked highest as a basis for interpreting and resolving patients' problems.
- This knowledge-power perspective can be viewed as a dialectical relationship where certain forms of knowledge are integrated into standardised methods that become instructive to the potential conditions for recovery in a psychiatric context.

Abstract

Aims and objectives. This paper explores the conditions for the possibilities of recovery in a Danish mental healthcare practice, expressed from the perspective of nurses. The results and discussion of the study help to make visible and explore the muddle of conceptualisations of recovery in mental healthcare practice.

Background. Few studies examine the possibilities of recovery for inpatients and outpatients in mental health centres from a nursing perspective.

Design. A qualitative design using a critical social-constructionist frame of understanding, in which the real world is considered as a series of social constructions.

Method. A Fairclough-inspired critical discourse analysis was chosen as the analytical strategy. The analysis is comprised of ten interviews in mental healthcare and notes, written by nurses, in

medical records of ten patients with a mental illness admitted to a mental healthcare centre in 2016-2017. The Consolidated Criteria for Reporting Qualitative Research checklist was used as a guideline to secure accurate and complete reporting of the study (See Supplementary File 1).

Results. From the findings of the textual analysis and the analysis of the discourse practice, it seems clear that the social relations and structures relating to recovery in Danish psychiatry are steered and controlled by discourses that reflect, in general terms, the essence of the core of neoliberal ideology.

Conclusion. Recovery is generally articulated from an overall discourse of neoliberalism with its embedded discourses of paternalism, biomedicine, self-care, and holism. All these discourses coexist in nursing practice, but the paternalistic discourse becomes the framework for the conditions for the possibility of how recovery is expressed in practice.

Relevance to clinical practice. Nurses need to be supported to seek clarity in the understanding and operationalisation of a recovery-oriented approach, if the agenda is to be truly adopted and strengthened.

Keywords: Clinical Decision- making, Mental Health Nursing, Patient Participation, Clinical-Research Approaches, Discourse Analysis.

Introduction

In several Western countries and regions such as the USA, Australia, the United Kingdom, and Scandinavia, recovery has become a buzzword (Bird, Leamy, Boutillier, Williams, & Slade, 2014; O'Keeffe et al., 2018) and in the literature, recovery is often seen as essential to ensuring quality of care and treatment in mental healthcare. (Joergensen & Praestegaard, 2018; Thórarinsdóttir & Kristjánsson, 2014; Vrangbæk & Christiansen, 2005)

Recovery can be said to be on different axes depending on whether it is seen as a result, a process, or as clinical, personal, individual, social, etc. (Borg, Karlsson, & Stenhammer, 2013; Karlsson & Borg, 2017), but, as a whole, it seems to be given one of two meanings; 'clinical recovery' and 'personal recovery'. 'Clinical recovery' has roots in clinical treatment with a focus on achieving remission and functional improvement. Clinical recovery is criticised for being paternalistic and biomedically anchored, and many people advocate for an alternative interpretation of recovery: 'personal recovery' (Davidson & Roe, 2007). 'Personal recovery' has roots in the user/consumer/survivor movements and organisations within the psychiatric field (Davidson & Roe, 2007; Slade, Amering, & Oades, 2008) and is defined as a deeply personal,

unique process that is about changing attitudes, values, feelings, goals, skills, and roles. It is a way to live a satisfying, hopeful, and contributive life, even with the limitations that result from the service user's disease or illness. From this approach, recovery has roots in discourses of democratic and social rights that emphasise maintaining the authority of service users and considering them as equal partners in decisions about their psychiatric treatment (Holen & Kamp, 2018; Karlsson & Borg, 2017). But recovery also involves the creation of new meaning and purposes in life as one overcomes the catastrophic consequences of mental illness (Anthony, 1993). Personal recovery, as distinct from clinical recovery, has come to dominate mental health policy. An orientation in mental health services towards supporting recovery is recommended internationally (World Health Organization, 2013), and central to national policy in many countries (Government, 2011; Mental Health Commission of Canada, 2012; National Mental Health Commission, 2017). The health professionals cannot directly create personal recovery, but they can adapt professional efforts in a recovery-oriented direction, thus, helping and supporting the user's recovery process (Karlsson & Borg, 2017; Madsen, 2018; Shanks et al., 2013). Although it is acknowledged that mental health professionals in a mental health centre setting should work in accordance with the principles of recovery-oriented practice, there is little research into what opportunities there are for fostering recovery-oriented practices into mental health settings (Giusti et al., 2019). Also, there is scarce scientific knowledge of how personal recovery is articulated in a psychiatric context. (Joergensen & Praestegaard, 2018; Oute, Huniche, Nielsen, & Petersen, 2015)

The social science sector within social work shows that mental difficulties often reduce the quality of service users' living environment and conditions. Users often express that they do not feel appreciated. They feel stigmatized, poor, lonely, homeless etc. (Deegan, 2002; Giusti et al., 2019; Topor, 2004). In the existent research on social support in a social psychiatry context, there seems to be a correlation between lacking social support and aggravated mental and social difficulties. Social support often aims to promote social relations, friendships, love, hope, personal finance and connectedness (Borg et al., 2013; Coleman, Frank, et. al., 2004; Karlsson & Borg, 2017; Topor & Ljungqvist, 2017).

Recovery takes place in interaction with others, and the individual's living conditions have been shown to play a significant role. Having a decent home can be an important base in the same way as having access to places of socialisation (Borg et al., 2005).

Despite that, recovery is a relatively unclear, theoretical, and methodological concept. Throughout treatment, social psychiatry, and the field of medicine, there are widely differing understandings of what constitutes recovery-oriented practices. Some recovery-oriented efforts

emphasize recovery as an evidence-based clinical effort (Jørgensen, 2019a; Madsen, 2018), while others build on the original psychosocial perspective, which emphasizes psychiatric users' own perspectives and desires for a meaningful and satisfying life (Borg et al., 2013; Karlsson & Borg, 2017). That there is no common understanding about what it means to be recovery-oriented is supported by a number of recent Danish and international studies of clinicians', users', and families' views on recovery and involvement, which indicate that the interpretation of these concepts is fluid and context-dependent (Hansen, 2016; Jørgensen, 2019a)..

In mental healthcare there is scarce research into how professionals work is recovery-oriented and how recovery is constructed in a mental health context. (K. Jørgensen & Rendtorff, 2017b).

Because the mental health context is embedded in governmental structures, recovery is, as a concept, governed by governmentality structures that apply in an institutional context where efficiency, objective outcomes, and rational management tools shape the professional's ability to articulate recovery (Oute et al., 2015; Rose, 2019).

Because an articulation about a subject does not come without history and power relations, we choose to follow Foucault's conception of power relations to shed light on our area of research into articulation on mental healthcare. Foucault does not approach power relations as inherently negative or destructive, but rather as a force that is grounded in every social relation. He sees power relations as a refined technique in disciplining humans as individuals by making sure they are mutually manipulable and controlled (Foucault, 2000; 2003, 2005).

Early in his career, Foucault focused on the archaeological revealing of the rules for which expressions, 'regimes of knowledge', that are socially accepted as meaningful, or unacceptable and unspeakable, within a specific historic era (Phillips & Jørgensen, 2002).

Through his genealogical work, Foucault understands power relations as positive conditions of possibilities for making and producing social practices. A condition for possibility is a necessary framework for entities to possibly appear, and it is often used in contrast to the unilateral causality concept. It is not free to us how we speak about social conditions. Time and context are just some examples of conditions of possibility that determine how we can talk about social conditions (Foucault, 2000; 2003, 2005). Foucault believes that power is the positive condition of the possibility for social life, which means that power becomes productive and limits what is allowed and possible within a social context (Prasad & Foucault, 1982). Power and knowledge mutually presuppose each other (Prasad & Foucault, 1982) and, thus, create the framework for the conditions of possibility for how we can talk about recovery, creating a discourse (Fairclough, 2008a, 1992a), which is assumed to have implications for how a person with a

mental disorder can be met, cared for, and treated from his experience of psychological problems (Barker & Buchanan-Barker, 2015).

The language is believed to be crucial to how nurses understand and act in a psychiatric context (Hansen & Bjerge, 2017; Joergensen & Praestegaard, 2017; Oute, Huniche, Nielsen, & Petersen, 2015). More knowledge is needed on how recovery is constructed in mental healthcare practice because our ways of discussing topics are influenced by different forms for knowledge, which create power relations that determine how one speaks and how something becomes possible or impossible (Foucault, 2003). From this perspective, it becomes relevant to explore the conditions for the possibility of recovery in Danish mental healthcare practice, especially given the wide variety of challenges that follow from different mental illnesses.

Therefore, this study aims to explore how recovery is constructed and which conditions for the possibilities of recovery in a Danish mental healthcare practice are expressed from the perspective of nurses.

Methodological approach

This study inserts itself into the tradition of critical social-constructivism and critical discourse analysis as starting points for reflection on the research's epistemological insights (Hansen, 2013). Social-constructivism is a framework of understanding in which the real world is to be understood through a series of social, political, economic, and historical constructions in which language and the way we talk about the world and objects are based on the social world (Fairclough, 1992b, 2008b,; Fuglsang, Bitsch Olsen, & Rasborg, 2013; Jorgensen & Phillips, 2002).

We explore our research in the light of Fairclough's discourse analysis. Fairclough is strongly inspired by Foucault, because Foucault provides an important understanding of the relation between discourse and power; the discursive construction of social subjects and knowledge; and the function of discourse in social change (Fairclough 1992 – Discourse and social change). Fairclough sees Foucault's focus as being on the conditions of possibilities of the discourse, and on the exploration of the conditions of possibilities of the articulations. Unlike Foucault, Fairclough has much greater emphasis on language use, creating a critical analysis on how sentences are constructed and wordings are used to form political engagement in social change. Fairclough describes discourse as a definite way of talking about and understanding (part of) the world in which language is seen as a form of social practice rather than an individual activity. Discourses constitute the social world and are constituted by the social world. The discourses help reproduce and change knowledge, identities, and social relationships, including power

relations (Fairclough, 1992a, 2008b). Fairclough's critical discourse analysis aims for emancipation by standing on the side of the oppressed. Fairclough aims to uncover and clarify the impact that discursive practices have on maintaining unequal power relations (Fairclough, 2008a, 1992a, 1992b, 1995a, 1995b) – power relations, e.g. relations between physicians, nurses and patients in a psychiatric ward.

Recovery in a mental healthcare nursing practice can be regarded as a set of social constructions, which are constituted by social practices where texts are constructed, received, and interpreted (Esmark, Lausten, & Andersen, 2005; Fairclough, 1992b). The Consolidated Criteria for Reporting Qualitative Research checklist was used as a guideline to secure accurate and complete reporting in this study (Tong, Sainsbury, & Craig, 2007) (See Supplementary File 1).

The empirical material

The empirical material consists of two different kinds of expressive texts; 1) interviews with nurses working in a psychiatric open in- and outpatient departments and 2) patient records from an open in- and outpatient mental healthcare centre in Denmark.

The interviews

Interview data were collected to situate the nurses' meanings and actions within larger social structures and discourses, of which they may be unaware. The intention was to uncover the assumptions upon which the nurses construct their meanings and actions.

The interviews were semi-structured and were conducted by the first author using open-ended questions and probing responses. Inspired by the existing knowledge in the field (Oute et al., 2015; Ringer & Holen, 2016), we formulated a list of themes to explore the conditions for the possibilities of recovery in a Danish mental healthcare practice, as expressed from the perspective of nurses. Based on the themes, we asked a few broad questions and focused on follow-up questions to obtain richness and depth (Table 1). The interview guide (Table 1) was discussed with the research team as well as with service users in a mental healthcare setting, alongside existing interview guides, and was tested in a pilot study (Kvale, 2008). The pilot study helped to formulate more specific individual questions, but the findings were not included in the analysis.

Please insert Table 1 here

The management at the mental healthcare centre were sent an email and ethical information and were asked to contact potential participants. When informants accepted to participate, they or the managers contacted the first author and found time to attend an interview. Before the interviews, the first author told the informants about the project and informed content.

Individual, in-depth patient interviews were conducted until thematic saturation was reached. Ten female nurses willingly accepted the invitation and were recruited; five from the inpatient and five from the outpatient department in a Danish mental healthcare centre (Table 2).

The nurses had a variety of experiences in a mental healthcare context, and all gave their informed consent to participate. Each interview lasted between 45-75 minutes. All interviews were audio-recorded and transcribed verbatim.

Please insert Table 2 here

Another way to express recovery in practice is in the patients' records. The patients' records provide insight into the language used for the care and treatment in practice, as opposed to interviews, where nurses are interviewed more specifically about recovery. We looked for how concepts related to personal, social, or clinical recovery were reflected in both oral and written language.

Accordingly, a request was sent to the management at the same mental healthcare centre, who passed the request on to several nurses. The nurses communicated with the service users, and the first author instructed them in writing and orally about the study, and they gave their informed consent. Ten patient records were collected from the mental healthcare centre; five from open inpatients and five from outpatients. The service users had been in treatment for at least one week, were over 18 years old, and had a wide variety of diagnoses (Table 3).

Please insert Table 3 here

Analytical strategy

To examine how discourses on recovery appear in Danish mental healthcare, we elaborated on the critical discourse analysis approach inspired by Fairclough (2008), which is rooted in a social constructivist direction about social life. This approach has previously been used to explore discourses in healthcare. (Aasen, Kvangarsnes, & Heggen, 2012; Joergensen & Praestegaard, 2018; Ravn, Frederiksen, & Beedholm, 2016)

Methodologically, according to Fairclough, the discourse is a complex concept that can be defined in many different ways, from several theoretical points of view. In linguistics, on which

Fairclough leans, the concept of discourse covers ways in which the language is used within different domains. It is through the use of language and our representations of the world that we are able to describe our experiences and interpretations of reality. The discourse is an important form of social practice that reproduces and transforms knowledge, identities, and social relationships, and at the same time, is shaped by other social practices and structures. Each of the communicative events, such as texts, reproduces or challenges the discourse order. Thereby, the discourse is closely associated with power. Power operates through the discourses by creating our social world and identities in certain ways. Power creates our world, through which it is productive, but by creating it in ways that exclude alternative forms of social organization, it is simultaneously limiting. Critical discourse analysis intends to identify how discursive practice plays a role in maintaining social practice and demonstrating and contributing to the equalization of unequal power relations and work for social change towards more equitable social relations (Fairclough, 2003, 2008b).

Fairclough established a three-dimensional framework that distinguishes text, discursive practice, and social practice as the three levels that can be separated analytically, but all three dimensions should be covered in any analysis of a communicative event. When covering all dimensions, the analysis should focus on (a) the linguistic features of the text (text analysis), (b) the processes related to the production and consumption of the text (discursive practice), and finally (c) the wider social practice (social practice) (Fairclough, 2003, 2008b).

In Fairclough's understanding, all three dimensions need to be covered because texts cannot be understood or analysed in isolation. They can only be understood through the meaning contained in other texts, and in relation to their social context. Discourses are dialectic (Fairclough, 2008a, 1995a, 1995b; Lassen & Strunck, 2011). Consequently, we analysed the texts using the above three-dimensional framework: as a text, as a discursive practice, and as a social practice.

Fairclough (1992) states that the analyst should consider various linguistic aspects of the text. Accordingly, we read each document several times to grasp how recovery is textually activated in mental healthcare. We analysed the texts both line by line and word by word. Initially, we focused on and discussed the *vocabulary*: which words and wordings are used to describe recovery until a concerted agreement is reached. Similarly, we focused on and discussed the main analytical questions that Fairclough outlines about *grammar, interactional control*, *transitivity,* and *modality*, see (Table 4).

Please insert Table 4 here

Ethical considerations

The study was designed according to the ethical principles from the Helsinki Declaration (World Medical Association & Wma.net, 2013) and Danish law (The Ministry of Health, 2014). The study was accepted by the Danish Data Protection Agency (j. no. 2015-41-4310).
All empirical material has been anonymised, treated confidentialy, and transcribed. All electronic and paper data will be retained for five years, and thereafter, will be destroyed.

Analytical findings

In this section, we present our findings based on the three-dimensional analysis. The three dimensions consist, as mentioned, of text analysis, discursive practice, and social practice. (Fairclough, 1995a, 2003, 2013; Joergensen & Praestegaard, 2018; Johnson, 2014).

The textual analysis

The vocabulary of the texts

Interviews with the nurses

The nurses refer to the following methods: 'psychoeducation', 'cognitive behavioural therapy', 'environmental therapy' and 'illness management recovery'. Keywords such as: 'recovery', 'recovery-oriented practice', 'recovery-support' and 'recovery-process', appear in their parlance, without direct definitions. It appears that the nurses generally subscribe to an understanding that patient participation is a part of recovery.
The wording 'recovery-oriented practice' is articulated as a collective term to describe recovery as a goal: *'We need to work in a recovery-oriented manner'; 'our manager of the ward has pointed out that we need to work in a recovery-oriented manner'. 'We learn it, and there is a good atmosphere in the ward to work on the recovery and participation of patients and relatives (IW 3)'*. It can be seen as a kind of professional culture to ensure the retention of a particular way of understanding clinical practice.
Some of the nurses articulate recovery as a kind of programme statement, as something the nurses should achieve: '*We require patients to make an effort; in the cognitive approach they need to work with themselves and be able to reflect (IW 10)'*.
The wording 'recovery support' is an umbrella term for a variety of methods used in psychiatric practices; e.g. 'cognitive behavioural therapy', 'psychoeducation' and 'environmental therapy'.

These therapeutic methods are considered to be a guarantee of a recovery-oriented focus. Psychoeducation is highlighted as a best-practice recovery-support method. The idea is that the more informed a service user is about his psychiatric diagnosis, the better the possibilities of recovery are: *'My experience is that the more the service user gets insight into his situation and acquires knowledge about his illness, the better he gets. In fact, the recovery is also about the patient becoming gradually more independent of us (IW 10)'.*

The 'recovery process' is said to be the service user's responsibility: '*We cannot recover the patient; the patient is in a recovery process where we can help and support them, but we cannot recover the patient; it must be done by the patient (IW 1)'.* This approach means that demands are made on the service user to manage their own recovery process.

However, some nurses emphasise that it can be difficult to leave all the responsibility to the service user because they consider some service users to be too vulnerable to take sole responsibility for themselves: *'It is also hard to involve a patient who is very psychotic or does not have the energy to deal with all sorts of questions (IW 3)'.*

Recovery-oriented treatment and recovery-supporting treatment are seen as the way to help the debilitated service user to recover. Recovery, however, is used in different ways. Several nurses see recovery as a way of incorporating the service user's experience and having the belief that he can fulfil his hopes and dreams, despite his mental illness. Some of the nurses claim recovery is a holistic approach from the service user's perspective: '*I am from a nursing school where I was trained to take a holistic view of the patient (IW 7)'.*

The wording also articulated some scepticism towards the concept of recovery . Nurses are accustomed to service users who are often overwhelmed by severe symptoms and do not have disease recognition, making it hard for them to relate to their own situation*: '[...] they may be very bothered by hearing voices and do not have the resources to do things other than to endure the voices and they need care. The patient may lack recognition of the disorder, and it is an uphill struggle if they do not share our perception of the disease (IW 3)'.* Others have taken the concept as an effective idea for service users with severe psychiatric challenges: *'Illness Management Recovery is an American treatment system that involves some different groups, and then you get to the other end of the recovery in the most beautiful sense (IW 8).*

Patient records

Patient records are built from a template, focusing primarily on data such as diagnoses, symptoms, and residence. Information and symptoms are systematically classified, which can be seen as an effort to document efficiently.

The wording articulates the service users. The notes focus primarily on the effect of medical treatment. There is no information on the service user's own interpretation of his or her problems or wishes for the future.

There is also no direct use of 'recovery' as a keyword. Words such as 'hopes', 'service user experiences', 'assessments' or 'expectations' are also not explicit. In addition, a type of coded language is used: 'action six is performed', 'action four: he is exhausted and will not go for a walk', 'action seven not done when Tom did not want to go'.

The grammar of the texts

Interviews with nurses

The transcribed interviews contain the nurses' statements that evidence-based and biomedical treatment methods lead to recovery. The service users are described as mentally ill individuals who should receive treatment.

Interactional control is generally demonstrated by a hierarchical and asymmetrical power relationship where nurses know what is best for the service users. *'Thus, the patients want to be involved in the treatment, but it is not always possible to meet their wishes, or that we consider their wishes will benefit them the most. For example, I experience a lot of patients wanting a conversation with our psychologist, but where we do not estimate the patient will benefit from this. What treatment will be best depends on the problems the patient has. It's not a free choice, but we listen a lot to the patients (IW 3)*'. However, there are several examples of the nurses advocating for a more equal relationship, where service users participate with their resources: *'I use open questions, creating a relationship, and small talk to access a relationship. I am very inspired by Travelbee's human-to-human relationships and how to create a relationship and to meet the person behind the disease and not a diagnosis; the relationship opens the way for insight into the patients' thoughts and lives, and we need that, so that we can know in what direction we should treat (IW 5)'.* Interactional control comes with challenges and doubts, though uncertainty and curiosity seem to have little space in the psychiatric practice, largely because of a lack of resources: *'I often go home with a feeling I did not talk enough to my patients, so if there were more people, we could also focus more on the individual; we probably use most of the resources on the debilitated patients (IW 6)'.*

When it comes to recovery potential, the affinity of nurses is more varied. Some have a great deal of confidence in the recovery, which shows: *'We have a common desire to work in a recovery-oriented manner, and that's the whole value base of the approach. I think we have come far and are experiencing patients who are satisfied with the treatment. We are asking all patients to evaluate how they have experienced the course. Here, most respond that they are satisfied (IW 3)',* while others use modalities verbatim: *'We also*

experience unfortunate circumstances, such as psychiatry; not everyone is getting a good life, someone must be admitted for periods, somebody commits suicide, etc. We try to do whatever we can to prevent them from being hospitalised or reaching the point where they commit suicide (IW 10)'.

The understandings of recovery vary, but an objective modality is used throughout the process; recovery involves following the standardised treatment, despite the aim of having the service users manage their course themselves. *'It is best if you think that it is the patient who manages his own course. But the patient does not follow the treatment, so you must go again. So, in some ways, this is the package. Take it or leave it. Thus, in one situation, we say one thing, and then we may act a little differently at other times. There are some paradoxes to it (IW 4)'.*

The nurses present the structural framework conditions as barriers to the orientation towards recovery in treatment. What the nurses agree upon most is: (a) There are too many tasks in relation to resources: *'Busy section with many patients and large flow (IW 1)', 'Too few staff resources (IW 6)',* (b) too much focus is put on the acute rather than the long-term: *'Many patients are debilitated and need a lot of help, and it's hard to focus on recovery (IW 6)',* and finally (c) There is *'Too much standardisation' (IW 1).* The latter has a varying affinity, because some nurses express a high affinity for standardisation, seeing it as a measure of professional quality: *'It's hard because everyone is currently pressured, even in the departments, and there's no time, because we are so crowded with beds and there are many patients and overcoats and so on (IW 6)',* while others show high affinity for statements such as: *'we are measured on benefits and evidence, not on soft values (IW 5)'.*

The nurses, thus, subscribe to a rational logic, where recovery is subject to conditions that make it difficult to facilitate individual progress based on the service user's own problem definitions, hopes, and goals.

The nurses refer to themselves as 'we' and use a form of transitivity where statements are mentioned in a normative and representative sense. However, the nurses articulate the recovery process as the service user's journey towards recovery, which suggests that the service users' perspectives are the starting point for recovery and, therefore, an individually tailored treatment is required. On the other hand, the recovery-support methods are articulated through standardised methods to support the service user's recovery process. Thus, the transitivity is articulated by using the agent noun 'we', and, on the other hand, it is emphasised that the service user must define his recovery journey and, finally, that the recovery methods are standardised: *'We have been standardised. Here is the offer; take the offer or leave (IW 1)', 'We try to be open to the patient's wishes, but our structure can be a barrier. It is also we who choose the offers, methods, etc. The patients have no free choice (IW 5)'.*

The nurses refer primarily to the service users with objective modality. This approach appears in statements such as the 'service user is', the 'service user has', the 'service user describes', the 'service user has experienced', the 'service user can', and the 'service user appears'.
The analysis showed no differences in vocabulary and grammar between the journals and the interviews with the nurses from the open in- and outpatient psychiatric centre.

Patient records

In the patient records, the health professionals describe the treatment plans, observations, and assessments. Service users are identified objectively in internal communication with healthcare professionals because they are neither recipients nor service providers. The interaction control is asymmetrical. The written notes draw on an indisputable biomedical cause-and-effect logic that addresses the recipients in a professional field. It appears that the medical logic is elevated as a natural structure in the notes, while the non-drug treatment is, to a lesser extent, described as meaningful and effective. There is evidence that there is no focus on the service user's recovery process or that this focus does not seem important to document.

Discourse Practice

Interviews with the nurses

The interdisciplinary discourses in the interviews show a manifest intertextuality that has roots in a predominantly paternalistic discourse. The nurses refer to recovery within a paternalistic discourse where the service user's lack of disease recognition and symptoms make recovery impossible to achieve. The paternalistic discourse manifests itself in standardised treatment offers which inform how the service user's problems are to be solved: *'We have been standardised. Here is the offer; take the offer or leave (IW 1)'.*
'Recovery-oriented practice' and 'recovery-supporting' show manifest intertextuality and are part of paternalistic and biomedical discourses. Vocabulary stemming from paternalistic discourse appears as a normative description of what is best for service users: *'We cannot expect patients to make big decisions when they are psychotic, etc. Then we take it easy, and in my view, this isn't a problem. If the patient is very weak, we take over a little' (IW 1).*
The recovery is achieved through psychoeducation, cognitive behavioural therapy, environmental therapy, and illness management recovery: *'Our manager of the ward has pointed out that we need to work in a recovery-oriented manner', 'the more the patient gets insight into his situation, and acquires knowledge about his illness, the better he gets. In fact, the recovery is also about the patient becoming gradually more independent of*

us' (IW 3). The nurses maintain a position as experts and authorities who can make important treatment decisions on behalf of the service users. The service users must be recovered, and the treatment methods are the answer to how recovery can be achieved.

The service users must have knowledge about their own disease and a cause-effect understanding that insight into the disease significantly aids recovery, which speaks to the biomedical discourse. The biomedical discourse is expressed through vocabulary which references medical treatment, electroshock, cognitive behavioural therapy, and psychoeducation about diseases and symptoms. The knowledge of the disease and symptoms, effects, and adverse effects of medicine, become an effective means for the service user to be able to cope with his own health problems and become independent of professional help. The service user must be able to take responsibility for his own illness and recovery, which draws on a discourse of self-care that becomes a goal for treatment.

The wording 'recovery' draws on a discourse from holism that the nurses consider to be an effective approach, involving the service user's experiences and attempting to build the service user's ability to achieve his hopes and dreams: 'recovery is a way of incorporating the service user's experience', 'having faith in hopes and dreams despite mental illness', 'recovery as something they should do', 'they must make an effort', 'severe symptoms', and 'lack of disease recognition'. The discourse of holism involves focusing on the service user's psychosocial problems and not just their disease. The nurses stated that the use of treatment methods would ensure the holistic participation and consideration of the service user's bio-psychosocial needs.

The nurses refer to the biomedical discourse that governs how recovery is achieved; the success of recovery is measured by whether the service user achieves self-care and independence from professional help. The nurses did not note a contradiction between the use of discursive holism and biomedical approaches in the treatment methods.

The nurses use the wording 'recovery process', which draws on self-care discourse. The service users have the responsibility for steering the recovery process. The recovery process is articulated as the service user's journey towards recovery. Some nurses use a paternalistic discourse, articulating that the service users are too ill to live up to the discourse of self-care. Recovery also becomes an ideological political directive, which the health professionals are subject to transform and incorporate into practice.

'Recovery is coming from politicians; they want people to take responsibility for their own health and save money, knowing that people can learn to handle themselves without requiring professional help (IW 7)'. These chains are intertextually stable because nurses often refer to them as requirements in practice.

In summary, the interpretative implications of the intertextual and interdisciplinary properties of the texts show that the discursive practice occurs within the discourses of paternalism, biomedicine, self-care, and holism. All of these discourses coexist within the nursing practice, and the discourses speak to a mode of management in which the use of the psychiatrist's efforts will make the users more independent and empowered. The paternalistic discourse becomes a framework for the conditions for the possibility of how recovery is expressed in practice. This steering and control by discourses serve, in general terms, as the essence of neoliberal discourse. Obtaining recovery becomes the responsibility of individual service users.

Patient records

In patient records, the interdisciplinary discourse is characterised by manifest intertextuality that is rooted in a predominantly biomedical deficit discourse with a vocabulary such as a 'lack of disease recognition', 'hear hallucinated', 'paranoid', 'delusions' and 'incoherent'. Psychological vocabulary concerning 'trauma', 'previous growing up', 'displacement', and 'abuse', is surprisingly rare, as seen in admission notes focusing on the status of symptoms and medication. For example, in one of the records, the note under the heading 'dispositions' reads as follows: 'mother is depressive, big brother, anxiety and depression, sister, anxiety, and depression'. This extract is an expression of heredity as part of the discourse of biomedical cause-and-effect. Intertextually, there are a few chains of the legal framework of psychiatry, e.g. 'voluntary hospitalisation', 'service user retention can be revoked', 'service user asks at some point why he should be forced to stay'. The implications of the intertextual properties of the text show that the discourse has a strong affinity for the medical discourse.

Social practice

In this analysis of social practice, we include theoretical perspectives to find possible explanations for why the discourse practice is part of the social practice. Recovery is articulated as achievable by everyone and is not for discussion, but recovery is best suited to the most resourceful service users, and the nurses know best which treatment methods will promote the service user's recovery. The treatment methods such as psychoeducation and cognitive behavioural therapy are defended by building on evidence-based knowledge, in which the nurses have great faith to promote recovery.

The intertextual analysis shows how the service user's problems were interpreted within the discourse of biomedicine, which ranked highest as the basis for treatment. This discourse of biomedicine makes it possible to identify symptomatic problems that can be treated medically. It

helps the nurses work more concretely to follow up and observe the effects and side effects of medicines.

The concept 'psychoeducation' was referred to as one of the most important tasks which the nurses were performing because recovery was intended to provide the service users with the knowledge to enable them to provide their own self-care. In the analysis of intertextuality, self-care was described as an aim of the recovery-oriented treatment, where the service users can cope with their problems and become independent from professional help.

The nurses are expected to promote recovery to enhance the service user's self-responsibility, ownership, and self- management of his symptoms, and the service users are expected to actively comply through rational choices, regardless of their mental diagnosis and symptoms. In accordance with Rose, the nurses' focus on recovery is guided by a type of normality in thinking, where the treatment aims to achieve the optimal goal in life, i.e., living a healthy life without disease and symptoms (Rose, 2009). In general, the nurses seem to adapt governmental structures about recovery as they make use of biomedical terminology to document within a clinical recovery approach. Thus, this example can also be seen as an attempt to apply an interdisciplinary approach with the physicians because they are the main users of patient records, an attempt which gives the nurses and their observations a voice.

In addition, none of the nurses interviewed were opposed to recovery-oriented work, despite some cautious scepticism, but recovery is, as Farkas et al. pointed out, presented as a human right, where every citizen has a democratic right to influence his own life (Farkas, Gagne, Anthony, & Chamberlin, 2005; Farkas, 2007).

Overall, the main notions of recovery in mental health research literature are clinical recovery and personal recovery. In this study, the understandings of recovery seem to draw predominantly from the viewpoint of clinical recovery. The nurses refer to their work as holistic, but this discourse is subject to paternalistic and biomedical discourses where there is a focus on the treatment of symptoms. Their oral and written words about practicing holistic recovery seems to be happening with the personalisation of power, the physicians, are out of sight and awareness.

The practice of recovery lies at some point in between these discourses. The service user's life is subject to paternalistic steering in a healthcare system that, in accordance with a previous study by Rose has traditionally deep roots in biomedical thinking (Rose, 2009).

Discussion

Recovery is articulated from discourses of paternalism, biomedicine, self-care and holism, all discourses that are increasingly encompassed by the Western discourse of neoliberalism.This

findng is complementary to existing evidence (Bird, Leamy, Boutillier, Williams, & Slade, 2014; O'Keeffe et al., 2018, Thórarinsdóttir & Kristjánsson, 2014; Vrangbæk & Christiansen, 2005, Borg et al., 2013; Karlsson & Borg, 2017, Davidson & Roe, 2007), In accordance with Rose, mental healthcare is constructed as a company that offers services, and their practices are associated with discourses such as biomedicine. The service user is subject to a neoliberal approach in which the person must take independent responsibility as a consumer in order to achieve self-care, and is also tasked with the role of fulfilling the need for a holistic understanding of the treatment course (Rose, 2019).

Self-care and holism are constructed as ideas for which service users are considered to be responsible, strong, able to act, controlled. They acknowledge and accept responsibility for playing an important role in managing their health problems. A paternalistic and biomedicinal framework keeps the authority with the professionals, but users must show self-responsibility within this framework.

Within this framework, the service users are designed as customers/consumers of health services from which they themselves must be able to choose their options for treatment, framed by the options offered by the professionals. There are no free choices of treatment, but users have to take responsibility for exploiting the opportunities presented, putting them into treatment and making sure they recover as soon as possible.

The discourse of biomedicine shows that the service users' problems are interpreted through a framework of biomedical understanding that dictates treatment with the aim of clinical recovery. Slade defines clinical recovery as when the user experiences full symptom remission, full or part-time work or education, independent living without supervision by informal carers, and having friends with whom activities can be shared, all sustained for a period of two years. This approach for defining clinical recovery in a way that is externally observable has allowed for epidemiological research into recovery rates (Slade et al., 2008).

The nurses expressed that when a service user is taught about his own illness, he or she will be able to cope with his or her health problems and gain self-care. This goal is also reflected in an effective approach which involves the service user's experiences to achieve his hopes and dreams. The discourse of holism is revealed through nurses' notions that recovery-oriented practices are based on a holistic approach. This perspective is articulated as involving the service user's perspectives. The service user's possibility to participate in the decision on treatment depends on how open the nurses are to let the user participate. The discourse of paternalism is reflected in the nurses' management of treatment and goals, and none of the patients seem to

contradict themselves and ask questions to be more involved in the courses or in the nurses' plans.

The nurses believe in the evidence-based methods because they see these methods as the best help to obtain recovery. Self-care is the nurses' goal for treatment, which is achieved through the provider's methods, e.g., psychoeducation and cognitive behavioural therapy. The treatment is offered, but it is up to the service user to accept the offers, and compliance will, according to the nurses, improve the service user's possibilities to recover.

Mik-Meyer and Villadsen emphasize that the neoliberal vision is an individualisation of the service users and their problems, which means that the service user acts 'responsibly', with 'willpower' and 'controlled', and 'sets' himself up to play the main role in the solution of his problems (Mik-Meyer & Villadsen, 2007). The view of the patient as a consumer has changed historically, up until today where the service user is expected to be able to act, participate, etc. on his own initiative and the basis of individual preferences. In this study and previous studies (Holen, 2012; Pedersen, 2008; Ringer, 2013) the service user's role has changed to become an active and contributing partner who takes control of his own course. In line with Rose's theory, they melt biomedical and neoliberal discourses together into one unit (N Rose, 2009). Recovery is subject to these neoliberal steering tools that the treatment is systematised, streamlined, and quality assured, and these tools form the governance mediated through paternalistic structures in the form of, for example, predetermined package paths and established treatment methods that together provide a framework for the patient's possibility to influence the course of treatment. Other researchers also problematise ambiguity, that prioritising patient participation and recovery can replace one dominant paternalistic, medical culture. When they use that approach, the same policy documents maintain a dictating and hierarchical language where doctors and evidence-based medical treatment ranks highest as the basis of treatment in the patient's world of experience. It is difficult to see how patient participation and personal recovery should gain ground on an operational level in nursing practice (Holen, 2015; K. Jørgensen, 2019; Karlsson & Borg, 2017; Madsen, 2018; Oute et al., 2015).

Despite some scepticism about the concepts, all of the nurses will involve patients and do recovery-oriented work, which some other studies also verify (K. B. Jørgensen, Nordentoft, & Hjorthøj, 2018; K. Jørgensen & Rendtorff, 2017a). The nurses are required to involve patients and do recovery-oriented work (Danish Regions, Government, & The Ministry of Health, 2016; HM Government, 2011; Mental Health Commission of Canada, 2012; National Mental Health Commission, 2017; World Health Organization, 2013), which sets the conditions for the opportunity on how to talk about the concepts.

Limitations

The Fairclough-inspired critical discourse analyses generated insightful knowledge of the discourses on which recovery draws. However, Fairclough's sophisticated model for the relationships between language use and the broader societal practices does contain theoretical ambiguities. For example, there are no guidelines for how much social analysis is sufficient, or suggestions for which types of theories one can or should use in, for example, the analysis of social practice. Moreover, it is unclear how to handle the dialectic between discursive and non-discursive dialogue, leaving a practical analytical problem. The unclear boundaries make it difficult to show how a non-discursive practice is in a dialectical relationship with a discursive practice. In the discourse analysis, we considered non-discursive practices such as financial frameworks, buildings, and interior design artefacts as social practice.

Implications

The conditions for the possibilities of recovery are subject to logic and biomedical steering, where recovery is put into a clinical thought-process. Recovery is articulated as a clinical concept that focuses on making users independent of professional help and able to take care of themselves. The service user is given greater responsibility for his own illness and health, which is what we and others will categorize within neoliberal discourse. Within this framework, the service users are constructed as customers/consumers of healthcare from which they themselves must be able to choose their treatment. Recovery and patient participation are built up as independent concepts, stemming from different paradigmatic ideologies. These elements can be both complementary and contradictory. If the objective of psychiatry is to offer individual help that supports the individual's desire for recovery, then health professionals need to respect and support the service user's own perceptions of what recovery means for the user to achieve a satisfactory individual life.

Conclusion

The findings show that recovery is mentioned as a positive phenomeon that promotes the patient's self-care and creates more quality of life. The findings in the analyses show how recovery is guided by a paternalistic power-structure, where biomedical and evidence-based knowledge is ranked highest as a basis for interpreting and resolving patients' problems. This knowledge-power perspective can be viewed as a dialectical relationship where certain forms of knowledge are integrated into standardised methods that become instructive to the potential conditions for recovery in a psychiatric context. Rather than explicating the meanings of the

concepts or the theoretical underpinnings, they are used to synonymise and professionalised recovery with various treatment methods that nurses believe provide the best basis for recovery. The nurses believe methods, such as psychoeducation and cognitive behavioural therapy, capture the patient's perspective. The methods appear to guarantee that the work will be recovery-oriented. Thus, the nurses are not critical of the use of the methods, despite the fact that several nurses have no confidence in either involvement or recovery because they think the patients are too sick.

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Table 1. Interview guide

What do you think of when I say recovery?
(Detailed description: What is recovery? How do you understand it?)
When you say xx, what do you mean by that?
Can you give a concrete example of that?
How do you see recovery in your daily work?
How do you think recovery and patient participation are connected?
Can you come up with some (more) examples from your daily life where you have experienced recovery and patient participation?
Can there be challenges involving service users? (Elaborate on the answer: where, when, why).
How do you find out what the service user's needs and preferences?
What are the criteria for successful recovery and patient participation?
Can you devise a status report on how your department is doing about recovery and patient participation? (For example, physical environment, intersectional collaboration, procedures/guidelines, time, knowledge of methods/tools, etc.).
Do you find that the management of your department sets out objectives for the recovery of the service users? (Elaborate on the answer: where, when, why, agree/disagree).
Any other comments or remarks? Is there anything you think is missing, or something you want to elaborate upon?

Table 2. The Participating nurses

	Age	Employment	Experience (years)
1 Sylvia	37	Open wards	12
2 Maria (middle manager)	29	Open wards	2
3 Mille	48	Open wards	18
4 Marianne	35	Open wards	9
5 Jette (ward manager)	38	Open wards	11
6 Katja	43	Ambulatory	17
7 Birgit (middle manager)	35	Ambulatory	5
8 Kirsten	42	Ambulatory	15
9 Henny	32	Ambulatory	7
10 Connie	52	Ambulatory	22

Table 3. The Patient records

Number	**Condition(s)**	**Sex and age**	**In- or outpatient**
Patient records 1	Bipolar affective disorder	Female, 62	Inpatient
Patient records 2	Depression, suicidal thoughts, hearing voices, delusional	Male, 54	Inpatient
Patient records 3	Depression, suicidal thoughts.	Female, 53	Inpatient
Patient records 4	Schizophrenia, hearing voices, delusional	Male, 27	Inpatient
Patient records 5	Paranoid schizophrenia	Male, 70	Inpatient
Patient records 6	Schizophrenia, substance abuse	Male, 23	Outpatient
Patient records 7	Anxiety disorder, unspecified	Male, 42	Outpatient
Patient records 8	Depression, suicidal thoughts	Female, 38	Outpatient
Patient records 9	Anxiety and attention deficit hyperactivity disorder (ADHD)	Male, 24	Outpatient
Patient records 10	Depression and anxiety	Female, 42	Outpatient

Table 4. The Fairclough inspired main analytical question (Joergensen & Praestegaard 2018).

Text analysis	**Vocabulary**		How are the meanings worded? What interpretative perspective underlies this wording? What are the 'key words'?
	Grammar	**Interactional control**	To what extent is control negotiated as a joint accomplishment of participants? Or to what extent is it asymmetrically exercised by one participant?
		Transitivity	What process types are most used, and what factors may account for this frequent use? Is grammatical metaphor a significant feature? Are passive clauses or nominalizations frequent, and if so, what functions do they serve?
		Modality	What sort of modalities are most frequently observed? Are the modalities predominately subjective or objective? And what modality features are most used?
Discourse practice	**Text production**	**Interdiscusivity**	What discourse types are drawn upon in the texts, and how?
		Manifest intertextuality	What other texts are drawn upon in the constitution of the texts, and how?
	Text distribution	**Intertextual chains**	What sorts of transformation does this (type of) discourse sample undergo; - are they stable, shifting, or contested?
	Text consumption	**Coherence**	What are the interpretative implications of the intertexual and interdiscoursive properties of the texts?
Social practice	What is the nature of the social practice of which the discourse practice is a part? Why is the discourse practice as it is?		