

Reconnecting with Life: Reconnecting with Self, Others and Time

*A grounded theory study of recovering from mental
health problems in an Irish context*

A thesis submitted by Yulia Kartalova-O'Doherty, M.A., M.Sc.
for a Ph.D. in psychosocial health at the School of Nursing,
Dublin City University

First supervisor Professor Chris Stevenson, School of Nursing,
DCU

Second supervisor Professor Agnes Higgins, School of Nursing
and Midwifery, TCD

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I hereby certify that this material, which I now submit for the assessment on the programme of study leading to the award of Doctor of Philosophy in psychosocial health is entirely my own work, that I have exercised reasonable care to ensure that the work is original, and does not to the best of my knowledge breach any law of copyright, and has not been taken from the work of others save and to the extent that such work has been cited and acknowledged within the text of my work.

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Abstract

Yulia Kartalova-O'Doherty

Reconnecting with Life: Reconnecting with Self, Others and Time. A grounded theory study of recovering from mental health problems in an Irish context

It has been recommended that Irish mental health services adopt a recovery perspective (Department of Health and Children 2006). However there is no unified theory of recovery capable of guiding services (Craig 2008). The aim of this study was to develop a coherent theory of recovering from mental health problems. This was the first grounded theory study of recovery in Ireland.

The study methodology was guided by critical realism and classical grounded theory. The study was based on open-ended individual interviews with 32 volunteers who had experienced mental health problems more than once over a period of two years and considered themselves in improvement. Most participants (n=23) were recruited via mental health services, and nine via peer support or community groups.

The core category of recovery was labelled as 're-connecting with life'. It had three interactive subcategories: 1) reconnecting with self through accepting the self as a worthy human being capable of positive change; 2) reconnecting self with others through empathic, accepting, and validating connection; 3) reconnecting self with others and time, through establishing coherence of one's past and actively shaping and executing one's present and future. Synchronising self and others in time was reported as an important goal and tool of reconnecting with life, and was achieved through talking, understanding, empathy and giving back.

This study shows that through non-judgemental and accepting connection with peers or service-providers persons can relearn to understand and value themselves and others, come to terms with the past, and plan and execute their present and future. This study provides evidence that through a dynamic connection with self, others and time one can regain meaningfulness of one's life, which was found to be crucial for physical and mental health. Implications for mental health policy, practice, education and research are provided.

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***There is a tide in the affairs of men,
Which, taken at the flood, leads on to fortune;
Omitted, all the voyage of their life
Is bound in shallows and in miseries.***

Shakespeare *Julius Caesar*. Quoted in (Macrone 1990, p.1).

***True love can be compared to a golden grail, for it can never be broken;
and if bent, can wisely repair itself.***

An inscription on the tomb of patriarch Iosif at Assumption Cathedral, Kremlin. Quoted in (Marienhof 1990, p. 3).

1. Introduction and Background

In this Chapter, I will first introduce the emergence of aims and methods of this study and the scoping stage which led to the shaping of the current project. The layout of the thesis will then be described.

I will then present the policy background, rationale, and aims of the study. The absence of a unified theory on recovery capable of accommodating of a recovery ethos in the modern mental health practice will be discussed. The Irish context of recovery will also be described.

1.1 Scoping and shaping of the current study

The idea of a study about recovery from mental health problems emerged from participants of a qualitative *Family Support Study* which I carried out in 2005-2006 during my work for the Mental Health Research Unit (MHRU) of the Health Research Board (HRB). As described in the findings of the study (Kartalova-O'Doherty *et al.* 2006), Irish family carers of persons with mental health problems expressed a wish for more research on individual recovery in Ireland, which would describe how people recover from mental health problems and what exactly helps them to recover. Family carers were of the view that the findings of such research will help them to improve their caring, which in turn would have a positive impact on the psychological well-being of both their relatives and themselves. They also felt that such research can reawaken hope for recovery of their relatives. In their view, information and advice on recovery-oriented caring were not always forthcoming from practitioners working within the mental health services. Family carers also felt that research on recovery would improve mental health service provision in Ireland and reduce the stigma associated with mental health problems.

The first draft of the research proposal for this study was created in January 2006 and coincided with the publication of *A Vision for Change* (Department of Health and Children, 2006), an Irish blueprint of mental health policy which introduced recovery as a cornerstone of mental health service delivery. The research proposal was discussed at the MHRU research team meeting. As a result, a study on recovery from mental health problems was included in the research programme of the Mental Health Research Unit of the HRB. Fortunately, my research interest at that time coincided with the research interest of Professor Chris Stevenson whom I met at a conference in DCU. An idea was born during our conversation to carry out an HRB research project which could form a basis for my part-time PhD study on recovery at the School of Nursing at DCU. After a joint seminar between MHRU and DCU, it was agreed that the study would go ahead and I was to submit a detailed research proposal to both MHRU and DCU.

During the two years prior to the submission of the final research proposals in 2007, I carried out on-going consultations involving service users, service providers, policy makers (HSE), and academic researchers regarding feasibility, purposes and methods of a study on recovery.

Service users provided three main pieces of advice which helped shaping the aims and methods of the study:

- 1) Recovery was very individual and personal, but there was a perceived need to learn as much as possible about how various people recover;
- 2) Some people may not be able to say what recovery was and would need some questions to start off;
- 3) Individual interviews were preferable to focus groups, as it may be threatening for some to speak in detail about their individual sensitive experiences in a group.

In addition, some service users were interested to find out what roles medication played in recovery for different people.

After preliminary reading around the mental health recovery I learnt that 1) the concept of mental health recovery had originally emerged from service users, rather than service providers, and 2) there was a lack of a unified theory of recovery understood and accepted by all mental health stakeholders. These two issues will be addressed in detail in the next section. Taking into consideration the origins of the concept of recovery, the lack of a unified theory of recovery, and the advice provided to me by service users, I felt that a data-driven rather than a hypothesis-driven approach was needed. Therefore, the study was conceived as qualitative, open-ended and based on subjective first-hand experiences and views of those with mental health problems rather than on experiences and views of other stakeholders.

There was a lack of published primary research attempting to find a shared ground among diverse experiences of individual recovery of persons with mental health problems. Grounded theory was selected as the most appropriate method, as it allows the researcher 1) to stay open to new data emerging from the participants and 2) to synthesise the emerging findings into a unified theory. However, as advised by service users, some questions needed to be pre-formulated for the story of recovery to start off. Hence some questions were formulated on the basis of consultations with service-users and preliminary reading on mental health recovery emerging from U.S. literature.

The original interview schedule (Appendix A) was compiled and shown to several representatives of the Irish Advocacy Network (IAN). The schedule received a very positive feedback from service users, who commented that it was giving them choice to speak about issues that they wanted to speak about, as opposed to ticking boxes or answering specific

questions which researchers often considered important but service users did not. The service users instantly provided responses to specific questions of the schedule, which showed that their expectations of recovery were indeed very different and shaped by their previous life experiences. IAN representatives offered me their support with the recruitment of potential participants for the study.

I approached several psychiatrists and psychiatric nurses for consultations regarding purposes, methods, and supports for this research. Two consultant psychiatrists offered their support with the recruitment of potential participants of the study from in-patient, out-patient, day care, and other community mental health services, pending the ethical approval of the research proposal by the Research Ethics Committee (REC) of the HRB.

I also sought advice from Health Service Executive (HSE) representatives about what type of research on recovery would be seen as feasible. The feedback from HSE was that any study advancing understanding of recovering from mental health problems in Ireland would be supported and welcomed.

Whereas I already had working experience in quantitative and qualitative research, I was not that familiar with classical GT. Most of previously published qualitative research in the area of mental health, including my own (Kartalova-O'Doherty *et al.* 2006) was using content or thematic analysis, and detailed description of issues emerging from narratives. Whereas specific issues and concepts of recovery were abundant in the recovery literature, few studies provided systematic data-driven conceptualisation of these issues. Due to the absence of a unified model of recovery, conceptualisation of issues into a theoretical framework was essential. Therefore, I resorted to extensive reading on grounded theory and subsequently selected Glaserian grounded theory as the most suitable.

In addition, Professor Chris Stevenson introduced me to the theoretical perspective of critical realism (Bhaskar 1978, 1989, 1998). Critical realism perspective allows integrating both observable physical and directly unobservable subjective phenomena in a quest for identifying underlying mechanisms of a broader stratified reality. I felt that critical realism perspective allowed me to try and integrate physical and social views of mental health recovery into a broader and more inclusive theoretical framework.

My second supervisor Professor Agnes Higgins advanced my understanding of classical Glaserian GT. GT aims to capture and conceptualise the shared main concern of the participants as opposed to describing the multiple themes and categories that may be individual and specific. Key GT procedures such as conceptualisation will be described in detail in the Methodology chapter.

Classical GT was also suitable with critical realism perspective, as it advocated starting with specific codes directly emerging from data, and gradually synthesising them into broader categories representing the main concern of participants through constant comparison of categories and their properties. In addition, resorting to extensive reading only after the broader categories have been identified, and the main concern had been loosely labelled, helped me to stay open to the data until the end of the project. Following guidelines of classical GT, I used the findings of the previous research as additional data, rather than as a primary guidance for theory-building. Open approach of classical GT to the emergence of theory allowed me to cross the borders of various disciplines and utilise relevant previous findings from psychiatric, psychological, social, natural and other sciences to clarify and strengthen the emergent theory.

As shown by the results of this study, classical GT underpinned by critical realism proved to be effective and efficient research methodology for a project which aimed to capture what recovery was and how it could happen from the point of view of those recovering. The study built a coherent theoretical framework of recovering from mental health problems as a gradual reconnection with life, achieved through iterative and nonlinear reconnection with self, others and time.

The layout of the thesis is as follows. Overall the thesis consists of five chapters. In the rest of this Introduction and Background chapter (1) I will describe the policy framework of recovery, the existing models of recovery, the Irish context of recovery, and the rationale and aims of this study.

In the Methodology chapter (2) I will discuss the philosophical underpinnings of the methodology, ethical research issues, and the design, recruitment and conceptualisation procedures followed for this study. In the Findings and Theory chapter (3) I will introduce the core category of reconnecting with life and its subcategories of reconnecting with self, others and time. I will then describe in detail eight interactive non-linear processes of reconnection of self, others and time identified in this study.

In the Discussion of theory chapter (4) I will present the relevance of the current theory to previous research and mental health practice. I will then discuss multiple definitions and overlapping constructs emerging from previous research which were mentioned or implied by the participants of the current study as relevant for their recovery. In addition, concepts emerging from classical physics and quantum theory considered relevant to the current study will be highlighted. Limitations to the study will also be presented.

The study implications for mental health policy, practice, education and research will be laid out in the Study Implications and Recommendations chapter (5).

1.2 Policy background to the study

As elsewhere, the concept of consumer recovery has recently become central to mental health policy and service planning in Ireland. *A Vision for Change*, the Irish blueprint of mental health policy, describes recovery as a belief that it is possible for persons with mental illness to recover their self-esteem and to regain control of their lives despite their illness (Department of Health and Children 2006). *A Vision for Change* recommends implementing the recovery perspective at all levels of mental health service delivery (Department of Health and Children 2006). However a recent report from the Independent Monitoring Group responsible for the reviewing of the progress of the implementation of the new policy highlighted that the rate of implementation so far has been disappointingly slow. In particular, the report pointed out that a recovery ethos has not been embedded consistently across the mental health services in Ireland (Department of Health and Children 2009). Among many possible reasons behind the lack of progress could be an absence of a unified, structured and clearly laid-out theory of how recovery happens, capable of guiding daily clinical practice of all mental health professionals and maintaining a recovery ethos within the mental health care (Care Services Improvement Partnership (CSIP) *et al.* 2007).

The main purpose of this study is to develop a coherent theory of recovering from mental health problems on the basis of first-hand experiences of those recovering. Such theory will add to understanding, acceptance, and practical know-how of mental health recovery, both in the Irish context and internationally.

1.3 The four models of recovery

Some describe three models of recovery: the bio-medical model, the rehabilitation model, and the empowerment model (Andresen *et al.* 2003, Fitzpatrick 2002). Recently, the model of psychological recovery viewed as a re-establishment of positive identity has also been suggested, which could be loosely positioned between the rehabilitation and the empowerment model (Andresen *et al.* 2003). In its purest forms, the bio-medical and the empowerment models represent two separate fields of the landscape of recovery : the former is seeing mental illness as biologically and genetically predetermined and environmentally non-modifiable, whereas the latter is denying the mere existence of mental illness and consequently the need for its treatment. The rehabilitation model is largely based on the biomedical model, but allows service users to voice their concerns and choices regarding suggested treatment (Andresen *et al.* 2003). A brief summary and critique of these four models of mental illness and recovery is presented in the next sections in order to demonstrate the lack of unified theoretical framework of recovery.

1.3.1 The biomedical model of mental illness and recovery

The biomedical model of mental illness is historically based on the degeneration theory. The degeneration theory assumed that progressive deterioration of mental and social functioning was carried forward from one affected generation to the next one (Hoff 2008). Such degenerative illness manifested itself through phenomenologically observable specific signs, or symptoms described in the psychiatric literature as clinical nosology (Hoff 2008). Symptoms of degenerative illness cannot be controlled by a person as they usually impair a person's judgement. Persons manifesting such symptoms were considered to be incurable, unpredictable and dangerous, and therefore had to be isolated from the broader community (Bracken & Thomas 2005).

Degeneration theory has never been based on empirical evidence (Hoff 2008). However it was readily accepted by most Western states' policies, as it suited the agenda of social control over the unfit, the poor, and the irrational during the industrialisation period (Foucault 2001, Walsh & Daly 2004, Bracken & Thomas 2005). Recovery from degenerative illness such as schizophrenia had been considered as highly improbable at the time of the emergence of psychiatric diagnostics (Kruger 2000).

The biological view of mental illness as a disease stemming from brain malfunctioning has not been supported empirically despite the magnitude of research carried out in this area (Kingdon & Young 2007). In psychiatric diagnostics, brain imaging is occasionally used to rule out observable organic neuropathology, such as brain injury, stroke, or paraplegia (Sheehan & Thurber 2006). No modern brain imaging technology is capable of detecting the presence of psychiatric illness as such (Osuch & Williamson 2006).

The genetic determination of mental illness has been challenged by modern genetic research, showing the environmental 'plasticity', or variability, of gene expression, influenced by multiple environmental mechanisms (Rose 1998). Whereas some genetic links and associations in schizophrenia and other mental disorders have been identified, a large subset of diagnosed and undiagnosed individuals exist for whom genetics play no role (Douthit 2006).

Bracken & Thomas (2005) highlight the problem of subjectivity associated with psychiatric diagnostics. Contrary to observable symptoms of a physical disease, symptoms of mental illness, such as voices or hallucinations, can not be observed by technology and can only be elicited from patients through direct questioning or observation by mental health professionals. Therefore, subjectivity arises from both patients answering questions and psychiatrists selecting the diagnosis on the basis of elicited subjective experiences of patients (Bracken & Thomas 2005). Paradoxically, despite the high degree of subjectivity in mental illness, control of

recovery from mental illness remains solely in the hands of mental health service providers, whereas the views of service users are often considered 'subjective' and therefore irrelevant (Bracken & Thomas 2005). Persons attending treatment are viewed as patients, or passive recipients of care, who have to comply with the suggested treatment in order to become 'cured' of previously documented symptoms and return to the former state of functioning (Bracken & Thomas 2005). Moreover, service providers are viewed as key decision-makers for the patients' current and future life (van der Post *et al.* 2008).

Despite the increasing evidence that people diagnosed with a 'severe and enduring' mental illness can recover and thrive in the society, the historical influence of the genetically predetermined and incurable mental illness view is still very strong (Bag *et al.* 2006). One of the suggested reasons behind the dominance of the bio-medical model in mental health care is that it suits the agenda of pharmaceutical industry (Read 2007). The introduction of selective serotonin reuptake inhibitor class of the antidepressants (SSRI) and atypical antipsychotic drugs in the 1990s was seen as a major breakthrough by psychiatrists and patients. The new drugs were aggressively advertised by pharmaceutical companies as being more powerful than older drugs and having fewer side-effects (Bracken & Thomas 2005). However the evidence that they are more effective than older drugs is currently being questioned, whereby the severe side effects of the new drugs, including suicidal risk in the early treatment stage, are now well recognised (Moncrieff 2003).

There is growing evidence of selective publication of the outcomes of clinical trials of drug effectiveness. The results of studies showing positive effects of drugs on amelioration of symptoms and social functioning are published more often than the results of studies where the drug was not shown to be effective (Turner *et al.* 2008). Meta-analysis of published randomised control trials revealed that antidepressants had only modest benefits over placebo effects. Moreover, with the inclusion of unpublished trials where the drug was not shown to be effective the benefits of antidepressants lost clinical significance (Kirsh *et al.* 2008). As underlined by growing quantitative and qualitative evidence, recovery can happen with or without medication or treatment (Anthony 1993, Ramon *et al.* 2007). However benefits of psychotropic medication have been shown for some people (Ludwig *et al.* 2007). Consumers viewed medication as helpful when doctors took their concerns and preferences into consideration (Happell 2008a). Mental health professionals may be useful for providing temporary assistance and support during crises when the symptoms become frightening or dangerous, and helping to select effective strategies for handling further crises (Mead & Copeland 2000). However lifetime responsibility for own wellness must be handed back to consumers by the mental health services.

Despite the progress in biomedical treatment of mental illness reported over the years, the biomedical model is still incapable of accommodating consumer recovery. Furthermore, practitioners closely adhering to the principles of the biomedical model can in fact create obstacles to reawakening of hope and regaining control of one's life, voiced as crucial by consumers for their recovery (Hasson-Ohayon *et al.* 2009). Such concepts as self-esteem or control of one's life have never been among the primary goals of biomedical treatment. The pessimism of prognosis of having a life-time disabling disease only manageable by medication can damage all hopes for recovery (Andresen *et al.* 2003). Impersonal standardised questioning and observation of patients considered necessary for psychiatric diagnostics can lead to disconnection of persons from service providers and disillusionment with treatment (Lakeman 2004, Cutcliffe & Barker 2002).

Due to the numerous reasons described above, a lot of consumers reject the biomedical model of recovery. Complete recovery from biomedical perspective is a 'cure' from symptoms and a return to a former state of functioning (Andresen *et al.* 2003). Some users argue that upon recovering they did not feel like the same person that they had been before the illness, continued to manage their symptoms with medication or other strategies, and therefore did not fit the biomedical definition of recovered (Fitzpatrick 2002).

Consumers argue that their symptoms should be viewed as a continuum of the norm rather than pathology distinguishing them from the rest of the 'normal' population, with everybody at times experiencing these symptoms in one form or another (Mead & Copeland 2000). In support of such consumer views, an epidemiological study found that between 10% and 15% of 18500 non-clinical adult sample admitted to experiencing hallucinations, and 2% to hearing voices (Tien 1991). Paranoid delusions were also found in non-clinical populations (Ellett *et al.* 2003).

In addition, a significant overlap was found between some symptoms of mental illness and characteristics of creativity (Sadre & Brock 2008). A recent study (Nettle 2006) found that poets, visual artists and mathematicians often displayed unusual and non-linear thought processes considered typical of both mild and severe psychopathology. However long-term use of psychotropic medication was shown to negatively influence creativity, especially among children and adolescents (Simeonova *et al.* 2005)

These findings support a dimensional rather than categorical view of mental illness and undermine the assumptions of the biomedical model. However, in the absence of a clear cut alternative theory of mental illness and recovery both mental health professionals and the public have yet to be convinced.

The outcome priority of reducing symptomatology creates an extra pressure for service providers in terms of their perceived responsibility for controlling, measuring and predicting

risk behaviours which may harm self or others on discharge (Davidson *et al.* 2006b), there is no evidence that people with mental health problems pose a higher risk to the community than the undiagnosed population, the biomedical model of mental illness fuels stigma associated with dangerousness and unpredictability of persons with mental illness. Public beliefs that mental illness is a hereditary biological brain disease beyond personal control leads to social distancing of the public from people diagnosed with severe mental illness (Bag *et al.* 2006).

As a result of social distancing and stigma, persons diagnosed with serious mental illness regularly experience social exclusion, bullying and loneliness in the community (Granerud & Severinsson 2006). Going back to hospital and handing over control of one's life to mental health professionals may sometimes look more attractive than trying to regain control of one's life when faced with the fearful effects of stigma, social exclusion, hostility, loneliness, unemployment, and poverty. A study of readmissions to Irish psychiatric units and hospitals during 2001-2005 found that those younger than 20 years old with a diagnosis of schizophrenia were five times more likely to be readmitted compared to those with other diagnoses and of other age groups (Daly *et al.* 2007). Some argue that in the Western world the passive identity of a psychiatric patient may be one of the few readily available to persons diagnosed with a severe and enduring mental illness (Andresen *et al.* 2003). Despite the increasing evidence that people diagnosed with a 'severe and enduring' mental illness such as schizophrenia can recover and thrive in the society, a belief that mental illness is an incurable genetic disease still persists, both among the general public and the mental health professionals (Bag *et al.* 2006).

1.3.2 The rehabilitation model of mental illness and recovery

The rehabilitation model of recovery is based on the disability model of physical illness and had been originally associated with de-institutionalisation of asylums in Europe in the 19th century (Shorter 2006). With further democratisation of Western societies and the progress in pharmaceuticals, psychiatry acknowledged that deterioration of functioning could be stopped, controlled, and in exceptional cases, reversed by suitable pharmaceutical treatment. However the view on recovery as a complete 'cure' from mental illness inherited by the rehabilitation model from the biological model of mental illness still creates difficulties to fully accommodating of the concept of recovery by the rehabilitation model. The concepts of recovery and rehabilitation were adopted by psychiatry after several longitudinal studies of schizophrenia, which showed that the majority of persons diagnosed with schizophrenia recovered from symptoms overtime and led productive lives in the community (Harding *et al.* 1987). A recent ICD-10 diagnostic classification manual finally acknowledged that schizophrenia is 'by no means inevitably chronic and deteriorating', and that 'in a proportion of cases, which may vary in different cultures and populations, the outcome is complete, or nearly complete, recovery (World Health Organization 1992).

The rehabilitation model holds that though it may not be always possible to completely cure the mental illness, the persons can still be rehabilitated, i.e., return to the approximation of the life that they had before the illness. However rehabilitation can occur only after symptom reduction by medication (Fitzpatrick 2002). Service providers still remain experts in consumer recovery, as they are trained on symptom detection and medication selection. However discussion and choice are allowed for service users with regard to available interventions, medication, or strategies of relapse prevention. This model does not contain a concept of personal growth beyond the disability of mental illness (Andresen *et al.* 2003).

The current community rehabilitation model of recovery is still heavily driven by biomedical model of mental illness with its dependency on psychopharmacology. Medication treatment seems to be replacing talking therapy in most countries, and psychiatrists world-wide spend less and less time with the patient (Shorter 2006). In nursing, the concept of human caring is currently being replaced by caring medical or treatment ‘interventions’, which can be considered efficient only when described by quantifiable outcomes and demonstrate value for money. However, consumers and their carers want person-centred genuine care when in distress (Peacock 2000).

The main concern of consumers with the rehabilitation model is that it ignores the experiences of those who fully recover in both social and clinical sense. Such persons may not have any original symptoms, and do need to stay on medication (Davidson *et al.* 2006a). The disability paradigm of rehabilitation model captures only experiences of those whose illness did not completely ‘go away’, as in recovery from spinal injury, and who perceived the need to control it with medication or therapy.

In the view of the diversity of functioning levels of recovering individuals, a concept of recovery must suit individual aspirations of all persons who wish to use services. In addition, recovery represents a critical civil right issue: to be treated like everybody else, and to be able to enjoy the rights and responsibilities of the general population, despite having been diagnosed with mental illness (Deegan 1992).

1.3.3 The empowerment model of recovery

The empowerment model originally emerged from mental health service providers through anti-psychiatry movement in the 60’s and 70’s (Crossley 2004). As opposed to the medical and the rehabilitation model, the empowerment model held that mental illness did not have biological origin, but was a sign of emotional distress resulting from overwhelming stressors. Advocates of the empowerment model often reject the notion of mental illness as such, and the associated need for any treatment (Andresen *et al.* 2003). Mental illness had been invented as a means of social control over persons whose behaviour does not fit into the subjective standards of ‘normality’. Optimism, empowerment, and peer support can help persons to resume their social

role, thus avoiding the 'label' of mental illness. Such persons are sometimes referred to as 'survivors' of psychiatric care (Speed 2006). The survivor movement was associated with restoration of civil rights of service users and the view that the diagnosis of mental illness was reductionist, labelling and debilitating (Crossley 2004).

Studies suggest that the concept of empowerment may be different in different countries due to the underlying cultural and societal values. For example a UK study of empowerment argues that political agendas of US and UK service users are different (Hatzidimitriadou 2002). The author suggests that the U.K. service user groups are not so radical and are not necessarily against mental health system as a whole, as compared to the U.S. consumers. As she points out, in the U.S. the mental health agenda is by and large driven by high consumerism and individualism. In the U.K. the welfare system is still the main provider of mental health services, and the users who depend on the services are more interested in their improvement rather than their complete abolishment or substitution with user-led ones.

Some argue that when taken to the extreme, survivor movements rejecting professional help and trusting only peers could divide society into 'us' (survivors) and 'them' (mental health professionals and 'normal' people). Social inclusion, viewed as one of the major goals of the empowerment model, may be challenging in the view of such division (Crossley 2004). In addition, the survivor movement considers family and carers as interfering and slowing down consumer recovery. Such extreme views disregard the interests of those who may wish to use the services or benefit from family support (Crossley 2004).

1.3.4 The psychological model of recovery

The study led by Andresen (Andresen *et al.* 2003) yielded a definition of recovery which fell somewhat between the rehabilitation and the empowerment model, namely, the model of psychological recovery: 'Psychological recovery refers to the establishment of a fulfilling, meaningful life and a positive sense of identity founded on hopefulness and self-determination. The person recovers from the psychological catastrophe of the illness.' (Andresen *et al.* 2003, p. 588).

The psychological model of recovery is 'silent' on the causation or presence of mental illness as such. Psychological recovery is more concerned in working towards health and social participation, and reflects aspirations shared by diverse groups of consumers. Psychological recovery can occur with or without symptoms, whereby persons who could hear voices may work and engage in normal life of the community (Andresen *et al.* 2003).

Both positive psychology and postpsychiatry describe the pathway to psychological wellbeing though pursuing personal goals. Setting one's own goals serves a double purpose of achievement of such goals and improving psychological wellbeing of a person (Sheldon &

Kasser 2001, Bracken & Thomas 2005). The psychological model of recovery highlighted new promising directions for defining recovery-oriented services.

The psychological model of recovery is based on personal accounts of consumers. Consumers are usually most willing to work for reforms in psychiatry and may at least partially accept the medical model of mental illness (Crossley & Crossley 2001). Most of the concepts described in the psychological recovery research emerged from consumers of mental health services, willing to use and to improve the existing mental health care.

The next section outlines the concepts and processes of recovery emerging from consumers of mental health services, or persons who identified themselves as having had experienced mental health problems.

1.4 Consumer-defined concepts and processes of recovery

In the consumer context, a widely accepted definition of the process of recovery is that of Anthony: 'A deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by the illness.' (Anthony 1993, p.15). Recovery can be viewed as 'reclaiming control and a positive sense of self as an emotional, spiritual, biological, and sexual being' (Higgins 2008, p.7). Some of the common themes underpinning consumer recovery were summarized as follows: voice; meaning; self-determination; trust in self; relationships; spiritual connection; positive self-image and identity; hope; personal resourcefulness; confidence and control (Higgins 2008).

Hope was mentioned in all consumer accounts as playing a central role in recovery (Onken *et al.* 2007) and has been identified as the shared factor of all successful psychotherapies (Snyder *et al.* 1999). Hope was defined as comprising a vision of a goal, pathways towards this goal, and belief in one's ability to reach the goal (Snyder *et al.* 1999). Such themes emerging from personal accounts as hope for the future, personal agency, the hopefulness of others, and inspiration can be viewed as pertaining to a broad and multidimensional concept of hope (Andresen *et al.* 2003).

Self-redefinition of identity was seen as important for recovery (Onken *et al.* 2007). At least two ways of such redefinition were suggested: either accepting illness as an inherent part of a growing spiritual self (Petti & Triolo 1999), or as a small part of the whole self which could be kept separate from the self and controlled by the self at the time of crisis (Deegan 1997).

A sense of spiritual reconnection with the self was reported as important in recovery (Higgins 2008). Among the characteristics of spirituality are 'innate essence of self; quality of being

uniquely and truly human; expression of will, drive, motivation; source of self-determination and personal control; guide for expressing choice' (Canadian Association of Occupational Therapists 1997, p.43). Similar to this definition, among factors identified by persons with schizophrenia as important for their recovery were: an active sense of self, the persons' determination to get better, and taking control of their illness (Tooth *et al.* 2003). Other scholars also state a sense of meaning or purpose in life underlies spirituality (Agrimson & Taft 2009). A phenomenological study of spirituality and occupation with people who experienced mental illness (Wilding *et al.* 2005) found that spirituality was unique to each participant, represented an individual journey through life, which often manifested through 'spiritual' or meaningful occupation, and was supporting participants in coping with mental illness.

In addition, consumers view emotional, physical and cognitive aspects of self as important for recovery (Heenan 2006, Crone & Guy 2008, Tooth *et al.* 2003). Persons recovering from depression used cognitive strategies to evaluate and manage their negative feelings and emotions (Skärsäter *et al.* 2003). Release of negative emotions was also viewed as an important and was achieved by engaging into physical activities such as walking, jogging, meditation and massage (Skärsäter *et al.* 2003). Art, exercise, and work were often reported as helping recovery, by promoting self-esteem, self-confidence, social contact, temporal structure, and distraction from illness (Heenan 2006, Goodwin & Kennedy 2005, Crone & Guy 2008).

Recovery involves an on-going process of healing mind, body and spirit in a holistic fashion, without concentrating on mental illness as a main aspect of life (Onken *et al.* 2007).

Concentrating on wellness as opposed to illness is viewed as helping recovery and self-healing (Allott *et al.* 2002). Being seen as a disease rather than unique individuals acts as a barrier to recovery as it makes it more difficult to take risks and make a personal choice to get better (Lilja & Hellzen 2008). Some underlined that it was not up to the mental health professionals to determine when a person is ready to start their recovery, but up to the person (Mead & Copeland 2000). The importance of being provided with a choice of available treatments in addition to medication was reported as assisting recovery (Skärsäter *et al.* 2003).

Supportive and trusting relationships with others were also described as important for recovery (Onken *et al.* 2007). Peers can both extend the social circle reduced by the stigmatising consequences of illness (Ralph *et al.* 2000) and serve as role models and guides of recovery (Smith 2000). Family, friends and service providers can also assist consumers in re-establishing social connections in a larger community (Onken *et al.* 2007).

Several dimensions, or stages of recovery were identified by international studies, such as reawakening of hope after despair; breaking through denial and achieving understanding and acceptance; moving from withdrawal to engagement and active participation in life; active coping rather than passive adjustment (Ridgway 2001). A qualitative longitudinal study

(Spaniol *et al.* 2002) identified the following three stages of recovery: being overwhelmed by the disability, struggling with the disability and living beyond the disability. Three major tasks associated with the process of recovery were described as developing an explanatory framework for understanding the experience of schizophrenia; getting control over the illness; and moving into meaningful, productive, and valuable roles in the society.

A review of previous publications containing consumer experiences of recovery summarised four key processes such as finding hope, re-establishment of identity, finding meaning in life and taking responsibility for recovery (Andresen *et al.* 2006). The authors synthesised five stages of psychological recovery emerging from five qualitative studies: moratorium; awareness; preparation; rebuilding; and growth. Elements of the final stage of recovery, i.e. growth, are similar to the notions of psychological well-being, and could be viewed as desired outcomes of the process of recovery. These elements involve personal growth, self acceptance, autonomy, positive relationships, environmental mastery and purpose in life (Ryff 1995). A study based on the literature review of consumer accounts developed the Stages of Recovery Instrument (STORI) for measuring recovery (Andresen *et al.* 2006). However the cluster analysis of STORI did not discriminate between the stages defined by the suggested model. The authors highlighted the need for more studies aimed at capturing the stages of the process of recovery (Andresen *et al.* 2006).

Consumers argue that not all dimensions and stages identified so far in the literature are necessary for a personal recovery to take place (Ralph *et al.* 2000). Moreover, some consumers are wary that once specific stages of recovery are defined and used in measuring recovery, responsibility and control will be taken away from them by the services (Ramon *et al.* 2007). Deegan claimed that the design of recovery-oriented programmes should be non-linear, with multiple points and levels of entry of service-users in such programmes (Deegan 1996). For some service-users, recovery may be about overcoming symptoms; for others, it may be living well despite the symptoms. The goals and views on recovery should be defined by the personal context, wishes, and capabilities (Higgins 2008).

Published concepts and processes of consumer recovery emerged from a small number of empirical studies of subjective experiences of those recovering, and continuous meta-analysis of the diverse existing recovery literature. An extensive literature review of the definitions and elements of recovery referred to eight original qualitative studies of consumer recovery, with the rest of the references containing published views of individual consumers on their recovery, views of service providers on consumer recovery, reviews of previously published quantitative and qualitative studies, and recovery policy documents (Onken *et al.* 2007). Whereas the meta-analysis of the existing recovery literature is undisputedly an important, valuable and necessary

undertaking, there is a need for more original empirical research aimed at conceptualising of diverse experiences of recovering individuals into a unified theoretical framework.

1.5 The Irish policy context of mental illness and recovery

The institutionalisation of the mentally ill in Ireland, as elsewhere, persisted for almost a century and a half (Walsh & Daly 2004). The rates of hospitalised mental patients in the Republic of Ireland were the highest in the world in 1960 (Walsh 1968). The 1945 Mental Treatment Act allowed for voluntary admissions and the boarding out of patients. However this was never adopted on a national level and admissions to inpatient care continued to rise. The Commission of Inquiry on Mental Illness in 1966 introduced voluntary treatment and made provisions for the development of the community services such as out-patient clinics, day hospitals, and social care, aimed at de-institutionalisation of the Irish hospital population (Government of Ireland 1966). After such measures, the Irish rates of those hospitalised finally fell by five-fold from 1958 to 2001 (Walsh & Daly 2004).

De-institutionalisation of mental health services was further promoted in the report *The Psychiatric Services – Planning for the Future* in 1984, a blueprint for development of community services and reducing in-patient care (Department of Health 1984). However some argue that the notion of consumers of services, necessary for the transformation of the passive patient to the active recovering service user was not voiced in this document. Service users were interchangeably described as ‘patients’, ‘persons with mental illness’, and ‘mentally ill persons’ (Speed 2002). Furthermore, there was no direct reference to family and relatives of service users as partners in care; family was referred to only when speaking about legal issues related to involuntary admissions (Speed 2002).

A significant landmark in Irish mental health policy was the introduction of Mental Health Act 2001 (Government of Ireland 2001). The act set up the Mental Health Commission with the purpose of enhancing quality of mental health services. In November 2006, five years after the implementation of the Act, the Mental Health Commission introduced mental health tribunals for all involuntary admissions which gave patients the right to have their involuntary admission reviewed within 24 hours by an independent group of three people: a solicitor, a consultant psychiatrist, and a lay person (Mental Health Commission 2006).

The introduction of mental health tribunals was a positive step towards enhancing civil rights of the person admitted to a psychiatric institution. However, in the Mental Health Act 2001, mental illness is still described by multiple overlapping properties implying disorder, disability, impairment, deterioration, irresponsible conduct, and the likelihood of causing harm to oneself and other persons (Government of Ireland 2001, p. 9). Terminology of the Mental Health Act

2001 is still deeply rooted in the biomedical model of mental illness. Control of one's own recovery and decision-making is not fully given to the consumer. Recovery vision as understood by consumers elsewhere has yet to make its way to the Irish legal system.

The vision of recovery in Ireland has become the focus of a Mental Health Commission discussion paper published in December 2005 (Mental Health Commission 2005). The paper described the activities of Irish voluntary groups such as S.T.E.E.R., GROW and Schizophrenia Ireland as being in tune with the international recovery movements. The Irish definition of consumers was accepted as that of service users. However some argue that service user movement in Ireland is still weak and not as vocal as in other countries (Speed 2002).

A Vision for Change became the first Irish governmental document in which service users were viewed as partners of service providers, on a par with their family carers and relatives. (Department of Health and Children 2006). The document further stated that in order to better address the needs of service users, it was necessary for the mental health services and other stakeholders to adopt a recovery perspective at all levels of service delivery. The document defines the principle of recovery as 'the belief that it is possible for all service users to achieve control over their lives, to recover their self-esteem, and move towards building a life where they experience a sense of belonging and participation' (p. 105).

However one of the barriers for developing recovery-oriented services in Ireland is the lack of understanding of the principles of recovery by service providers, service users and their carers (Higgins 2008). Prevalence of mental health problems in Ireland has been largely defined by the use of in-patient services and diagnosis (Brennan 2004, Higgins *et al.* 2006, Irish College of Psychiatrists 2007). Despite the emphasis on de-institutionalisation, the current community services in Ireland are still underdeveloped (Higgins 2008). Multidisciplinary teams consisting of psychologists, social workers, or occupational therapists are scarce (Irish College of Psychiatrists 2007). The service delivery in Ireland is still primarily medical-nursing led, with few alternative options to medication (Higgins 2008). Readmissions to inpatient services are still quite frequent and in 2007 constituted 72% of all admissions (Daly *et al.* 2009).

The lack of a recovery approach within mental health community residential services was highlighted in a joint study carried out by the HRB and MHC (Tedstone Doherty D. *et al.* 2007). The study reported that the recovery approach to treatment and care had yet to be implemented in community residences, and in general the culture of institutionalisation still persisted. A further lack of a recovery approach was highlighted in the 2007 Joint Committee on Health and Children report on the adverse side effects of pharmaceuticals. The authors of the report advised that in Ireland the use of psychiatric medications represented an unwarranted medical intervention used even in the case of emotional difficulties considered within the normal range (House of the Oireachtas 2007).

The Irish family carers of the Family Support Study reported that despite the general limitations of the health system, genuine, understanding and hopeful care existed on an individual level within Irish mental health services (Kartalova-O'Doherty *et al.* 2006). Most carers highlighted the need to ask persons about their recovery in Ireland and elsewhere, to find out what it meant, how people recovered, and what role medication, treatment and family can play in recovery (Kartalova-O'Doherty *et al.* 2006).

To date, no research on first-hand experiences of recovering from mental health problems has been published in Ireland. In order to make recovery possible, the local consumer views on recovery need to be listened to and understood at all levels of service provision (Ramon *et al.* 2007). After all, the job of mental health services should be directed at meeting the needs of service users, as opposed to the service users meeting the needs of mental health practitioners (Happell 2008b, Department of Health and Children 2009).

1.6 Rationale to the study

At least four models of recovery exist in the current mental health literature: the biomedical model, the rehabilitation model, the empowerment model and the model of psychological recovery. As discussed in the previous sections, some priorities of both pure biomedical and rehabilitation models of recovery can be at odds with those of consumer recovery. The empowerment model in its extreme form rejects the need for any treatment and therefore could not guide mental health services. The model of psychological recovery is based on multiple concepts, processes and stages emerging from few original studies of consumer recovery. Such concepts and processes have not been yet conceptualised into a unified theory of recovery capable of guiding mental health practice.

The concept of recovery from mental illness has been described as a vision, belief, philosophy, ethos and stance (Mental Health Commission 2005). In a stark contrast to this intuitively attractive but somewhat obscure concept, there exists a structured and constantly refined model of biomedical illness and its treatment. The biomedical model is taught in academic institutions and supported by the pharmaceutical industry. It is argued that until consumer recovery has been clearly understood, documented and accepted by the mental health practice and education, the service provision will continue to follow the treatment priorities of the biomedical model instead of focusing on consumer recovery. This may lead to further stigmatization of mental illness, unwillingness to seek treatment, disengagement from services, overreliance on services, demoralisation of service providers, and a further rise of societal costs incurred by unresolved mental health problems.

To successfully implement a recovery-oriented approach in mental health care, we need a theory to guide practice in mental health recovery in Ireland, generated by persons who have recovery experience. Such a theory needs to identify the main concern and basic social process of recovery, shared by different groups of persons with mental health problems in the Irish context.

1.7 Study aim and objectives

The main aim of the study is to generate a theory of recovery through documenting and analysing the first-hand experiences of recovery of persons with mental health problems within the Irish context. This will add to both the local and international understanding of what is recovery and how it can happen.

To achieve this aim, the objectives of the study are:

1. to explore what recovery means and how it happens from the point of view of persons with recurrent mental health problems in Ireland;
2. to build a theoretical framework of recovering in an Irish context;
3. to inform specific recommendations for mental health services, professionals and policy makers.

2. Methodology

This chapter will first present and discuss aims and philosophical underpinnings behind the methodology for this study. It will then describe the design, methods, recruitment and analytical procedures. This chapter will also discuss quality criteria applied to this study.

2.1 Philosophical underpinnings behind the selection of methodology

The four hierarchical elements inherent in social research are its epistemology, theoretical perspective, methodology, and methods (Crotty 2003). Theoretical perspective includes ontology (understanding of what reality is) and epistemology (what it means to know, or how we know about reality) (Crotty 2003). Epistemology concerns philosophical assumptions of types of knowledge about reality, and how one can ensure that they are adequate and legitimate (Maynard 1994). The main three current epistemological views on knowledge about reality are objectivism, constructivism and subjectivism (relativism) (Crotty 2003). Epistemology underpins the theoretical perspective of a researcher informing the methodology, logics and criteria of the research process. Some of the theoretical perspectives in health and social research include positivism, interpretivism, and critical realism. Methodology (e.g. survey research or grounded theory) with its strategy, design and selection of methods (e.g. interviews, observations, questionnaires) is informed by theoretical perspective, which in turn stems from epistemological assumptions (Crotty 2003).

Historically, objectivism viewed meaningful reality as consisting of objects, existing apart from conscious human awareness of these objects. The sensual, or technological awareness of these objects represents an objective, factual truth about reality. Epistemological lens of objectivism separated the observer from the objects of the observations, which made it possible to claim that things that are seen, touched, smelled or perceived otherwise by technological equipment exist independently from the observer; observation can either verify or disprove that these things exist and thus constitute reality (Crotty 2003).

Such separation of the observer and the observed stemmed from the concept of mind-body dualism suggested by Descartes: a fundamental distinction between the 'inner' world of the mind and the 'outer world' of the body. Descartes considered both body and mind as 'things': a body as a 'res extensa', or a thing that occupies space, and the self, or soul, or mind as a 'res cogitas', or a thing or substance that thinks (Descartes 1968). The main two Cartesian points which influenced the development of a scientific approach to studying the subjective world were: 1) a separation of the subjective mind from the objective outside world, and 2) the

possibility of the description of mind as an objective 'thing' through reflexive clarity and meditation (Descartes 1968).

Objectivism is associated with the theoretical perspectives of positivism and development of scientific accurate and unambiguous knowledge about the world through repeated experiments, empirical studies, and statistical methods (Crotty 2003). Following the ontological assumptions of objectivism, positivism treats mind and body as two independent entities, which can however both be described by the formal methods of scientific inquiry (Bracken & Thomas 2005). It is also possible to identify generalisable laws, or the 'universal truth' through objective observation of subjective phenomena through targeted phenomenological observation and description.

Positivism gave rise to Jaspers' scientific approach to description of psychopathology through a technical language of psychiatry (Bracken & Thomas 2005). Jaspers made a clear distinction between the observable form of a static psychic state manifested via symptoms of pathology, and the interior or contextual meaning of these symptoms: 'It is true that in describing concrete psychic events, we take into account the particular contents of individual psyche, but from the phenomenological point of view it is only the form that interests us' (Jaspers 1963, p. 59). Jasper's phenomenology is not concerned with values and judgements and considers them outside the scope of psychopathology: 'Ethical, aesthetic and metaphysical values are established independently from psychopathological assessment and analysis (Jaspers 1963, p. 1).

As opposed to objectivism, subjectivist, or relativist epistemology claims that subjective experiences and values play a primary role in shaping and describing the world. Subjectivist epistemology presupposes that the accuracy of our knowledge about the world can only be relative, as it is distorted by the 'lenses' of our perception. There are no universal truths as such or generalisable laws (Bergin *et al.* 2008). There exist multiple truths about reality, which are constructed by individual human beings; such truths shall be understood, described, and acknowledged (Mills *et al.* 2006). Subjectivist epistemology gave rise to a theoretical perspective of interpretivism which is concerned with describing and interpreting lived experiences of social actors. In turn, the theoretical perspective of interpretivism gave birth to methodological branches of symbolic interactionism and hermeneutics (Maynard 1994).

Constructionism views knowledge about meaningful reality as being constructed by interaction of human beings within a specific social context (Crotty 2003). Therefore, this world is not discovered, but is being constantly constructed. Meaning, or truth *per se* is neither objective nor subjective, but is constructed by social players embedded in social reality of being in the world. Inherent in constructionism is the concept of intentionality of human consciousness. Objects of the world are shaped by human consciousness which is directed towards the objects (Crotty

2003). For example, mental illness may only exist as a social construction intentionally directed towards domination of power, and recovery from mental illness can be viewed as an intentional resistance to this power, i.e. empowerment, and subsequent deconstruction of the concept of mental illness.

Whereas positivism of the biomedical model may often downplay social or circumstantial vulnerability factors of mental health and illness, constructionism of the empowerment model may limit the study of mental illness to studying discourse of resistance, thus ignoring the real difficulties and suffering involved in mental illness. Some people can experience severe physical pain as a result of mental illness (Mulvany 2000, Bushfield 2001). Thus, both positivists attached to biomedical model of mental illness and recovery and constructionists of the empowerment model of recovery may offer only partial explanation of mental health and illness (Bergin *et al.* 2008). As discussed in the previous chapter, some consumers viewed recovery as holistic, involving inseparable and interactive processes of healing of body and mind (Onken *et al.* 2007). Therefore, a theoretical perspective of exploration of recovery should be able to accommodate both physical and subjective phenomena of mental illness and recovery. As will be discussed in the following section, philosophical underpinnings of critical realism allow accommodating of both types of phenomena and can therefore guide a study of recovery from mental illness.

2.2 Critical realism

A more inclusive epistemological approach going beyond objectivism, subjectivism and constructivism is critical realism. Critical realism is a relatively new philosophical approach which claims a shared epistemology for the natural and social sciences (Sayer 2000). The epistemological basis of critical realism has been shaped and described by the British philosopher Roy Bhaskar and his followers (Bhaskar 1978, Archer 1995, Sayer 1992). Bhaskar promotes a critical realist approach to science, both natural and social (Bhaskar 1978, Bhaskar 1989). The three distinctive features of Bhaskar's transcendental argument of critical realism are: 1) differentiated and stratified reality; 2) causality and emergence; and 3) the transitive and intransitive aspects of knowledge.

Following critical realism, there are three domains in the social and natural world: the real, the actual and the empirical (Bhaskar 1998). The real domain exists independently of the human experience and includes mechanisms and powers shaping the world. It encompasses the actual and the empirical. The actual domain includes events that may or may not happen, that is, outcomes of the real domain. The empirical is the smallest domain which contains events that are observed or experienced. There is a gap between what we experience (empirical domain), what really happens (actual domain), and the mechanisms of the real domain which can make

things happen (Danermark *et al.* 2002). For example, through exploring verbalised experiences of recovery from mental illness (empirical domain), we can gain an understanding of what events can lead to mental wellbeing (actual domain), and what generative mechanisms of the real domain may be producing recovering and staying well.

A critical realist ontology acknowledges that mechanisms or powers exist which may not have been exercised (Bergin *et al.* 2008). It may be possible to understand what could happen from what has not happened, that is, how we could be from what we are not (Sayer 2000), e.g., from being mentally healthy to mentally ill. For example, through experience of mental illness (empirical) we can explore the generative mechanisms (real domain) that may be producing an event of mental illness (actual) (Bergin *et al.* 2008). Conversely, through exploring experiences of recovery from mental illness (empirical domain) we can gain an understanding of what is mental wellbeing and what generative mechanisms may be producing recovering and getting well.

Generative mechanisms of 'the real' are also viewed by critical realists as stratified, or representing different strata or layers of reality (Collier 1994). Layers can include the 'physical', 'social', 'spiritual', 'biological' and other (Bhaskar 1978). Sayer (1992) argues that we cannot fully understand and explain an ability to think through identifying and describing the brain cells of a person. Critical realists claim that human emotions could not be understood at only one level (chemical, physical, or social) and may represent a synergy of a combination of various elements (Danermark 2002). Both in the natural and social world, identification of constituents of a phenomenon cannot always explain the combined effect of these components. A famous example from natural sciences is the entity of water which consists of chemical elements of hydrogen and oxygen which are mutually exclusive. However when combined they produce a new substance of water rather than destroy each other. From a critical realism perspective, causality is concerned with 'identifying casual mechanisms and how they work, and discovering if they have been activated and under what conditions' (Sayer 2000, p.14). In the area of mental health, whereas some biological risk factors for depression have been identified (Hannigan & Cutcliffe 2002), a set of vulnerability factors and situations associated with depression has also been revealed, such as loss, abuse, socio-economic class. This highlights the equal importance of both social and biological issues in causation of mental health and illness (Brown & Harris 1978).

Critical realism ontology may be best suited for studying mental health and illness as it has a potential to embrace both sociological and biological explanations of health and illness, often considered as polarised and mutually exclusive (Bird & Rieker 1999). By studying the mechanisms of the real domain which take part in forming mental health and illness through the actual events and empirical observations and verbalised experiences, the Cartesian division of

body and mind can be overcome. Critical realism can facilitate the amalgamation of medicine and sociology through balancing between structure and process during exploration of biology and culture (Carpenter 2000).

The guiding logic of investigation in critical realism is retrodiction, which allows the researcher to explore properties that are necessary for the phenomenon to exist (Bergin *et al.* 2008). This involves developing understanding about underlying structures and mechanisms of phenomena on the basis of observation and lived experience (McEvoy & Richards 2006). Retrodiction can be defined as 'a mode of analysis in which events are studied with respect to what may have, must have, or could have caused them. In short it means asking why events may have happened in the way they did' (Olsen & Morgan 2004, p. 25). Counterfactual thinking is essential to retrodiction, which involves the researcher's experience and knowledge and the ability 'to abstract and to think what is not, but what might be significant' (Danermark *et al.* 2002, p.101).

The critical realism ontology and epistemology allow us to study and describe numerous probabilities in the areas of mental health, mental illness and recovery from mental illness as a possible transitional stage between mental illness and mental health. Some argue that various biological, psychological and cultural mechanisms need to be explored and understood in order to improve delivery of care for individuals with mental illness (Bergin *et al.* 2008). Critical realism supports a wide range of research methods, including both qualitative and quantitative, whereby the choice of method should be determined by the type of the study and what is hoped to be learned (Sayer 2000).

As evidenced by multiple experiments in macro and micro science, a portion of uncertainty will always apply to any scientific evidence, no matter how rigorous the research endeavour may be (Satinover 2006). Whereas randomised controlled trials undoubtedly contribute to medical knowledge, they are only one of a number of useful ways of understanding and shaping health and social services (Glasby & Beresford 2006). Some argue that clinicians and researchers who blindly adopt a narrow version of evidence-based practice without considering other types of knowledge fail to act with intellectual integrity, by knowing the truth but choosing to turn away from it for the benefit of routinisation, efficiency or lack of self-confidence (Murray *et al.* 2007). Restricting acceptable health knowledge only to already verified evidence-based medicine can strip service providers of good faith, intuition, self-confidence and innovation in health service delivery (Murray *et al.* 2007).

It may be reasonable, worthwhile, and time- and cost-effective to try in good faith to uncover as many objective and subjective probabilities leading to positive health outcomes as possible, hoping to increase the number of known probabilities and choices in our quest for better understanding of constituents of good health and psychological well-being. In this context, subjective first hand experience of persons recovering from recurrent mental health problems is

acceptable, valid, and highly relevant evidence, on a par with randomised control trials or systematic reviews (Glasby & Beresford 2006). Such evidence is capable of enriching and extending health research and service delivery beyond previously established empirical domain to yet unexplained but often intuitively perceived mechanisms of the real domain.

2.3 Critical realism and grounded theory

Following critical realism, the mechanisms of the real domain operate in the open systems, and their effects may or may not be observed and even may or may not occur (Bhaskar 1978). The task of the researcher is to use perceptions of observable events to uncover the mechanisms that gave rise to those events (Collier 1994). Classical GT approach advocates constant comparison of observed or verbalised descriptions and incidents (empirical and actual domains in critical realism) in order to identify the abstract higher-level concepts or processes underlying these incidents (real domain in critical realism) (Glaser 1978). Therefore, GT approach is in agreement with critical realist epistemology of stratified reality.

Traditional GT researchers believe in the existence of a latent social or psychological pattern of behaviour which could be discovered by rigorous conceptualisation procedures, provided that the researchers stay open to the data and minimise influence of *a priori* knowledge and preconceptions as much as possible (Christiansen 2007). Following Glaser (Glaser 1978, Glaser 1998, Glaser 2001), GT approach is based on identifying the underlying processes, or behaviours they continually use in order to resolve their main concern. The main concern in grounded theory presupposes the existence of latent behaviour pattern, of which participants may not be consciously aware. However, through uncovering the problem, meaning and behaviour of participants, the researcher can identify the participants' main concern, or problem which they are continuously trying to resolve.

According to classic GT, the main concern and its recurrent resolution has to be conceptualised by one unique concept, or core category, which has to explain most of the variation in the studied behaviour (Christiansen 2007). The core category 'represents that particular behaviour pattern that is highly important for the participants... It is what drives and directs these people's behaviour.' (Christiansen 2007, p.43). The core category should be grounded in the data, and emerge directly from the participants, as opposed to have been formulated by the previous theoretical findings, or professional community. The role of the core category is to delimit the study in order to find the most fitting solution shared by all participants.

Strauss and colleagues later developed Glaser's grounded theory approach in order to accommodate relativist epistemology (Strauss & Corbin 1994). Grounded theory developed by Strauss assumes the existence of multiple truths, whereby meaning is mutually constructed by

both the interviewer and the interviewee (Mills *et al.* 2006). Therefore, the theory is grounded in both the participants' and researchers' experience and it is their interaction that creates the emerging data (Guba & Lincoln 1989). Such view does not accommodate the existence of a broader real domain extending beyond the empirical and the actual knowledge of 'here and now', and cannot be readily transferred to context outside the research interaction. However the aim of this study was to build a theory of recovery applicable to variable contexts of recovery, capable of guiding any clinical practice, community services, or family caring. Therefore, classical GT underpinned by theoretical perspective of critical realism was more suitable for the exploration of empirical domain or individual recovery, the actual domain of how recovery happened to participants, and the underlying mechanisms of recovery (real domain) which may not have been exercised but had a potential to be exercised in the future in favourable circumstances.

2.4 Conceptualisation procedures in grounded theory

The main conceptualisation procedures used in GT are coding, memoing, categorising, theoretical sampling, and constant comparison. The procedures are described below.

Glaser distinguishes between two main types of codes: substantive open codes which capture the substance of the area of research, and theoretical codes, which address relationship between substantive codes during theory integration. Substantive codes emerge from the data but should be abstract from person, place and time and can therefore be applicable to any social area. Substantive codes can emerge from the data directly (*in vivo* codes) or can be constructed by the researcher (*in vitro* codes) (Glaser 1978).

Substantive coding is open at the initial stage of the analysis when all data is opened and fractured into codes, and become selective as the analysis progresses, when only selected excerpts of text containing incidents related to already existing substantive codes are explored.

GT further distinguishes between a category and its property. A category is broader than a code and can embrace several codes into a higher level abstract concept. A property is a conceptual aspect or element of a category which can further classify or describe a category. A core category is the highest level of categorisation of the data which runs throughout the data and constantly reoccurs in the narratives and is relevant to all categories and properties, and explains most of the behaviours of the participants (Glaser 1998).

GT is based on constant comparison of codes within and between the data emerging from participants, whereby all incidents related to the emergent code are constantly compared for similarities and differences of conditions of these incidents which may indicate categories and their properties. Constant comparison is carried out throughout all the analysis and only stops

when theoretical saturation is reached and results have been written up (Glaser 1998). Following Glaser, 'Theoretical saturation of a category means that through constant comparing ... the conceptualisation of each comparison yields properties of the category until no new properties emerge' (Glaser 2001, p.191).

Both Glaser and Strauss (Glaser & Strauss 1967) and Strauss and Corbin (Strauss & Corbin 1998) underline the importance of memo-writing in a grounded theory study. Memos are 'written records of the analysis that may vary in form' (Strauss & Corbin 1998, p.217) and may contain observations, codes, categories and theoretical notes. However in classic GT memos are more concerned with the generation of categories rather than general observations or notes pertaining to the analysis. In classic GT, sorting of memos is the main procedure of theoretical coding. Memos containing categories and their properties are constantly sorted and resorted, until the relationships between categories are clear and all related categories fit into a unified theory and theoretical saturation is reached.

Strauss and Corbin also offer three levels of coding: open coding, axial coding and selective coding (Strauss & Corbin 1998). Open coding somewhat coincides with substantive coding, albeit open coding in Strauss and Corbin (1998) may generate hundreds of codes running beyond the data which would need substantial reduction through the use of axial coding (Heath & Cowley 2004). Strauss and Corbin suggest using axial coding for further generation of concepts which replaces theoretical coding and partially substantive coding. A specific conditional/consequential matrix is used instead of classical theoretical coding in Strauss and Corbin (1998). The matrix aims to produce a linear model of causes, conditions and consequences explaining the phenomena, context and actions. Glaser argued that such matrix may lead researchers to forcing data prematurely and undermine the natural emergence of theory from the data (Glaser 2001). However some argue that the strategy of axial coding may help the researcher to delimit the data faster and thus facilitate theory generation (Charmaz 2000, Volkoff *et al.* 2007, Christiansen 2007).

Theoretical sampling is another core procedure in GT whereby all further recruitment stems from the previous findings and emerging categories. For example when a role of peer support groups in socialising emerged in the narratives of the first group of participants, further participants were recruited among those attending peer support groups in order to look at the conditions and properties of socialising in recovery. However, at the initial stage when the key concepts are still unknown, it may be useful to follow the principle of maximum variation sampling, i.e. recruiting representatives of diverse groups of the population under study (Glaser & Strauss 1967). Maximum variation sample facilitates exploration of the underlying concepts and processes shared across different contexts and various groups of participants (Glaser & Strauss 1967). Further theoretical sampling was guided by the findings of the first and second

stages of interviewing and conceptualising, which will be discussed in detail in study design section.

During the interviewing and analysis I tried to stay focussed on the underlying main concern of the participants and their behaviours aimed at resolving their main concern (Glaser & Strauss 1967). I constantly asked myself three GT questions (Glaser 1978): What is this data a study of? What category or property does this incident indicate? What is actually happening in the data?

2.5 Study design

In line with its objectives, this study was conceived as qualitative and open-ended, aiming at eliciting individual definitions and processes of recovery in order to facilitate in-depth understanding of what recovery means and how it happens from the point of view of persons with recurrent mental health problems in Ireland.

Due to the fact that that the concept of recovery had originally emerged from service users rather than service providers, it was decided to invite self-nominated persons with mental health problems who considered themselves in recovery and were willing to participate in the interviews (Tooth *et al.* 2003). For the purposes of theory-building, I was interested in the underlying concepts and processes of recovery shared by a broad group of persons with recurrent mental health problems (Glaser & Strauss 1967). In addition, due to the requirements of the MHRU research programme guiding the study, had to limit participation to those who identified themselves as having experienced mental health problems more than once during at least two years, considered by the service provision as the most problematic and costly group of consumers (Schinnar *et al.* 1990).

The original interview schedule was drafted following consultations with service users and service providers and designed as open-ended and flexible, with a view of its further adjustment on the basis of concepts emerging from the interviews (Appendix C). The views of participants on recovery were elicited by the prompts: ‘So what does recovery mean to you? How would you measure the success of your treatment and recovery?’ The original and revised interview schedules are available in Appendices C-E.

For descriptive purposes participants were asked to fill out a brief questionnaire where they stated their age, gender, educational, employment, and marital status, the nature of their mental health problems (diagnosis if known), the approximate duration of their experience with mental health problems in years, and the use of various mental health services and peer support groups in the last 12 months and in the past, and their general satisfaction with the services and support provided to them over the years (see Appendix F). This was completed at the end of the interview so as not to influence responses to the open ended questions.

The project was carried out in the area of two Irish counties and included nine participants of peer support groups in urban locations who did not use mental health services at the time of the study and 23 current users of mental health services who attended day centres in suburban and rural areas. The day centres and peer support/advocacy groups located in suburban, urban and rural areas were selected in order to facilitate maximum variation of the sample at the initial stage of research, in order to capture as many issues and concerns of a diverse group of participants and theoretical sampling aimed at further verification and exploration of the identified codes and categories (Glaser & Strauss 1967). Day centres are part of public community services and are attended by users of diverse services, including users of inpatient and community residences facilities, and day care, day hospital, and rehabilitation services. The functions of day centres include provision of outpatient nursing care, administration of medication, participation in work and self-management skills programmes and other activities facilitating integration in the bigger community.

2.6 Ethical issues and considerations

International best practice (World Health Organization 2000) pertaining to the conduct of ethical research in the social sciences served as a basis of the selection of methodologies and procedures for the present study.

The literature review, methods and ethical considerations were discussed in detail in the research proposal presented to the Health Research Board Research Ethics Committee (REC). Prior to submission to the REC, the proposal had undergone two peer reviews. The HRB ethical approval and the ethical approval of the Clinical Director of the participating catchment area were granted in March 2007. Approval to proceed with the recruitment of study participants was granted by the CEO of the Irish Advocacy Network in June 2007 and the CEO of GROW in September 2007.

Prior to the interviews, the contents of the information letter (see Appendix A) were read to participants. Written consent was obtained from the respondents to indicate their willingness to participate in the study (see Appendix B). Participants were informed that their participation was voluntary and confidential, that the interview would be audio taped with their permission, and that they were free to withdraw at any time. No personal information, such as names, addresses, or contact details of participants were reported. Participants were assured that any personal identifying information collected by the research instruments would be stored confidentially and would not be available to other support groups members and/or mental health representatives. All data emerging from study interviews would be used in the research report in the manner which would not allow identification of the respondents.

Ethical issues in the area of mental health research are also concerned with weighing the potential benefits for the individual or society against the possibility of causing emotional distress to the interviewee. One can argue that the research interview aimed at identifying concepts, processes and desired outcomes of recovery from recurrent mental health problems can be therapeutic to some participants as it is associated with such 'positive' concepts as hope and well-being. Such research can also benefit persons with mental health problems, mental health services and society by developing a theoretical framework of recovery capable of informing all stakeholders on design and improvement of recovery-oriented services and practices. On the other hand, speaking about previous negative events possibly associated with the onset of mental health problems may cause emotional reactions in some participants. However the evidence that talking of one's experiences will produce uncomfortable emotions is equivocal (Munhall 1993). The possible risk was catered for by explaining to the participants that they were free to stop or completely discontinue the interview at any time, or refuse to answer any questions asked during the interview.

The following protocol was suggested for the follow up of any cases of emotional distress during the interviews. In the event that discomfort or distress, I was to terminate the interview and inform the interviewee about the Helpline and Counselling Services run by Schizophrenia Ireland and Irish Advocacy Network (IAN). If required I was to book a support session for interviewees with Schizophrenia Ireland or IAN on their behalf. In addition, participants recruited via mental health services were to be offered an option of contacting their local unit manager or key worker if available, either themselves or via the researcher. No participants experienced emotional distress or refused to proceed with the interviews at any time of the research.

2.7 Stages of theoretical sampling, interviewing and analysis

The study involved three iterative stages of theoretical sampling, interviewing and analysis. The first stage involved six interviews carried out in April 2007; nine more interviews were carried out during the second stage between June and November 2007; and 17 interviews were carried out in April-May 2008. All interviews lasted for between 30 minutes and 2 hours, and were recorded and transcribed verbatim. The next three sections will separately describe the three stages of recruitment, interviewing and analysis of the study.

2.7.1 First stage of theoretical sampling, interviewing and data analysis

Prior to conducting first six interviews, I delivered a presentation to mental health nurses and psychiatrists of the catchment area and answered questions about the aims and methods of the study. I then visited a day centre and a community residence facility located on the grounds of

the hospital and spoke to the service users and staff about the aims and methods of the study. The information letter (Appendix A) was distributed to the staff and service users. Persons willing to participate contacted me directly in person or by telephone, and the time and place for the interviews was agreed. Six interviews with mental health service users were conducted during the first stage of the study.

The first six interviews took place in day centres located in suburban and rural areas of the catchment area of the hospital. All six interviewees had used in-patient mental health services in the past. Half of the interviewees reported that they had been diagnosed with a schizophrenic illness, two with depression, and one with bipolar disorder. Four interviewees participated in peer support groups either in the last 12 months or in the past. Two participants considered such participation helpful whereas two did not.

The first interview schedule started with a question: 'First of all, tell me a bit about yourself. Basically, what is your background, where did you grow up, how many people in your family, - that kind of thing' (Appendix C). The first six interviewees were somewhat limited in their responses when asked about their previous background at the beginning of the interview, and started talking at length only when asked directly about their recovery. However at a later stage of an interview they sometimes got back to their family background and talked about it at length if it was considered important for their recovery. In most cases, family memories were negative and associated with some difficult times. I decided to move the question about previous background to the end of the interview as an optional prompt. The new interview schedule now started with an open-ended question: 'Thank you again for participating in this interview. I would like to ask you about your personal experience with mental health problems and recovering' (Appendix D).

I studied the transcripts and field notes of six interviews and performed line by line open coding which yielded 305 in-vivo codes. I entered the codes on an Excel spreadsheet with a view of further categorising them into more abstract concepts. The sheet also documented the coded interview number and page of the transcripts from where the code originated. This sheet was being constantly updated and modified during the study. Appendix G provides an example of open coding of the first six interviews of the study.

The development and change of some concepts and processes over time, as emerging from the narratives of participants about their past and current experiences, and their future aspirations were explored (Charmaz 1991) (Appendix H). Selective coding of open codes pertaining to definitions of recovery yielded two *in vitro* codes: getting rid of negative feelings, and acquiring positive feelings and actions.

The *in vivo* codes of ‘giving up’ and ‘fighting to get better’ emerged from the first six interviews. Tentative dimensions of the code ‘fighting to get better’ are shown in Appendix I.

The identified codes of ‘giving up’ and ‘fighting’ lead to further research questions. Does the phenomenon of giving up occur only in in-patient units or can it happen outside hospitals? When, why, and to whom can it happen? How does ‘giving up’ affect recovery? What is the connection between ‘giving up’ and ‘fighting’? Are these codes mutually exclusive, or are they interrelated? Do they interchange with each other? At what stage and in which circumstances can giving up turn into fighting, or vice versa? What exactly is a person giving up? What would one fight for and against, what are the external and internal motivators?

On the basis of the emerging codes, question 7 was added to the interview schedule which contained some of the following prompts (see Appendix D for details):

Some of our previous interviewees mentioned that you had to fight to get better, and not to give up. Do you think it is important to fight for your recovery? Have you ever ‘fought’ to get better? How and when? What would you fight for, what would you fight against? What can motivate you to fight for your recovery?

What about giving up? Have you ever given up? When and how did it happen? Why? Have you seen other people who gave up? Where and when? How do you know that they gave up?

As only some but not all participants identified ‘turning points’ in their recovery, I decided to include more prompts on turning points hoping to identify possible stages of the process of recovery. The following prompts were included in Question 1 (Appendix E):

Was there a turning point of some kind which started your road to recovery? What do you think helped you get on the road of improvement?

The elicited definitions and goals of recovery were very individual and diverse, which made them difficult to compare, contrast and synthesise. I felt I needed to elicit as many individual meanings of recovery as possible, and look into some concepts or phenomena shared on a deeper level that may underlie individual meanings of recovery. Question 3 was added to the interview schedule (Appendix D):

What does recovery mean to you? How would you like to feel, what would you like to experience or to be able to do when fully recovered? How would you know that you are fully recovered?

In addition, questions pertaining to self-perceived highest level of recovery on a good day, lowest on a bad day, and the desired highest level were added to the interview schedule (Appendix D, question 4):

Several interviewees told me that they can have different levels of recovery on good days and bad days. Would you agree with that?

So what would be your good day? How do you know it's a good day? What do you do on a good day? What are your experiences? What are your emotions? How do you think good days impact your recovery? Is there anything that can spoil a good day?

What about your bad day. How do you know it's a bad day? What do you do on a bad day? What are your experiences? What are your emotions? When and why can they stop? How long would they last? What can turn a bad day into a good day?

Interviewees mentioned various external supports and internal strategies that helped them in their recovering (Appendix H). Taking the preliminary findings into consideration, more prompts about perceived roles of various mental health professionals, medication, peer support groups, talking, self-talk, and negative and positive energy in individual recovery were added to question 5 of the interview schedule (Appendix D):

5. What do you think helps your recovery?

How do nurses help? How do doctors help? How does medication help? How do inpatient services help? How do they not help?

Have you ever participated in peer support groups? How do peer support groups help/not help?

What activities help with your recovery and why? What else?

A couple of interviewees told me that talking helps them to get rid of some negative energy. Would you agree with that?

What is negative energy? Where do you think it comes from, what can cause negative energy? How does it affect your recovery?

A piece of advice to remember that 'It is not the end of the world' emerged from a participant of the study. I thought that this piece of advice may lead an underlying category related to hope and hopelessness. In order to explore this concept further, prompts on the importance of remembering it was not the end of the world were added to question 8 Appendix D):

One of the pieces of advice given by interviewees to other people was to remember that it is not the end of the world. Do you think it's helpful advice? What do you think makes you feel that it is the end of the world?

All six interviewees had used in-patient mental health services in the past. Two participants participated in peer support groups in the last 12 months. Two participants considered such participation helpful whereas two participants did not. I needed to explore how participation in peer support group can influence recovery.

The next step of theoretical sampling aimed at recruiting several volunteers who did not use mental health services, were living in the community and were participating in peer support or advocacy groups. An attempt was made to include one or more volunteers who had never used mental health services, at least in-patient ones.

2.7.2 Second stage of theoretical sampling, interviewing and data analysis

The second stage involved contacting GROW (World Community Mental Health Movement in Ireland) in Dublin via e-mail and arranged a meeting to discuss the nature of the study and potential participation of GROW members in the study. After the meeting the GROW representative distributed the information letter to potential participants who then contacted the researcher directly. I also had a meeting with an Irish Advocacy Ireland (IAN) representative who distributed the information letter to IAN members, who then contacted the researcher directly. GROW and IAN are two major Irish peer support and advocacy groups whose numerous and diverse participants having experience with mental health problems but living in the community and not necessarily using mental health services.

Nine more interviews were carried out with six volunteers attending GROW, two IAN members, and one volunteer who independently found out about the on-going study on the internet and expressed his willingness to participate. Following volunteers' preferences, one IAN peer advocate was interviewed in a private room in a Dublin university and another in a cafeteria of a Dublin general hospital in the evening when it was quiet. The interview with a self-recruited person with recurrent mental health problems took place in the researcher's office meeting room. Four interviews with members of GROW took place in the GROW Dublin office, whereas two other members of GROW were interviewed in the researcher's office meeting room.

After completion of the next nine interviews, more coding was performed and combined with the results of the first stage of the analysis. Thus, there was substantive coding of 15 completed interviews, and comparison of new data with the previously collected data. I performed sorting of memos and designed a preliminary theoretical framework of recovery which captured both positive and negative cases of recovery (Strauss & Corbin 1998). Figure 2.1 shows the preliminary framework of recovery.

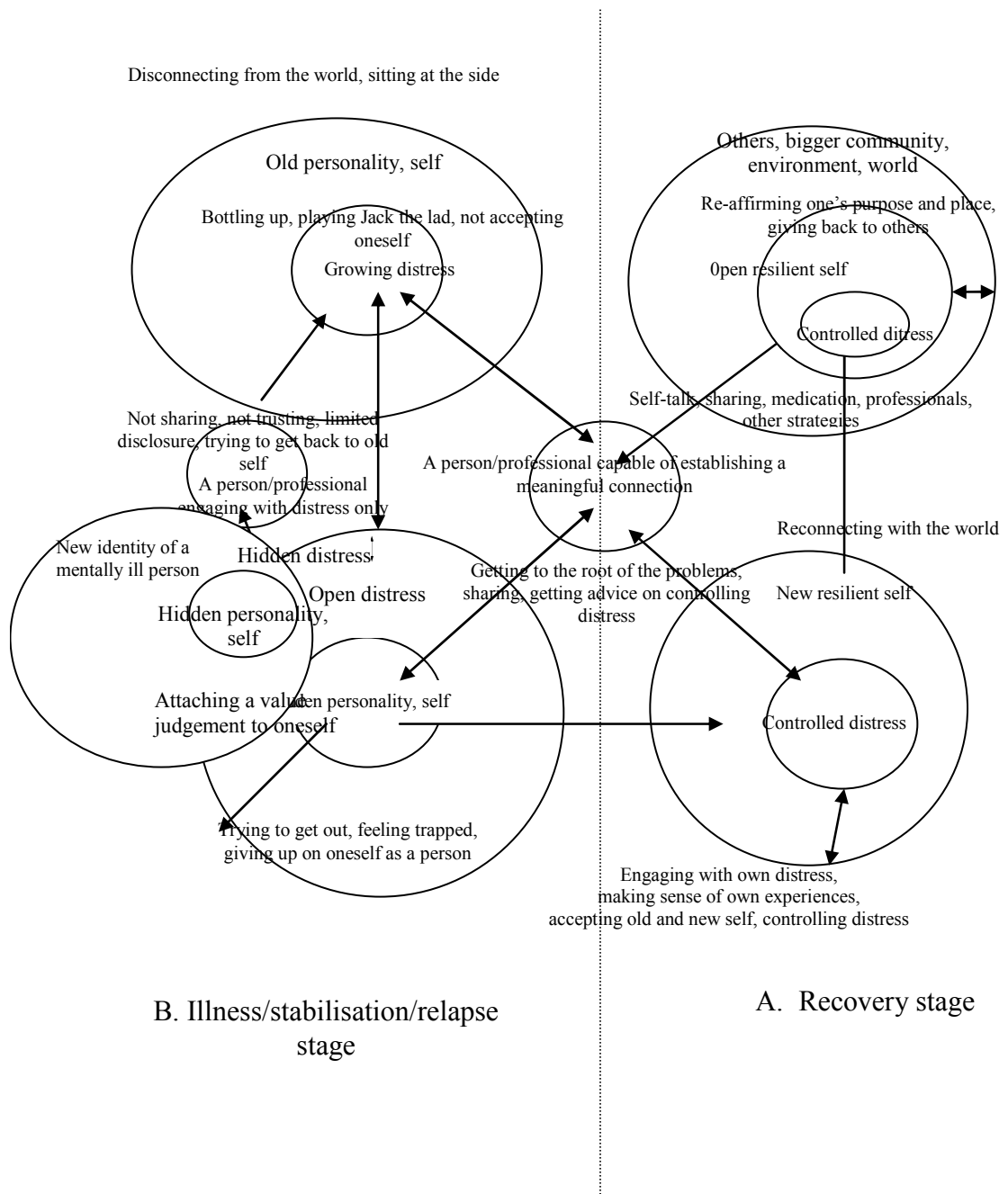


Figure 2.1 Preliminary theoretical framework of recovering from recurrent mental health problems based on the first 15 interviews

As can be seen from Figure 2.1, depending on the type and quality of help the persons got at this lowest point of their experiences, they either started on an effortful journey of transformation of their personality and looking for new ways of coping with their illness and life in general (A) or completely gave up their hopes for their future recovery (B). The preliminary framework distinguished among the positive and negative cases of recovery, described below as scenario A

(positive) and scenario B (negative). The stage of establishing meaningful connection with others seemed to play the crucial role in progress towards positive recovery.

If a person or professional managed to establish a meaningful connection with the personality, or 'self' hidden under distress, and conveyed hope and belief in the person, a process of 'fighting' with distress, transformation of self and getting on the road to recovery started (see part A of Figure 2.1). Once a connection was established, telling a story about one's experiences, trying to get to the bottom, or to the root of one's mental health problems was viewed as the most essential step towards one's recovery.

However if a person or professional could not see the person beneath the current distress and was not interested in personal experiences, the process of stabilization often started at the expense of the confused and hidden 'self', further loss of confidence and could not progress to recovery (see part B of Figure 2.1).

When persons felt that no meaningful connection was possible and they were perceived only in terms of qualifying and quantifying their distress, they limited their level of communication and self-disclosure to a minimum in order to protect themselves from extended hospitalisation or over-medication.

An important part of recovery seemed to be self-acceptance and being aware of one's limitations and potentials. Most of participants acknowledged that their mental health problems were part of themselves and therefore will always be with them. However, once explained, accepted and controlled, negative past experiences did not pose a threat to recovery and living a fulfilling life.

The important role of one's past in one's future emerged. People who had experienced violent or self-annihilating encounters with others felt that the past negative experiences were 'paralysing' them in the face of new situations. The themes of 'looking behind', 'dwelling in the moment', 'being stuck', 'being trapped' and 'not moving on' pointed to the underlying category of one's own perception of time as wasted, unfilled, static, having no movement, no future and no potential. However with meaningful connection with others they started their 'fight' for recovery in the future. The preliminary core category of recovering was labelled as 'fighting with the past for the future'.

The preliminary framework and core category needed verification in further interviews I needed to look further into the transition from being overwhelmed to self transformation and recovery. The following questions were added to the interview schedule (Appendix E):

So how do you think this leap happens, from being overwhelmed by mental health problems to recovery? Is there a specific timing, how would you know a person is ready

to get on with their recovery? What got you motivated, what else could get people motivated?

The conditions determining the amount of disclosure and the establishment of trust needed to be clarified. The following questions were included in the revised schedule:

When do you know you can trust a person with your story? Who are among those you trust and why? Whom would you not trust and why?

Several participants commented that the prompt 'It's not the end of the world' sounded a bit offensive, like 'pull up your socks'. I decided to delete this question from the schedule. Besides, questions pertaining to 'giving' up already covered the phenomena of feeling like it was 'the end of the world' so there was no need to duplicate the data.

I decided to interview more people using mental health services in order to explore the crucial effect of meaningful connection, and the negative influence of formal, impersonal communication, the lack of hopes for the future associated with the pessimistic diagnosis and prognosis possibly delivered by mental health services in the past. I wanted to compare the pathways to recovery of those using community mental health services with those who were using peer support groups.

As several participants considered environment important for recovery, I wanted to explore the role of local community in recovery. Some persons mentioned that people in the country were friendlier than people in urban and suburban areas. The next step of theoretical sampling aimed at involving service users attending day centres in rural areas.

2.7.3 Third stage of theoretical sampling, interviewing and conceptualising

The next step of interviewing included persons currently using mental health services.. As a result, 17 persons using outpatient mental health services were interviewed in private meeting rooms of three day centres of urban and suburban areas. One person perceived himself as nearly given up on recovery.

Nearly half of the participants (n=8) had used in-patient services in the last 12 months, and all of them used outpatient community services at the time of the study. One person reported currently attending a peer support group. The majority of participants recruited at the third stage of the study (n=11, 68.8%) lived in rural areas.

The new 17 interview transcripts, and the previous 15 transcripts were reread and their fit with the emerging framework was analysed through constant comparison. Substantive coding was performed and the following incidents were selected and compared within and between transcripts: relationships between feeling and thinking; getting back to 'reality'; meaningful connection; fighting with the past; purposeful future; fighting with the past for the future;

negative and positive energy; being able to make a difference. Selective coding and constant comparison was continued for previously identified incidents related to definitions of recovery; role of environment in recovery; good days and bad days and their place in recovery; roles of medication in recovery; and roles of mental health services and professionals in recovery.

Eleven more memos were created which further defined categories of fighting with the past for the future; connecting with others; getting in touch with emotions; accepting oneself through others; coming to terms with one's past; fighting to make a difference to somebody; reconnecting with time; getting back to self in here and now; futurising; designing one's own recovery; and synchronising self, others and time. Sorting of all 30 memos was performed in order to establish how the old and new categories fit into the preliminary theoretical framework.

Frustratingly, some categories did not fit the preliminary theoretical framework. Whereas meaningful connection with others as a starting point of recovery was confirmed and further clarified by some participants, all participants strongly viewed their recovery as self-driven, starting with their own decision to get better according with where they wanted to be in the future. All participants were in agreement that it was necessary to fight for recovery themselves as nobody else could do it for them. However non-judgemental encouraging support from others was much appreciated, especially empathic support.

Self-acceptance, self-belief, self-confidence, self-respect, self-discovery and other alternative wordings associated with re-evaluating oneself in a positive way and starting feeling better about oneself were strongly emerging from the interviews. It did not quite fit with the preliminary framework of transformation of self, but had more to do with developing and strengthening of existing spiritual, emotional, cognitive and physical resources which had already been there but had not been properly exercised before. The importance of activation of the four interconnected levels of the self (spiritual, cognitive, emotional and physical) emerged *in-vivo* from the interviews carried out at the third stage of the analysis and were further explored in the previous transcripts.

However others were still essential in this process, including friends and family, peers, nurses and psychiatrists if they were accepting, understanding, non-judgemental, and encouraging. It was clear that acceptance and active reconnection with all aspects of self did not happen in isolation but required support, encouragement, and 'positive energy', more so at the beginning of the journey and less so as the persons gained more confidence. Participants were speaking about friendly environment in terms of people rather than the landscape or quality of facilities.

Concepts of continuity of time, re-entering the point of time where the personal life journey was interrupted or stalled and 'moving on' to the positive future led to further comparisons of participants description on how they moved on in time. Some of the strategies of living through

bad days were: structuring one's day, living one day at a time, not looking too far but breaking the day into little pieces of daily activities in order to get up in the morning and synchronise oneself with own plans.

The preliminary core category 'fighting with the past for the future' was not specific or parsimonious enough to form the basis of theory. However the constituents of the past and future seemed to be reversible. I used flip-flop technique to look at what was missing or abundant in the past and compare it with the desirable or undesirable things in the future (Strauss & Corbin 1998). Disconnection from others, non-acceptance and non-control of self, giving up, lack of hope about the future, 'sitting at the side', attaching value judgement to one's thoughts, denying the reality of own experiences, accepting the identity of mental patient pointed to the state of temporary disconnection from life. The negative things from the past fit in the three broad areas of disconnected self, others and time.

Other memos corresponded to the positive concepts of fighting to get better, meaningful connection with others, seeing one's positive future and striving to live up to it, in order to be able to not only to cope but to enjoy, accept and control one's life. Figure 3.2 shown in Chapter 3 was created to represent relatedness and interconnectedness of self, others and time in one's life.

Alternative wordings of 're-entering life as an active part of life' were considered and discussed with my supervisors, such as re-entering life as an active component of life, re-joining life as an active part of life, re-joining life as an active agent of life, and re-entering life as a meaningful part of life. Also, disconnection and reconnection were *in vivo* open codes identified during the second stage of the analysis.

Encarta online dictionary gave the following definitions of 'connect' which fitted the emerging category: 1) link two things: to join two or more people, things, or parts; 2) to associate somebody or something with another: to make a psychological or emotional association between people, things, or events; 3) get along well: to develop a good rapport with somebody (MSN Encarta Dictionary). Re-connecting was applicable to physical, spiritual and emotional levels of self, relationships between people (others), time (past, present and future). Re-connecting with self, others, time, and life in general was accepted and selective coding was performed on all narratives to find instances of the main category and compare and contrast the incidents. The category had excellent fit of the data and the interactive layers, or properties of spiritual, emotional, cognitive, and physical reconnection were identified.

The core category of 'reconnecting with life' became visible and meaningful only at the final stage of the research, after its subcategories of self, others and time, and the multiple layers of reconnection were identified. Whereas such themes as 'getting one's life back', 'getting out to

the garden of life', 'coping with life', 'having a life of my own' and the word 'life' itself recurred in the data from the very beginning, I did not see the broader underlying concept of life behind its constituents until the final stage of the project. Some argue that the importance of everyday life in mental health recovery may seem invisible simply because it is too visible and therefore often goes unnoticed in research (Borg & Davidson 2007, Gullestad 1989). The abundance of reference to 'life' in previous literature on recovery from mental illness also confirmed its intuitive relevance (Biley & Galvin 2007, Davidson 2003). Transcripts were reread again and the fit and relevance of this category and its constituents were tested within and between incidents. The selective coding of the core category and its subcategories was performed. All narratives fit into the core category and its subcategories, and theoretical saturation within the data was considered to have been reached.

The emergence of the core category was as chaotic, painful and non-linear, as often reported by GT studies (Coyne & Cowley 2006, Christiansen 2007, Heath & Cowley 2004). Trying to keep preconceptions at bay and resisting the urge to adopt a core category from some previous studies led to periods of confusion, frustration and disappointment. At the final stage of analysis I was close to opting out to either selecting a core category on the basis of previous research in agreement with Strauss and Corbin, or adopting multiple categories as core variables and main concerns. Similarly to other researchers, doing GT analysis helped me to develop tolerance to extended confusion (Christiansen 2007) and to learn how to surrender theoretical-disciplinary autonomy often used in quantitative research and to develop data-driven conceptualisation autonomy necessary for completion of a GT study. Some argue that such data-driven conceptualisation autonomy cannot be obtained without accomplishment of a major GT research project (Christiansen 2007).

2.8 The use of literature in the study

Glaser agrees that reading prior to and during research should take place in order to sensitise the researcher to possibilities in the data; however it should be wide and diverse without narrowing it down to specific categories (Glaser 1978). At a later stage when the theory has been already formulated and the core category has emerged Glaser recommends substantive reading around the core category and treating literature as data to see how the emergent theory fits with the previous research (Glaser 1998, Glaser 2001). Therefore the preliminary reading on recovery was broad and more concerned with policy and historical development of recovery models, rather than with specific categories of recovery.

I did not resort to substantive reading on the emerging categories until the preliminary theoretical framework was formulated in March 2008, and 17 more interviews were conducted in June-July 2008 in order to test and refine the emerging framework.

An extensive literature review pertaining to concepts and categories emerging from the study was performed during the final stage of theory building. The following electronic databases were searched: Academic Search premier; PsycINFO; Wiley InterScience Direct; Medline. These databases contain peer-reviewed multidisciplinary publications on mental health, mental illness, sociology, psychology, education, pharmacology, neuroscience, biology, science, general health and other qualitative and quantitative research. Due to the magnitude of the existing literature on reconnecting with life and its identified interactive and multilevel constituents of self, others and time, only selected findings viewed as most relevant to the current study will be presented and discussed.

Reading around the categories of 'meaningful connection with others' yielded lots of previous findings on 'empathic connection', 'empathetic maturity', 'therapeutic relationship' and 'presence' in the nursing, psychotherapy and addiction literature which helped me to further clarify and formulate the subcategory of 'reconnecting with others'.

Definition of continuity of time emerged from the literature search performed with the phrase 'reconnection with the past' and fitted the data collected from all participants (Deleuze 2001). The constructs of explicit (conscious) and implicit (unconscious) temporality in phenomenological psychiatry were also found to fit the framework (Fuchs 2005).

The concepts of entropy, or irreversibility of the increase of disorder of material things, and negative entropy as one of the main characteristics of living things which have an intrinsic ability to heal and sustain order emerged from publications on quantum theory (Bishop 2005, Schrödinger 1944). Quantum theory concepts of complementarity, entanglement and uncertainty were explored and considered useful for their inclusion in discussion as they provided further clarity and substance to the emergent theory of recovery.

Reading around the concept of 'life' and its multiple definitions suggested by various disciplines in the absence of a universally accepted one confirmed my opinion that this concept was suitable for capturing the shared social reality of recovering for all interviewees.

A substantial body of quantitative and qualitative research in epidemiological, psychological, social, psychiatric, nursing, general health and even natural sciences literature was found to be relevant to the theoretical framework of reconnecting with life. Moreover, the core category was in agreement with Anthony's definition of personal recovery as 'a way of living a satisfying, hopeful and contributing life even with the limitations caused by illness' (Anthony 1993, p.15) and Deegan's as 'the real life experience of persons as they accept and overcome the challenge of disability' (Deegan 1988, p.11). The category also added to understanding of life as a personal construct which is individually unique, multilevel and dynamic.

Taking into consideration that the core category emerged only at the final stage of the study, I approached one service user for further discussion of the core category and its subcategories. The core category, its subcategories, and multiple layers (spiritual, emotional, cognitive and physical) or properties of the processes involved in recovery made perfect sense to the person, and more clarification was provided to help further understanding of the emerging theoretical framework.

2.9 The use of technology in the study

Glaser does not recommend recording and transcribing the interviews and insists that field notes may be sufficient for the analysis as the researcher needs to start coding for the core category from the very beginning of the interviewing as opposed to post-interview.

I felt it was necessary for my own confidence that all the key issues were captured, in case that I miss anything during interviews due to the fact that English was not my native language. I also felt that the abundance and accuracy of data may help constant comparison and detailed exploration of properties, which requires ongoing deconstruction and reconstruction of the data (Coyne & Cowley 2006). However the amount of data I collected was very difficult to handle. Fewer interviews could have been done and a less hectic pace of the coding and categorising would have been preferable.

Glaser does not recommend using computer software for sorting data or coding data, except for writing purposes (Glaser 2003). His main arguments against the use of technology for coding and categorising are the dangers of pre-framing, forced choices, lack of flexibility and fixing attention to limited pieces of text as opposed to staying open to the data as a whole throughout all stages of analysis and theory-building.

Word was the only programme used throughout all stages of the study in order to write memos, manage, delimit and compare data. It was also useful for deconstruction and reconstruction of the data, whereby in vivo excerpts pertaining to substantive codes were saved separately and then collapsed with the emerging broader categories. Selected excerpts saved on Word were also useful for exploration of properties of emerging categories. During the first stage of analysis Excel was used for open coding and categorising as the amount of open codes was likely to be very high at the beginning of the study. In fact 305 open codes emerged from the first six interviews which were then delimited to 13 on Excel. Excel was not used during the third stage when the analysis reached a more abstract theoretical level and I needed to explore categories and their theoretical relationships.

2.10 Balancing subjectivity with objective spirit

The goal of the researcher engaged in a classic GT is to strive to stay free of assumptions and preconceptions and to minimise *a priori* knowledge as much as possible (Christiansen 2007). All assumptions should be derived from data and all the theoretical elements should be grounded in data, and documented by memos. In the original publication *The Discovery of Grounded Theory* the authors stress the importance for the researchers to retain enough detachment from the research area despite the need to observe and immerse themselves in the participants world: ‘He has been sufficiently immersed in this world to know it, and at the same time has retained enough detachment to think theoretically about what he has seen and lived through’ (Glaser & Strauss 1967, p.226).

Throughout the study, I tried to stay focussed on the underlying main concern of the participants and resolving behaviours and processes aimed at resolving their main concern. This helped me to keep my preconceptions at bay as much as possible and concentrate on the data as opposed to my own preconceptions.

However it was impossible to rule out my own beliefs and knowledge completely and therefore I feel that they need to be accounted for. The underlying mechanisms identified and described in this study do not claim to represent the full truth about recovery. However they can highlight a certain amount of new probabilities leading to recovery. Only practice can show how relevant and helpful these probabilities are for the mental health care and beyond.

My previous research experience has been foreign language teaching, cross-cultural communication, and social research in the area of drug misuse and mental health. My views on the world have been first shaped by the relativism of foreign language teaching, objectivism of epidemiological research, and pragmatism underlying educational and psychosocial research. Centrality of the research question is the cornerstone of pragmatism, similarly to that of critical realism, as well as other research methods (O’Cathain *et al.* 2007).

On the one hand, I felt that my multidisciplinary background may help me to stay relatively free of assumptions and preconceptions of medically oriented understanding of mental health, and to avoid ‘theoretical capitalism’ of any particular discipline by using an open-ended interview schedule, and looking for categories directly emerging from the data rather than from previous publications (Glaser 2001). On the other hand, I was starkly aware that I did not have psychological, psychiatric or nursing background or practical experience which sometimes affected my confidence when trying to identify issues relevant to recovering from mental health problems. I tried to compensate the absence of medical background and experience by reading in the area of mental health and recovery at the beginning and especially at the end of the

project. Following Glaser's advice, I tried to treat previous literature as additional data supporting or disproving the emerging theory, and continued to ask myself the three GT questions which I slightly modified for my literature review: What is this data a study of? What studies found similar or opposite categories or properties? How similar or different are the properties of categories or conditions of identified processes?

In addition, I participated in workshops on grounded theory led by Professor Kathy Charmaz (Sonoma State University, California). Professor Charmaz is one of the leading experts on constructionist grounded theory. During the workshops, I became familiar with the theoretical framework of self and time in chronic illness developed by Prof Charmaz throughout her grounded theory studies (Charmaz 1983, Charmaz 1991, Charmaz 1995). This interpretative framework was found to be useful, and provided more directions for the discussion of the current theoretical framework. By staying open to previous studies and views helpful for further clarifying and strengthening the current theory, I tried to stay detached from quick judgements and to balance my own subjectivity with the objective spirit of the existing knowledge.

2.11 Criteria to assure quality in grounded theory

Some argue that the various criteria used for quality assurance in quantitative and qualitative studies serve two broad and not uncommon goals: establishing reliability of quantitative research and rigor in qualitative research (Sale & Brazil 2004). Reliability criteria of quantitative research are normally assessed by internal and external validity, reliability and objectivity. The four major criteria for rigor in qualitative studies are credibility, dependability, transferability, and confirmability (Sale & Brazil 2004, Lincoln & Guba 1985).

There may be more commonalities rather than differences between these two approaches to evaluation of quality (Sale & Brazil 2004). For example, internal validity in quantitative studies and credibility in qualitative studies strive for establishing truth value; external validity and transferability has to do with applicability of the findings; the cornerstone of both reliability and dependability is consistency; and assuring neutrality is the underlying aim of both objectivity and confirmability.

The classical Glaserian criteria to assure rigor includes relevance, fit, workability, and modifiability (Glaser 1978, Glaser 1998). Glaser claims that GT easily meets most of the data analysis guidelines such as credibility, transferability, external validity, dependability and confirmability accepted by qualitative researchers (Glaser 2001). For example, GT meets the credibility criteria because it is abstract of time, place and persons, and is relevant and highly modifiable. Fit is very close to the notions of external validity as the data in GT is generalised through constant comparison. GT has transferability as the same process can be applied to other

areas of study and life. GT possesses dependability as categories and their properties are constantly verified during theory generation. Therefore, quality of GT can be assured by its own criteria of fit, relevance, work, and modifiability (Glaser 2001). I decided that Glaserian criteria of quality suited the current study.

Relevance refers to the applicability of generated theory to a specific area of field by identifying the main concern and latent behaviours used by people to resolve this concern (Glaser 1998). This provides professionals and field workers with understanding and helps to reassess their practices to better meet the needs of their users of their services. According to Glaser, grounded theory can be relevant across several fields, as it uncovers conceptual patterns which are abstract of people, place and time (Glaser 2001).

The core category, with its subcategories and the core process were discussed with my two PhD supervisors with extensive practical, academic and research backgrounds in mental health nursing, two work colleagues with psychology backgrounds, one psychiatrist, and one service user. All involved identified with the theory which showed that the framework was relevant across various disciplines. Also the core concepts and categories were researched in the previous literature and were found to be relevant in mental health, drug addiction, physical health, social research and other areas of health and psychological well-being.

Fit refers to how adequately the categories express the patterns in the data (Glaser 1998). That is concepts and categories should be derived directly from the data and not adopted *a priori* from previous studies about the world, and will fit and reflect the data. Constant comparison of incidents and categories help to achieve perfect fit (Glaser 2001). The categories were constantly fitted and refitted first in the data and then in the previous findings, until the emergent framework explained all variance in the data and the theoretical saturation was considered to have been reached.

Workability stands for the ability of the theory not only to explain the main concern resolving behaviour in the studied area, but also to interpret and predict what is happening now and may be happening in the future (Glaser 1978). I believe that the current theory can offer understanding and to some extent predict what could be happening when a person is recovering from mental health problems.

Modifiability of grounded theory reduces the need for testing and verifying, because it can never be completely right or wrong : ‘GT produces a lasting contribution that is easily modifiable since it is conceptual not empirical descriptions which endure and change.’ (Glaser 2001, p.123). The current theory could be further modified should new data emerge from other interviews. For example, if more data emerge with regard to the importance of the aesthetic

nature of surroundings, for example beauty of landscape, the influence of weather and climate, this category could also further incorporated in the existing framework.

Glaser claims that confirmability does not really apply to GT, as it is not confirmed but constantly modified. The abstract concepts, such as fighting spirit, self-esteem, spirituality, futurising meaningful connection and others identified in this study, exist independently of researchers or sample bias, as they represent conceptual patterns. Moreover, some of these have been documented in multiple qualitative and quantitative studies and can be tested in further research. In this study confirmability was achieved through verification of concepts with further participants through the constant comparison process, verification of the theory with one service user, reading around the concepts in the previous literature, peer reviews, and discussions on coding and labelling of major categories.

3. Findings and Theory

The current chapter will present the socio-demographic and other characteristics of the total sample and some quantitative findings. Next, an overview of a theoretical framework of recovering from recurrent mental health problems built up on the basis of 32 study interviews will be provided. I will describe the core process of progressing from disconnection to reconnection, the core category of reconnecting with life and its three subcategories, and the interactive non-linear processes of reconnecting with life.

3.1 Overview of socio-demographic and other characteristics of the sample

The total sample of the study was 32 persons with recurrent mental health problems who considered themselves in improvement. Table 3.1 shows socio-demographic characteristics of the interviewees.

As can be seen from Table 3.1, most participants (n=23, 71.9%) were recruited via mental health services, and nine (28.1%) via peer support/advocacy groups, including one self-recruited volunteer from broader community. More than half of participants (n=18, 56.3%) were male, and 14 (43.8%) were female.

Table 3.1 Socio-demographic characteristics of participants, by numbers and percentages

<i>Source of recruitment:</i>	Mental health services 23 (71.9%)	Peer support groups/broader community 9 (28.1%)	
<i>Gender:</i>	Male 18 (56.3%)	Female 14 (43.8%)	
<i>Age in years:</i>	M= 48, median = 49.00, SD = 11.4, range 25-68		
<i>Area of residence:</i>	Suburban/urban 17 (53.1%)	Rural 15 (46.9%)	
<i>Type of residence:</i>	Own/relatives' accommodation 16 (50%)	Community residence provided by public mental health services 16 (50%)	
<i>Marital status:</i>	Single 18 (56.3%)	Married/cohabiting 7 (21.9%)	Separated/divorced/widowed 7 (21.9%)
<i>Children:</i>	Yes 12 (37.5%)	No 20 (62.5%)	
<i>Highest completed level of education:</i>	Primary/some secondary 9 (28.1%)	Completed secondary 7 (21.9%)	Certificate/diploma/degree 16 (50%)
<i>Employment:</i>	Unemployed 13 (40.6%)	Mainstream employment/homemaker 9 (28.1%)	Sheltered empl/retired/training/study 10 (31.3%)
<i>Social benefits and insurance :</i>	Medical card 27 (84.4%)	Disability allowance 24 (75.0%)	Private insurance 6 (18.8%)

Half of participants (n=16, 50%) lived in community residences, nearly half (n=14, 43.8%) lived independently, whereas two resided with parents/relatives. The average age of interviewees was 47 years (SD = 11.4; min=25; max=68). More than half (18, 56.3%) were single, seven (21.9%) were married/cohabiting, and seven (21.9%) were separated/divorced/widowed. Over one third of participants (n=12, 37.5%) had children.

Slightly over one third of participants (n=13, 40.6%) were unemployed, whereas six (18.7%) were in mainstream employment. Less than one third (n=7, 21.9%) were in sheltered employment or training, three (9.4%) were retired, and three (9.4%) were homemakers.

The majority of interviewees (n=27, 84.4%) had access to free medical care (medical card) and were receiving state disability allowance (n=24, 75%). Out of six participants who had private medical insurance, one person had both a medical card and a private insurance.

Table 3.2 shows self-reported nature and length of recurrent mental health problems and use of mental health services and supports.

As can be seen from Table 3.2, half of participants (n=16) reported that their main diagnoses were mood disorders such as depression or bi-polar disorder; about one-third (n=10, 31.2%) had been primarily diagnosed with a schizophrenic illness including schizophrenia or schizoaffective disorder, whereas six (18.8%) reported unspecified anxiety disorders as their main diagnosis. In total, all participants reported having at least two different diagnoses they had been given overtime, with three persons reporting having been provided with three diagnoses and one person reporting four different diagnoses. The reported average experience with recurrent mental health problems was 20.2 years (SD = 13.2, min=2, max=54) (Table 3.2).

Table 3.2 Self-reported nature and duration of mental health problems, and use of mental health services, professionals and others supports by numbers and percentages of participants

<i>Primary diagnosis:</i>	Schizophrenic illness 10 (31.2%)	Mood disorder 16 (50.0%)	Anxiety disorder 6 (18.8%)
<i>Years of experience with recurrent mental health problems</i>	M = 20.3, median = 17.0, SD = 13.2, range 2 - 54		
<i>Current use of psychotropic medication</i>	Yes 24 (75.0%)	No 8 (25.0%)	
Use of mental health services, professionals and peer support groups ¹			
	In the last 12 months		Prior to the last 12 months
<i>Inpatient services</i>	11 (34.4%)		25 (78.1%)
<i>Outpatient services and professionals:</i>	28 (87.5%)		13 (40.6%)
Nurse	24 (75.0%)		21 (65.6%)
Day care	1 (3.1%)		2 (6.3%)
Day centre	23 (71.9%)		6 (18.8%)
Day hospital	0		3 (9.4%)
Psychiatrist	27 (84.4%)		32 (100%)
Psychologist	4 (12.5%)		6 (18.8%)
Psychotherapist	3 (9.4%)		1 (3.1%)
<i>Participation in peer support groups</i>	11 (34.4%)		14 (43.8%)

The majority of participants (n=24, 75%) reported use of some psychotropic medication in the last 12 months, with a quarter (n=8) not reporting use of such medication. All participants used services of psychiatrists in the past, with the majority (n=27, 84.4%) having been in contact with psychiatrists in the previous 12 months. Most of participants used services of nurses in the last 12 months (n=24, 75%), whereas 21 persons (65.6%) had also been in contact with nurses prior to that. The majority of the sample attended day centres in the last year (n=23, 71.9%), whereas six persons (18.8%) had also attended day centres prior to that. Nearly half of participants (n=14, 43.8%) had participated in peer support or advocacy groups prior to the last

¹ Numbers and percentages of participants reporting use of various services and supports are based on multiple responses of each participant. Therefore total numbers of participants reporting use of specific services and supports may exceed 32 (100%).

12 months, whereas over one third (n=11, 34.4%) were participating in such groups in the last 12 months. Other services and professionals ever used included day care, day hospitals, psychologists and psychotherapists. However the reported frequency of use of other services by participants was negligible compared to that of psychiatrists, nurses, day centres and peer support/advocacy groups (see Table 3.2).

In total, the majority of participants (n=29, 90.6%) had used some professional inpatient or outpatient mental health care at least once in their lifetime, with three having used only peer support/advocacy groups. Five participants did not use any professional support in the last 12 months, but participated in peer support/advocacy groups. Interestingly, no participants reported that they were dissatisfied or very dissatisfied with services and support provided to them throughout their experiences with recurrent mental health problems. In fact, the majority retrospectively reported that they were satisfied or very satisfied (n = 25, 78.1%), with seven persons (21.9%) reporting that they were neither dissatisfied nor satisfied. However the general satisfaction question did not distinguish between professional services or other available resources. The majority of the study participants were satisfied with the overall level of support which helped their improvement. After all, the inclusion criteria of the study were persons who considered themselves in improvement and wished to talk about recovery. The participants who were neither satisfied nor dissatisfied with services and support were unsure what role the external support played in their individual recovery.

The rest of this chapter will describe the theoretical findings of the study.

3.2 From disconnection to reconnection

The core category of recovery representing the main concern of the participants of this study was identified as becoming reconnected with life, through reconnecting with self, others and time. Prior to describing the core category and its subcategories, I will introduce the stage of disconnection from life as a symbolic starting point of the journey towards reconnection.

The stage of disconnection from life was associated with an awareness of participants that they were not moving on with their lives and were somehow different or distanced from others. It entailed realisation of being ‘disconnected from the whole’, ‘sitting at the side of people’, ‘being stuck’, or ‘being in a hole’. Participants felt that they lost a sense of purpose, started doubting their own judgement and abilities, and tried to ‘get to the root of the problems’ on their own, in isolation from other individuals:

But the next thing was an awareness that I was sitting at the side of people, people appeared to be talking about things that were plain and getting on with living and I felt

that I was somehow stuck at the side just looking, that was an awareness I was coming up with about myself...I didn't seem to function like them, in that ordinary way, I was inhibited or if you want, retarded or undeveloped in that area, it depends on how you want to put it. I was sitting at the side... (14).

Figure 3.1 below shows the state of disconnection from life which preceded the process of reconnection.

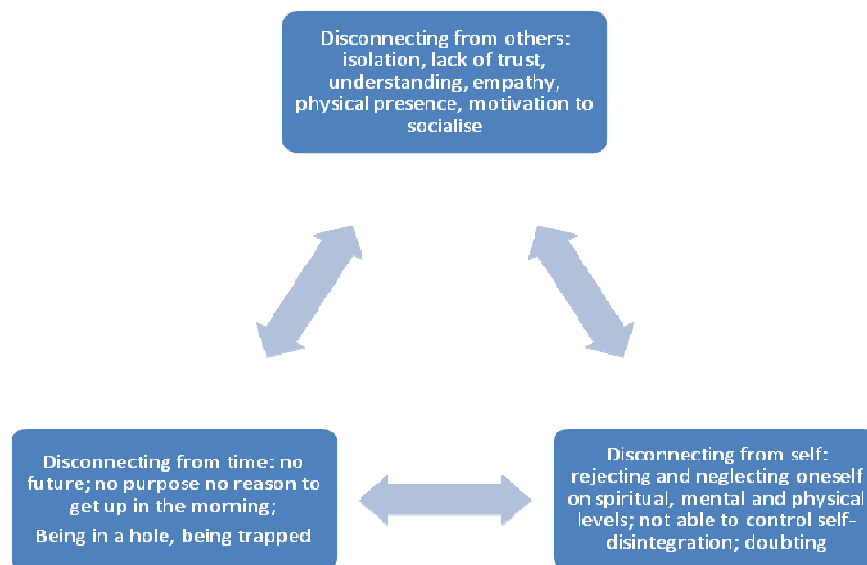


Figure 3.1 Disconnection from self, others and time

The lowest stage of disconnection from life, or being overwhelmed with distress, was characterised by the inability to face one's responsibilities, such as work, study or household duties; seeing no reason to get up in the morning, fear of people, going down the 'negative spiral' to the 'black hole' of emotional turmoil or the total absence of emotions. There was no sense of self, no hope for the future, and no others at the bottom of this nothingness. There was often no desire or energy to look after one's body physically:

You lie in the bed all day and you won't want to get up and you won't want to talk to anybody and you're so low, that no matter who talks to you, you won't want to talk to them. I've had so many people that said 'If you ever feel low like that and feel suicidal or anything, just please give me a ring'. But when you feel low you don't want to give anyone a ring. You are in a hole and you just want to be on your own, you don't want to talk to anyone, not your parents, family, friends. But em, you just want to sit there thinking of all the worst thoughts in the world (7).

I just felt numb. Just didn't care about anything anymore, didn't care how I looked and all, just didn't care (28).

Often it was emotionally and mentally unbearable for a person to face the 'here and now' due to loss of a significant other, physical injury, bullying or abuse, or stress at work. Alternative

realities of self, others or time could take over the reality of 'here and now'. Such alternative realities as voices, visions, feeling different from others, existing in a different time or a different place felt real to people and possibly served as a temporary protection from complete disconnection, loneliness, depression or emotional turmoil:

But what had happened in my life was, I had used a lot of strategies as a child to cope, but when you enter into adulthood those strategies don't work anymore... [Like what strategies had you used as a child?] Daydreaming... I mean really kind of taking myself away from situations and carrying that on in my everyday life. Just taking myself off my head basically, now when you get to the adult world you can't do that anymore you know, you have to be in the moment and you're going to be working and doing all these responsible things as an adult, you can't be taking yourself off (9).

What sticks in my head mostly is my husband passed a remark... that I was going to end up a lonely old woman on my own, and when I'm at home thinking about that, I've a habit of just leaning over the kitchen sink and staring out at the garden... Well the mind drifts, I mean you stare and your mind is empty sometimes, you're somewhere. That's the expression I use, you're somewhere else (18).

It may become difficult to fully control alternative realities, which can start living a life of their own and thus take over a person's life:

And then I was working on landscaping and building and I got sick, there were lads hammering floorboards and it started playing on my mind and I thought it was a woodpecker... And I got all jumbled up in my mind, I couldn't concentrate on my work and I was trying to do it too quick, and I was climbing ladders and trying to hold on to a bucket of cement climbing a ladder, and I was afraid of my life I'd fall because I wasn't thinking right, you know, things were playing on me, you know, the boss was playing on me and I was imagining things (31).

Inability to share or express one's thoughts or feelings due to fear of rejection, shame, and disconnection from others can lead to further disconnection, confusion and frustration:

We were out in [European country], my husband was going out there to work and everything seemed to be ok, there were no real problems with finances or relationship or anything at all... and after a few days I started to feel unwell, physically, just tired and wouldn't eat and... that went on for about a week or so. I didn't know at the time but... I was imaging things happening and that I was part of a big programme, and my husband used to go to work and I never said anything to him, I used to go around the shops and you know just imagine everything... I thought everything was real, so that's probably why I didn't say anything, you know my husband used to say occasionally, 'What are you saying those things for?', you know, he was very straight sort of a guy, didn't like too much stupid talk or anything, if things didn't make sense he'd say 'For goodness sake', you know (23).

Connection with others could be difficult and required an effort due to a lack of concentration or attention which was diverted inwards towards alternative reality rather than outwards in here and now:

I change as a person when I get sick alright. [How do you change?] You'd be talking to me and I couldn't answer you, my mind would be racing, thinking of something, and then I'd say 'Pardon, what's that?' and you'd have to repeat it slowly to me (31).

Participants felt disconnected from time and could not see the future:

I just couldn't think straight, I didn't know what the future held for me, you know (26).

Whereas physically persons can escape a dangerous or self-annihilating situation which happened in the past, they can still stay emotionally and spiritually 'trapped' in it. They may be still re-living the past, going in circles between the past and the present, and incapable of fully reconnecting with the future, until the past had been sufficiently explained, made sense of and left behind:

[Now anything else you'd like to tell me about your recovery?] Just my husband broke my nose a few times like that [...]. I got out of the house that night, that happened on a Saturday, and I got out of the house and went down to my sister's, so a doctor brought me over, he brought me over to my sister's and it happened a couple of times [...]. I left him and went up to [hostel] and I'm in [hostel] since. I was at home for a while, but when he started hitting me, I had to get out of the house, I just made me way getting out of the house, did not want to come back, I think it happened on a Saturday night (17).

The state of disconnection could persist for several days, months and even years. Participants got to a stage of extreme disconnection when they realised they could not go on like this anymore, they needed something changed in their life. However for various reasons they either could not understand what was wrong or were unable to make changes they were aware of. At the time of such crisis, they either sought help from mental health professionals themselves, or got professional help through other people such as family members or friends:

I mean I hadn't been really going anywhere very much for a long time, I didn't change the job which I felt I needed a change from, I didn't move that house, I didn't marry that lady... So maybe a couple of years later I began not to function. [What do you mean?] I was walking the streets and I wasn't going to work, I wasn't fit to... Obviously within me there was this feeling to move still, and I wasn't doing it, I wasn't able to... I felt I needed something in my life and I was looking for somebody to give it to me rather than making the move myself... I went to a [GP] practice... And the doctor immediately said 'Listen, you are not... How long have you not been working effectively?' and da da, and 'I'll make an appointment for you at the hospital'... and from there on there was a history of involvement with the services (14).

In the extreme cases, participants got professional help only after a suicide attempt:

At the time I was running several companies, I had family, I was involved in my rugby club, so I was running around very fast and doing a lot of things, and a number of my projects were taken from me by my business partners who were less than loyal I would say, and as a result of that I actually attempted to take my own life... I ended up in hospital, and they knew there was something more than just my physical injuries, and so they sent down a psychiatrist (8).

However in retrospect participants considered the state of extreme disconnection as a prelude to making changes and the beginning of reconnection with their life:

I knew something was wrong, I went to see a doctor, I took time off work and I lay in bed for, certainly two months, I couldn't get out of bed... Now that's years ago, now how I relate to recovery at that stage, I think there's, in my own experience, a lot of wisdom in 'breakdown to break through.' I know a lot of people relate to it, I can

remember actually saying to myself, 'I can't go on with this anymore'. And that's when I really took a dive. I probably lay in the house for about six months...I had a GP out plenty of times and there was all sorts of tests done on me...But it was really psychological, so it took me to say to myself, 'Right, this is a psychological thing, you'll have to see somebody who has an expertise in mental health'(9).

The next sections will present a brief overview of the core category and its three interactive subcategories.

3.3 Core category: reconnecting with life

The core category of recovering representing the main concern of the participants was a gradual self-induced progression from disconnection from to reconnection with life. This process had no final destination but represented a gradual strengthening of re-connection with one's life, sometimes involving repeated cycles of disconnection and reconnection.

And I joined GROW, I got some counselling and gradually I became more connected with myself and the world around me... Suddenly I was talking to people who I thought were far superior to me, and they would listen, and for the first time things began to change, so that you can see a pattern there. So, from a lack of connection to a connection (15).

The core category of reconnecting with life had three major overlapping and interdependent subcategories, or stages of reconnection: 1) reconnecting with self through accepting the self as a worthy human being capable of positive change; 2) reconnecting self with others through experiencing accepting, non-judgemental and validating connection; 3) reconnecting self with time with support from others, or re-establishing the flow and coherence of the past, present and future, and actively shaping and executing one's present and future by synchronising self and others in time.

From an empathic connection in the here and now, whereby a person felt accepted and validated as they were, came a glimpse of hope that a positive future was possible. After the decision to get better was made, persons felt that with support from others they were ready to start remembering the past and the associated emotions or fears in order to explain the meaning of such experiences, and to connect the fragments of self extended in time. The sense of coherence of the past, present and future was then gradually re-established and the persons felt more in control of their present and future. The persons were then ready to set up goals and to gradually execute them, which further contributed to their reconnection with life. Synchronising themselves with others in time through development of empathy and understanding, and giving back to others emerged as an important tool and goal of reconnecting with one's life. Reconnection with one's life became easier over time and with practice.

There is no final stage of reconnecting with life but a qualitative development of connections which allows the person to feel more ‘in tune’ with, and in control of one’s life, especially when experiencing negative setbacks or facing difficult tasks:

It’s about discovery, recovery is about discovering yourself, and for me it’s about being honest with yourself... I may well be recovered, if I’d got to certain stage, when the less I will panic when I come to a problem in my life, the less I will be distressed, and the more I feel in control, and think like, ‘I can handle this’... Once I do something about it and not just sit and worry about it... And sometimes, when I’m just going to play golf with a friend, it just takes away a lot of stuff, just by doing that, just being involved in something else, and being with somebody (9).

Figure 3.2 represents a horizontal one-dimensional cut-off view of reconnecting with life through reconnection of self, others and time.

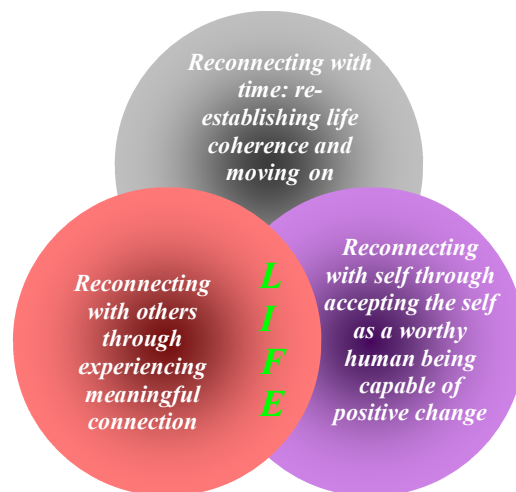


Figure 3.2 Reconnecting with life: reconnecting with self, others and time

The interactive subcategories of reconnection with life did not represent linear stages, but could occur simultaneously or in any order. Moreover, the stages of interaction also interacted with each other and ‘dispersed’ through each other. For example, reconnecting with self and others was sometimes triggered by reconnecting with time as in gaining hope for positive future, and so on. Whereas some participants reported that their reconnection with life started with reconnection with others such as mental health professionals or peers, others felt that their own hope and self-determination pulled them through the crisis and in turn helped their reconnection

with others and the moving time. Still others felt that some positive things from the past were feeding their hope for the future, and helped their reconnection with self and others and thus with life.

However despite some overlaps, the sequence of reconnections of self, others and time represented a coherent pattern, and progressed from reconnecting with self in here and now, to reconnecting self and others through experiencing meaningful connection, to further reconnection of self and others with own past, future and shared present time. The ideal stage of reconnection with life was synchronisation of self, others and time: being happy to be me today and feeling connected to others, by moving with time, and feeling happy about one's life:

[You were saying that you're probably a totally different person now?] Oh yeah. Well I'm back to what I was, but better than I was. [Better, how better?] Well to be having a life of my own is better, getting the house on my own is better, everything is better, everything that most people take for granted I now have, so it's like winning the lotto, going into [town] or [city], it's given me a sense, it's great happiness (23).

Though the elements of self, others and time were interactive and overlapping, for the ease of presentation I will first describe them cross-sectionally and separately, and then proceed to the detailed description of multidimensional longitudinal interactions of these three elements of reconnection with life identified in this study.

3.4 The three subcategories of the core category: reconnecting with self, others and time

Subcategories of the core category, and their underlying processes, specific tasks formulated by participants, and strategies used by participants to achieve these tasks will be presented in the next three sections.

3.4.1 Reconnecting with self

Reconnecting with self started with physical or bodily reconnection with the here and now. It entailed an awareness of being in own body in the place and time, reawakening of thoughts, emotions and perceptions, and an increase of energy. Reconnection, or resynchronisation with here and now was triggered by rest, sleep, medication, nutrition, or calming down. It could also be triggered by focussing on somebody funny, positive or calm.

Reconnecting with self spiritually was associated with the reawakening of hope for the future and the will to fight to get better. It included such concepts as motivation, intentionality, looking for meaning and purpose. Reconnecting with self spiritually also involved prayer, development of empathy, understanding, finding meaning and purpose in life.

Reconnection with self also involved making a conscious decision to get better. It entailed saying to oneself that one will get their life back and was ready to fight for it. It further involved sustaining such motivation and reminding oneself from time to time what one was fighting for.

Fighting to get better involved trying different activities and supports and choosing the ones that helped to stay connected with life and its interactive components of self, others and time:

- Reactivation of cognitive resources involved taking control of negative emotions by self-talk, talking to others, and activating cognitive resources such as memory, concentration and reasoning through talking, reading, studying, or writing. Medication was also viewed as helpful by some participants when it helped them to concentrate or ‘think clearer’.
- Reconnecting with self emotionally involved allowing oneself to feel, experience, explore, explain and eventually take control of one’s emotions. It included allowing oneself to experience both negative and positive emotions, such as fear, anxiety, anger, calm, joy, happiness, empathy and love. Medication was perceived as helpful if it allowed one to calm down, and take control of one’s emotions.
- Reconnecting with self physically entailed getting out of bed, walking, exercising, deep breathing, relaxation, improved nutrition and so on. Medication was reported as helpful when it was perceived as giving energy, improving coordination and in general made it easier to physically reconnect with life.

Table 3.3 below represents processes, strategies and tasks of reconnecting with self.

Table 3.3 Processes, tasks and strategies of reconnecting with self

Processes	Tasks	Strategies
Getting back to oneself in the here and now	Physical reconnection with self in here and now; awareness, focus, concentration	Getting sleep and rest, nutrition; taking medication; calming down
Seeing hope, will and way	Believing that positive change is possible; Developing one's self-determination and intrinsic motivation to get better; Making a decision to start fighting for reconnection with life	Imagining one's future life Finding reasons to get better Seeing oneself as a human being capable of positive change Comparing self to others
Fighting to get better: designing and executing own recovery	Telling oneself that one is going to get better Reconnecting with the past and linking it to the future Designing own recovery through trial and error Developing courage, patience and reflexivity Development of self-esteem, self-confidence; Activating and strengthening own cognitive, emotional, physical and spiritual resources ²	Talking, self-talk, reasoning, explaining, learning, doing things with others, taking medication, getting advice; exercising; getting positive and constructive feedback; strengthening memory, concentration, physical fitness

Reconnection with self involved getting back to oneself in here and now, reawakening of hope, will and self-determination to get better, and designing and executing one's own recovery, or fighting to get better. Activities helping reconnection with self were getting rest, deep breathing, exercises, studying, self-talk, talking to others and some others (see Table

² The *in vitro* concepts emotional, spiritual, cognitive and physical aspects of self emerged from the participants as 'feelings', 'thoughts', 'mind', 'body', and 'spirit, courage, will, fight' etc. *In vitro* labelling of these levels was explanatory rather than descriptive and was loosely applied to capture functional properties of these levels in the process of reconnecting with life.

3.4.2 Reconnecting self with others

The crucial stage of reconnection with life included experiencing meaningful connection with others, which led to further reconnecting with self and triggered reconnection with time.

Reconnecting with others was crucial for further reconnection with self and strengthening one's spiritual, cognitive, emotional and physical resources. The table below shows processes, strategies and tasks of reconnecting with others.

Table 3.4 Processes, tasks and strategies of reconnection with others

Processes	Tasks	Strategies
Experiencing meaningful connection: Feeling accepted and validated as a person and a human being capable of positive change	Encountering somebody friendly, funny and helpful Calming down Seeing oneself as a human being through another person's eyes Having a glimpse of hope through another person's eyes Getting positive energy	Focussing, looking, listening, relaxing, concentrating, speaking, expressing oneself to others
Synchronising self with others	Developing trust Opening up, releasing negative energy Developing understanding and empathy	Listening, talking, narrating, taking part in a dialogue, synchronising eye-contact, speech, body language; humour, joking
Futurising about giving back to others: re-establishing one's meaning and purpose	Becoming aware of a possibility to give back positive energy Developing self-esteem and self-confidence through getting feedback; Improving one's performance and communication skills	Doing something together; Getting positive, supportive and constructive feedback from others; giving back some positive energy to others

Reconnecting with others involved focusing on somebody positive, feeling accepted and validated as a person capable of positive change, getting involved in interaction and dialogue,

releasing negative energy of disconnection, developing empathy and understanding of others and self, giving back positive energy to others, and developing self-esteem and self-confidence through doing things and getting positive and constructive feedback.

3.4.3 Reconnecting self, others and time

An important stage of the core process of reconnection with life included reconnecting with time with accepting and encouraging support from others. It included processes of getting hope for the positive future, linking one's past to one's present and future and thus re-establishing coherence of one's life. A feeling of time coherence helped to plan and to actively execute one's present and future. Synchronising self and others in the present and future emerged from participants as one of the major tools and outcomes of successful reconnection with life.

Table 3.5 below represents processes, strategies and tasks of reconnecting with self, others and time.

Table 3.5 Processes, strategies and tasks of reconnection with time

Processes	Tasks	Strategies
Getting a glimpse of positive future (hope)	Becoming aware of a possibility of positive change Becoming aware of one's self-worth Making a decision to change for the better	Reinstating one's right to a positive future as a human being Starting to believe that positive change is possible
Coming to terms with the past	Re-establishing coherence and meaning of major events of one's past in the present and future	Remembering the past and narrating it to others; Making the connection of past experiences to the present; Setting goals for the future
Futurising and moving on	Futurising: planning and structuring short and long-term future Doing, changing: moving on Synchronising self, others, and time in the living present	Dialogue: synchronizing talking, listening, eye-contact, body language with others Doing things together with others: work, study, arts, dancing, singing, sports, socialising, etc Comparing self in the past with self in the present and image of self in the future Making decisions and following them through
Turning bad days into good days	Recognizing signs of disconnection and fighting for reconnection	Seeking help from services or peers Futurising, music, exercise, deep breathing, prayer, working, medication, synchronising self with others

Reconnecting self, others and time involved getting a glimpse of positive future, going back to the past and linking it to the present and future, futurising and moving on, and gradually learning how to turn bad days into good days. Activities helping reconnection with time were talking to others, music, exercise, deep breathing and some others (Table 3.5). The previous three sections presented the three subcategories with their underlying processes, strategies and tasks separately, as a cross-sectional cut-off view on these processes (Figure 3.2). However the

elements of self others and time were intertwined and their interactions formed a multidimensional longitudinal pattern. The next section will describe in detail the interactive multidimensional processes of reconnecting with self, others and time.

3.5 Interactive multidimensional processes of reconnecting self, others and time

The current section will describe in detail the interactive multidimensional processes of reconnecting with life through gradual reconnection with self, others and time. Facilitators and barriers to these processes will also be presented throughout the section.

Figure 3.3 illustrates a multidimensional longitudinal view of some of the processes of reconnecting with life, as a progressive, non-linear cyclical reconnection with self, others and time.

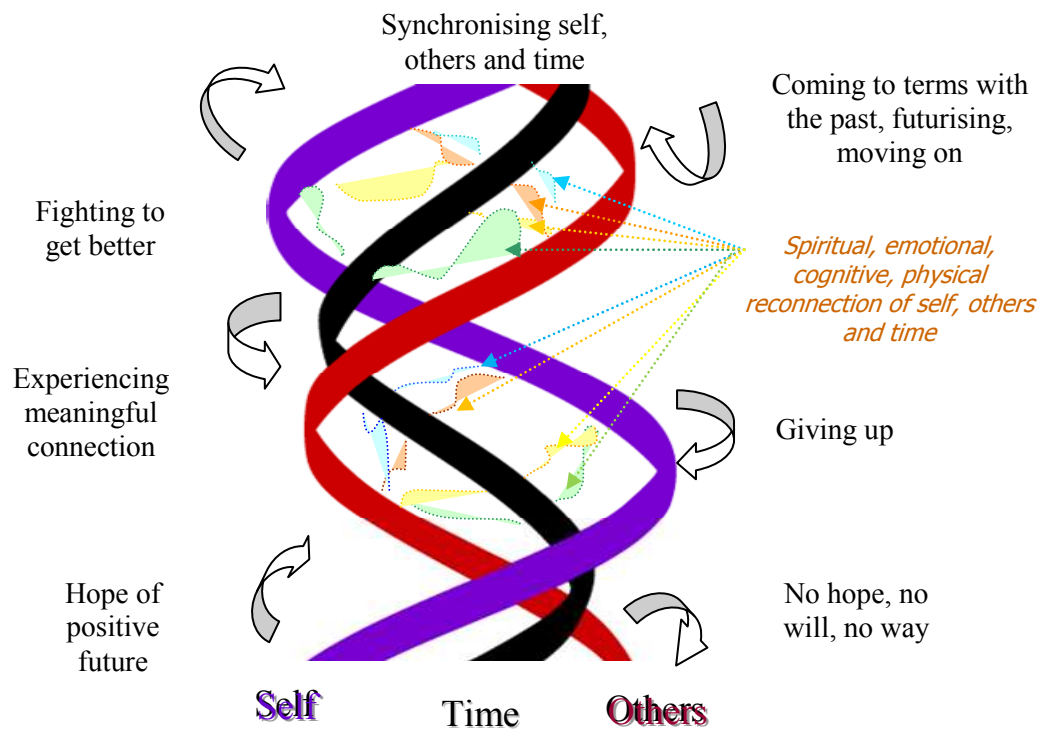


Figure 3.3 Multidimensional interactive processes of reconnecting with self, others and time

In total, eight non-linear processes resulting from the interaction between self, others and time were identified and will be described in detail in the next eight sections. These processes

included getting back to here and now, seeing hope, will and way, experiencing meaningful connection with others, coming to terms with the past, fighting for reconnection, synchronising self and others in the living present, futurising and moving on, and turning bad days into good days. Inherent within these processes were facilitators and barriers to reconnection of self, others and time.

3.5.1 Getting back to oneself: getting back to ‘here and now’

The initial re-connection with self for all participants of the current study started with getting back to oneself in ‘here and now’ and ‘clearing the fog’ of disconnection through medication, or admission to hospital. As the fog of ‘nothingness’ was partially cleared, cognitive and emotional functioning began to improve slowly:

[What does recovery mean to you, what would it mean for you to be recovered?] Starting to feel better, maybe be able to, I’m not sure, I was going to say to think clearer, I’m not sure that is true. To think clearer (30).

Hospital provided safety, rest and regular meals which contributed to physical reconnection with self. Physical presence of others could also help to start breaking complete disconnection from others and therefore getting back to here and now:

Well the good things that you were fed, you know I didn’t have to worry about getting a meal for myself, which I am capable of doing anyway but I got balanced food, that’s on the plus side, and it was handed to me three times a day... There’s a certain breaking of isolation, a certain amount, a breaking of isolation of being in there, I was not on my own (14)

Getting away from stress or hostility of previous experiences and getting rest helped persons to reconnect with self emotionally.

Well they [doctors] had a civil tongue in their head, put it that way, I wasn’t dealing with confrontation, night, noon and morning like in my job, so it was kind of, it was a good feeling (26).

Medication could also help to calm down, relax and ‘clear one’s head’, and reconnect with self emotionally and cognitively:

Ah sure I’ve had psychosis twice, I had psychosis 5 years ago and it was terrible, it was ... accusing other people of different things, the doctors and other people, all people, I thought everyone was involved. Everybody was guilty. But when I got the tablets it took it away from me, I spent 10 weeks, 10 weeks here in [name] ward and the tablets, I was on them for 10 weeks for it to clear away from me (25).

I was put on quite a lot of medication, you know anti-depressants and tranquilisers and sleeping tablets... [So were the tablets helpful?] They were really. I think there is a place for medication... the anti-depressants did lift my mood a little bit. And the tranquilisers cut the edge off the severe panic I was having, and the anxiety (10).

However overmedication or heavy side-effects of medication could contribute to further disconnection with self, either physically or spiritually:

I personally think when you come into hospital you have severe symptoms, they give you a really high dose of medication so you get rid of symptoms, but when the medication goes to your brain it doesn't only hit the part of the brain that's damaged, it hits the whole brain. And I feel it takes the whole brain out and it almost, I used to call it, it numbs your brain, the fact that you are zonked out. You are like a zombie and your personality goes and your confidence goes, and you've no energy and you put on weight and all them symptoms. That's how you get worse (7).

Reduction or change of medication sometimes helped to reconnect with self cognitively, physically and spiritually:

And then as you get more energy back and the medication is lowered you start coming back to yourself a bit more. That's what happened to me like, the lower the medication went, the better I got. The more energy I had and the more I got back into my hobbies and activities. Then I got back to my old self... So medication halved, that was the big turning point for me. Eventually it came back, the personality came back slowly, and the confidence came back, and I got back into my sports activities and got back into society and get back to socialising over the space of the next few years (7).

I was on anti-psychotics for years and they weren't good but they tried me with one in '97. And it worked, in the sense that it let me, I relaxed a lot more, my head became a lot clearer, so it was that which kind of started a recovery as such... I think it [medication] helped me in the sense that it, if I take this Olanzapine stuff, I take 20 milligrams of it, or if I take it at night, I wake up in the morning refreshed, I mean I can start the day from square one, I don't have to start it with a hangover, not an alcohol hangover but a kind of, the problems of yesterday (15).

Getting back to the here and now was sometimes triggered by re-focussing on somebody that was accepting, helpful, positive, familiar, or funny. It entailed having a glimpse of outside life, and thus getting out of the 'hole' of disconnected alternative reality. Focussing on somebody perceived as accepting and helpful switched attention to the reality of here and now and led to awareness that it was not the end of the world and that there was life out there:

[What advice would you give to somebody who is experiencing mental health problems similar to yours?] ...Just bear with it you know, bear with it and relax... It's not the end of the world, you know, ask for help because you'll get it, and listen, listen is the key word, you know, it's the key thing, listen to what's going on, even if you don't take it in, just try and listen, try and focus on what people are saying (1).

Reconnection with others could be established through talking, body language, and eye-contact. Such instant connection, or instant 'click' could lift one's mood and provide a source of 'positive energy':

But eh, sometimes if you are having a bad day as in like you are not in good form or just a bit low, or you are paranoid, you might change if you are out in public and somebody you really get on with really sparks a bit of life into you. Somebody who you really click with. And somebody that you can bounce off and have a bit of fun with will cheer you up. Somebody that's funny. Like one guy, he was in hospital with me, and he used to cheer me up in hospital and try to make me laugh and stuff like that even though

I was in a catatonic state, I was barely blinking... I was in a zombie-like state, and he'd still get half a smile out of me... I do believe that laughter is the best medicine, you know, at times (7).

It was seen as very important to express one's feelings to somebody or to the outside world, be it by talking, texting, self-talk, writing, arts, or prayer. Expressing one's feelings and doubts and getting a response from somewhere helped to get rid of some 'negative energy':

I would say what can help is to express it, express where you are, whatever it is that is sort of worrying you and what is in your mind, you know, and try to get a response from somewhere on it, you know that gives one understanding and insight, that helps, that would be my friendly advice. One can be in a condition where it can be difficult to actually take advice, so where advice can be useful but it is not necessarily advice but an interaction in some way, either within oneself or with others (14).

The process of getting back to oneself entailed reconnecting with physical, cognitive or emotional self in the present here and now, through medication, a possibility to rest, nutrition safety, and partial break of disconnection from others. Focussing on somebody positive, non-judgemental and accepting was reported as helping to escape alternative realities, and refocus on the 'here and now'.

3.5.2 Hope, will, and way: giving up, or fighting?

3.5.2.1 Hope, will and way

After reconnection with self in here and now, persons faced two visions of their future life: as hopeful, active, and enjoyable, whereby reconnection was seen as possible and desirable, and as hopeless, passive, and meaningless, whereby active reconnection was viewed as impossible, undesirable, or both. The vision of the future was crucial for shaping their decision of to either give up on their future, or start a 'fight' for their reconnection with life. It is very difficult to push oneself to reconnect with life which has no meaning, if there are no future goals and no others in it:

Basically one has to have something to get up for, life is, if you want to put a term on it, meaningless or relatively meaningless, it's going to be hard to get up and engage with life that is not full or relatively full... You know with older people that may be more of an issue, if they don't have a job or if they don't have any family around them what have they to get up for (14).

Those who had hope for the positive future, who believed that reconnection with life was possible, and had some reason to fight, made a conscious decision to fight for it and took upon themselves a responsibility for this fight. For those who did not see a positive future, did not believe that reconnection with life was possible, and did not see a convincing reason for fighting, giving up on recovery could have been the only option.

[What would it mean for you to be recovered?] In a flat looking after myself. Or sharing with my ex-girlfriend, that would be quite pleasant. [What about your girlfriend, does

she visit you?'] Yes she had visited me but eh... I don't write to her. And she would like to write, so there's a bit of breakdown...I'm a bit sensitive to the relationship in that em...this is where I am. And she naturally would rather something a bit better. To put it a bit bluntly... [And so, what is your message about recovery? Is it possible?'] Yes it's possible...given fairly ideal circumstances, so maybe it's not possible if it is a fantasy (24).

Without downplaying the role of others, participants felt that self-determination played a major role in their reconnection with life. The decision to start fighting to get better had to come from within the self, through reconnection with a positive vision of the future and realising the need for change. Non-judgemental support was important at this time, but the 'push' had to come from within the person:

But definitely, if you're not going to fight, nobody, nobody can do it for you, absolutely not, but every little bit helps, you know really just a little bit of support here and there really helps you know (23).

Some persons recalled that they had always had hope that their life could get better, whereas others needed to get reassurance that one was worthy of reconnection with life:

I suppose, I've always held a lot of hope that things would get better, you know (9).

The first improvement, I come here. To the day centre. I was talking to [peer name] and nurse. It's nice to know what you're around for, that you're not a burden on anyone or anything like that (16).

3.5.2.2 *Fighting to get better*

Fighting entailed an active, on-going, day-to-day, substantial, and risky effort. To make a decision to fight, one had to believe that reconnection with life was possible, and to find a strong motivation, or reason to begin and sustain the fight. Quite often one had to reassess what was there in life which would justify fighting for reconnection with it. For example, a presence of children or significant others in one's life contributed to the decision to start their 'fight' to get better:

I mean every day you have to fight, you're fighting one thing or another, but if you lose the battle, you know, depression can take over your life. It can totally ruin you, if you let it, but find something in your life that you want to fight for, and it helps a great deal. I fought for my children, my grandchildren (6).

The will to fight could be triggered by a realisation that life could be better than it had been before, just because a person was a living human being capable of positive change and doing things:

[Why would people want to fight to get better?'] Because they feel their life would be different, if they got better... Because eh, we're all human beings, you know, and we all have kind of, we should be grateful for what we have, that we can walk, we can talk, we can run, go out and do things (12).

Fighting entails taking responsibility for one's own recovery, and constantly sustaining one's own motivation to fight:

Oh you have to be very motivated to recover, you have to motivate yourself, you have to say to yourself, you have to have a lot of willpower, you have to say to yourself, 'Now I'm going to get better, I'm going to evolve, I'm going to get better', you know (5).

Now one of the things which did go through my head when I was telling myself to get out of bed is you know, this is something that I can only do, no one else can do this for me, I have to do it for myself (9).

The decision and motivation to get better could be also triggered by seeing other people getting better, listening to the radio or surfing the internet, talking to friends, relatives or other patients at conferences:

Sometimes I've seen, maybe at a conference, someone else speaks and all of a sudden it triggers someone else, it's kind of inspirational in fact sometimes, and it's actually quite positive, so you've used hospitals and we're in hospital now, and you haven't got that problem and you're out doing things, and maybe I could be doing that, or maybe life could be better for me instead of just resigning myself to this... (9).

I think the statistics on recovery should be published...and if more people saw them, it would give them hope, particularly people that are thinking about suicide (4).

Reading information on the Internet also helped to accept and validate your experiences, realise you were not the only one, which added to the positive view of the future and staying in control of here and now at the time of temporary disconnection:

I only realised a long time after that that I started hearing voices. I didn't know at the time what they were, they were real, very real to me at the time... The second time it was seven years on, and I had read up on it and it didn't scare me. It didn't scare me because I knew what they were, and I knew they weren't real, and no matter how weird things got, I didn't let it get to me. I just figured out these voices weren't real... [How did you figure out they were not real?] Well I looked up my illness on the internet, I had seen it in black and white, the ins and outs of my illness, and I did say to myself, 'Well look at all these other stories, other people have what I have, and I'm not the only one'. So for instance, I read about a guy who thought cameras were watching him. I said, Jesus I thought cameras were watching me as well. So the next time it happened, I thought about it, I was going through something similar, and you get a lot out of that (7).

Sometimes through comparison of themselves with other people who 'gave up' persons realised they did not want to be like them and developed their own motivation to get better:

Within a couple of days I was sent to [hospital name] and while I was there, spent the first couple of weeks not really knowing where I was and very deeply depressed, and then I started to realise that there were a lot of patients within the hospital, certainly within the ward that I was in, who did not want to get better, they were waiting for the pills to do that, and I knew pretty quickly that the only way for me to recover was for me number one to want to, so that was my first step. I saw other people who didn't want to recover and I didn't want to be like them (8).

3.5.2.3 Giving up: no hope, no will, no way

Giving up was associated with a lack of hope for the positive future, accepting the identity of a mental patient, and handing over control of one's life to medication, service providers, or carers.

In some cases, giving up was seen as an easier and more acceptable option in their life circumstances. A lack of belief in the positive future damaged motivation to engage in an active effort to reconnect with life.

Though only one participant of this study identified himself as the closest to 'giving up' on reconnection with life, the concept of giving up was relevant to all participants. Some recalled period when they had given up, or knew other people who had given up. The ultimate form of 'giving up' was mentioned as suicide:

[So have you seen people who gave up?] Well I know some people who've given up, committed suicide. And I have, yes, I've seen people giving up. [And how do you know that they gave up?] Well they resigned themselves to having mental health problems for the rest of their lives, they resigned themselves to using mental health services for the rest of their lives, and they can't seem to see outside of that, for whatever reason. So they've lost the struggle, lost the fight in some sense, you know. It's not to say they will not get it back or whatever, but at that point they seem to have given up or something (9).

In the absence of connection hope for the future, some people may accept alternative identity of a mental patient for life and 'give up' their struggle to reconnect. The process of connection is handed over to mental health professionals who create and organise your reality. There is no pressure in a hospital to manage your day, there is no reason to get up as you don't have to do any household duties or other responsibilities:

You know because it's so easy to go in the hospital, and you're kind of, you give up, you're there lying in bed, you get your meals handed to you, you know, you can go to bed when you like, you can get up when you like, and it's so easy to just say 'That's it, I am finished' (6).

The option of 'giving up' was often inadvertently supported by the pessimism of diagnosis and prognosis, a hopeless and impersonal stance of service-providers, and the biomedical system of service provision as a whole. Persons who had experience with in-patient units felt that while hospital environment provided some space for initial reconnection with self in 'here and now' and resynchronisation with time, their prolonged use interfered with further reconnection with life. It was very easy to lose hope and give up on your life when you stay too long in hospital environment:

But definitely, keep from long-term in the hospital, you know. [And what happens if you stay too long in the hospital?] Well you begin to get kind of... you want to stay there, just don't see any other way, you know, just stay there (5).

You feel better in yourself and you should be outside. That's the idea of hospitals (32).

Being given a diagnosis of a chronic mental illness with no hope for recovery made it difficult if not impossible to accept oneself as a worthy human being capable of positive change:

Well I was diagnosed with paranoid schizophrenia which is quite a frightening diagnosis for a young fellow to have on his shoulder... And I felt I was a reject, I was rejected from family, friends, the whole world and somehow, you know, distanced from the whole... And with this diagnosis they don't offer, they didn't offer me any hope, they didn't say you can do this and you'll be alright. Nothing really, they said 'medication' (15).

Schizophrenia, that's what I suffer from. And they said 'It's a lifelong disease'. And I don't like that... I'd like to be fully recovered, that's why I don't like the idea that this is a life time (4).

If self was accepted as something negative, static, and disconnected from others, reconnection with self and others was seen as impossible, and giving up could not turn into fighting:

I think it's just...the personality I was given at birth. I can't relate to other people. And I have a rather negative personality. [And how do you feel about that?] Well there's nothing I can do about it. I mean it's not a thing you say to a doctor, you can't have a pill for talking. [And why can't you say it to your doctor?] Because it's only a, eh...my problem. A doctor can't help me really. [Some previous people told me that it's important to fight for your recovery, not to give up...] Yes...I would say I'm the nearest to it [giving up], of the people I know. The others are coping well with their own problems (24).

Once you 'give up' on life and accept the identity of a mental patient, there is very little chance of reconnection with self as you start to identify yourself with your diagnosis and do not trust your own thoughts and perceptions of reality:

If you look at yourself as an illness or as someone who suffers from an illness, you feel that your thoughts are somehow wrong, you attach a value judgement to your thoughts... You judge yourself by your thinking processes, that they're wrong (15)

In some cases persons became dependent on medication and could not find courage to reconnect with life without it. Handing over control to medication when facing stressful situations prevented starting an active 'fight' to fully reconnect with life:

I did become very dependent on the tranquilisers. Yeah, I did, and I needed them, you know, for every small task I had to do, and I continued on for another few years in that state, it was like being in a fog [laughed] you know, I was just about getting through life (10).

Fighting for reconnection may look too challenging for some people. It requires strong will for self-induced change, which has to be sustained by a lot of courage and patience:

[How do you know that people 'gave up'?] It's like as if they want to stay where they are... [Why would they want to stay where they are?] Ah, because, like, it takes time, you know, you have to give yourself time, and you have to have patience too as well, and you have to have courage, and character, and all that (12).

Benefits of 'giving up' on life and staying on medication or in hospital permanently may outweigh the disadvantages, as there is always a fear of having a relapse or becoming homeless:

I've had it for many years. And I'm on disability allowance and now I'm on old age pension... Well I think I've always been schizophrenic, I was born like that, it's in the blood line... Well I managed to get a degree and I went teaching... So I really was in good order when I was a teacher, so I wasn't actually diagnosed until a few years ago. I have been here [in hostel] more than two years... I'm really grateful to them in a sense that if I wasn't here I might be in the gutter (24).

Old age and lack of concentration made it hard to start the 'fight' for reconnecting with life outside hospital:

I think I'll still be in the hospital because I can't afford a house, and I haven't the concentration for work, and I'm sixty-one anyway (2).

Deprived, stagnant environment could affect motivation and belief that positive change was possible:

But I also know that other people live in run down areas, and all you can see around you... are unemployed and deprived and all the rest, it's certainly not a nice place to recover, and you know, it must be very hard for people. And I suppose in my own recovery, my environment has changed from kind of very deprived upbringing to where I am now, pretty affluent area where I live now, not that I'm rich, but I kind of departed from that stagnant, depressed, deprived environment, which would only kind of keep you in your place sometimes (9).

Making somebody do something against their will was referred to among the most difficult experiences which could affect one's motivation to reconnect with life:

[What was the most difficult period of your experience?] I think when I was in [hospital], I was up on a ward and I wasn't eating at the time and they made me eat, put my hand behind my back and... I'll always remember that (19).

If a person has not made their own decision to get better, trying to talk somebody into their own recovery could sound judgemental and condescending, like 'pull up your socks' or 'pull yourself together':

I remember one time I went to facilitate a group in a day hospital in a psychiatric unit... and started talking to them about recovery, and one of the ladies in the group in about ten minutes started screaming at me and shouting at me, 'And you think you can come here, talk to us and we get all fixed, and we'll all be recovered?' and the nurse had to take her out... And in fact it was an affront to her, because she thought, it's like saying 'Well why haven't you', you know, 'I'm going to teach you about recovery' (9).

After getting back to oneself in the here and now, participants projected themselves in the future. Depending on the vision of the future and the development of hope and will to get better, participants made a decision to either start fighting for reconnection, or to give up on such fight. Fighting could be triggered by the belief that a positive change was possible and one deserved a better life in the future. Sometimes hope could appear and persist despite and against the negative vision of the future presented by others or witnessed in others. Hope and will to

reconnect with the future could also be fostered through meaningful connection with others described in the next section.

3.5.3 Experiencing meaningful connection with others

Getting a glimpse of hope for the future, a will to reconnect with life, and the decision to get better described in the previous section was often achieved or further facilitated through meaningful, spiritual and empathic connection with others. Meaningful connection entailed feeling accepted and validated in here and now, instilling hope for positive future, and sharing some past experiences. Such connection could develop instantly through relatedness of feelings and thoughts, or gradually through talking, discovering a common ground, and developing trust in the other person.

Feeling accepted and validated as a person and not as somebody ‘strange’ or ‘nuts’ helped to instantly establish trust in helpfulness of others and reawakened hope that one was capable of positive change:

I was terrified to sit down, because I was afraid that I’d fall off the chair, because I was so nervous going in. The first impression of [peer support group] was, they don’t think I’m mental, you know, they don’t think I’m nuts, they said ‘Yeah, no problem, of course you can sit on the floor’. So I think the first thing that hit me was, here’s people who accept me for where I am, who I am, they don’t really care whether I want to stand on me head, once I’m here, and they’re going to help me, you know (11).

Trust stemmed from feeling that you were accepted, understood, and being listened to.

Continuity of meaningful connection with a person also helped to develop trust:

I talked to Dr. [name], now he is fabulous, I could trust him, trust is very important, do you know what I mean... [And how do you know you can trust a person?] I don’t know really, how can I trust them, because you probably get to know them. I used to meet Dr. [name] every month, every six weeks. He just listened I suppose, he didn’t really do anything much, he just listened, which is important enough (26).

Finding about some shared experience or background through talking helped to develop spiritual connection and trust with others. There is an element of recognition of self and own feelings or thoughts in another person, which makes you feel not alone, makes you feel supported and being accepted as part of a bigger life:

One nurse in particular who happened to share a background in philosophy with me, as I realised when we were talking, helped me a lot, and every time I was really down she would know it by looking at me, and she would make a point of stopping and saying ‘I’ll be up to you in twenty minutes’, and in twenty minutes she would come up and she might only spend ten or fifteen minutes with me, but it would be very useful in helping me to calm down, to avoid the negative spiral, to avoid all the doubts and the darkness, and so she helped me greatly (8).

Reconnecting with somebody made persons feel that they were not alone, that there were other people like them out there:

Going to [peer support group], what it's done for me is realising that I wasn't out there alone, that I wasn't the only person, you know, with mental health problems (13).

I enjoy coming here [day centre]. A bit of company and a bit of independence... then I meet other people who are not well or sick or whatever. Whatever problems they have, I'm not the only one that comes here so... (3).

Talking to other people who were non-judgemental and whom one could trust helped to verify own reality against others', and therefore define the boundary between the reality of here and now, and the alternative reality. First and foremost, somebody had to validate the experiences as real and to believe what the person was saying. After that it was possible to start questioning the reality of these experiences in here and now:

The [peer support] group can say 'No, you did hear voices, you did see things, but they're not real', and they believe the group, because they trust the group at that stage, it's trust, the friendship and the trust, you know. Like people, who have even recovered from schizophrenia, telling another person who is suffering with schizophrenia, 'I know you think you heard that voice, but it isn't real' (11).

A positive future often became visible through a meaningful connection with others who were caring and hopeful. Persons could get a glimpse of a positive future through the eyes of others:

I signed myself in, as far as I can remember, and I was just totally destroyed, I couldn't think straight, I didn't know what the future held for me you know... They just they sent me for a couple of tests, I can't remember which it was, but it was alright... I talked to Dr. [name], now he is fabulous, he said, I was ok, I'm going to live (26).

Compassion and non-judgement, believing in persons even when they did not believe in themselves, wanting to help, or to help a person to help oneself fostered hope and fighting spirit and further reconnection with life:

There's a huge element of trust and compassion and no judgement and non-direction, you know that was the most important part for me, believing in somebody else that they had the power to recover themselves (8).

They [peer support group] started to invite me out on their social occasions, which I found extremely difficult to do, because of the shyness, and the symptoms, but I went anyway, and I did every task they gave me, because I've got to believe in something, even if I felt absolutely dreadful, which I did, just going, you see when you're in [peer support group], they believe in you twice, you know (11).

Environment was described first and foremost in terms of people and their friendliness rather than buildings and facilities. The main characteristics of good environment were friendliness, acceptance, joyfulness, and positive energy which facilitated reconnection with others and with life in general.

[Do you think environment is important for recovery?] I think so. Good environment. Feel good in [hostel]. Because the nurses are good and the people are good. People yeah (16).

[What's a good environment?] Friendliness. Yeah, like a lot of people on the streets of [town name] say hello to you. A lot of people in [another town's name] wouldn't say hello. They're not friendly. (19).

Acceptance, empathy and joyfulness facilitated open interaction and were viewed as major qualities of good environment:

What I liked about it [peer support group] was an underlying joyfulness, even though people were dealing with, you know, very profound issues, everybody was obviously there for a reason, but beneath it there was an underlying joyfulness, which I know was there beneath all the sorrow, and it seemed to be alive in that setting. People were listening to each other, taking each other seriously etc, and there was a form of community which everybody looks for, sort of a gathering of people that could have some interaction (14).

Good-natured, open persons were perceived as providing positive energy which was somehow contagious and helped reconnection with self and others:

You need happy people, you need positive people, you need optimism, all those sorts of things, say if you're going out for an evening and you want to enjoy yourself, to be happy, you don't go and sit with a load of sad people, you go and sit with a load of happy people (23).

Empathic, warm, caring interaction sometimes combined with humour, brought feelings of calm, warmth and happiness:

He's nice [psychiatrist], he's really nice, he's real calm, calms you down, you know. Sometimes he has a laugh with you. [And is it good to have a laugh?] It's good, yeah. Because I feel happy inside (28).

Establishing meaningful, spiritual connection was often challenging in in-patient facilities. Being in hospital was described as a lonely experience due to a lack of 'normal' human interaction either between service providers and service users, or between service users themselves.

It was the loneliest experience of my life. Because while one was with people, maybe it was people's inability to communicate or because they're numbed down on medication and one doesn't have a normal communication with the staff, except they may express concern for you and they may inquire whether you've slept, whether you've eaten, whether your bowels have moved, you know, but they're observing you very largely (14).

I always have the impression that they [nurses] treat you as an illness rather than a person. Like, you are schizophrenic, we are going to give you this, this and that, you take them all and see if it works. You are a manic depressive, take this, this, just like I gave the last manic depressive, and see if it works for you. I know they are not psychologists and not counsellors, not there to listen as such, but at the same time I'd like to be treated like a person and not just like a guinea pig, like a guinea pig that you just throw pills into (7).

Judging by the narratives, it was not easy to find doctors who would listen or engage in a dialogue, or interaction. Some psychiatrists assumed they already knew what the problem was and preferred to talk themselves rather than to listen to others, which made meaningful connection impossible:

[And what people you would talk to and what people you wouldn't?] Well the doctor wouldn't let you talk to him, he wants to talk on, he wouldn't listen to me, will turn his back on you and walk away and say he'll see you (31).

So I went to a psychiatrist Yulia, I paid two hundred and fifty euro for one hour, and I actually came out of that room far worse than I went in. [How come?] Well I went in, and the first thing she says to me is 'Have I met you before?' I said 'No,' and then she says 'What's your problem?' So I described what I had put up with for the last two years [bullying at work], and she kind of, rather than listening and asking questions about it, she started to tell me about the consequences of going down the litigation route... meaning like having a GP report in litigation is good, but to have a psychiatrist report would be more helpful to my case... I was absolutely shattered, I just sat there in disbelief that I was being given this kind of lecture... So for about an hour I just sat there and just listened. I actually came out of the room absolutely feeling destroyed, I felt I was like a child in a classroom, she followed me out of the room, I wrote the cheque, she never asked me was I pleased with the meeting? She never suggested or asked was I returning for another counselling session, or? (13).

In the fear of either being judged, or being diagnosed with incurable illness with no hope for recovery, people sometimes limited their communication and sharing of thoughts and feelings, and decided not to disclose one's experiences such as hearing voices, sexual and physical abuse and so on. Some of the risks associated with the disclosure of feelings and experiences were being heavily medicated, extended hospitalisation, being perceived like 'a freak', and being judged of the 'rightness' of one's own ideas and experiences:

Yeah there was care, genuine care, but initially they asked me a question which I was afraid to answer, you know the usual questions about, do you think you have special powers, are you hearing voices all that sort of thing, and I was afraid to answer those questions... Because part of the religious tradition that I was in was dialogue, part of the Christian tradition is the internal dialogue with the voices... I looked and I bowed my head and I said no, I denied the reality of the experiences I had gone through, and I denied it because I was afraid, because of the way it was said and the implication behind admitting it, I was going to receive some sort of treatment to get rid of it, those ideas... If you hesitate on that one, immediately you're on tablets (14).

When faced with formal, cold or impersonal attitudes, persons can completely 'shut down' and refused to communicate with service providers whom they did not trust:

You have to trust the doctors. When I first started, I really didn't trust her [psychiatrist] at all, so I didn't tell her anything. [Why didn't you trust her?] Because she was very rude, she didn't say 'How are you?', she'd say 'Now what's the mood like?' and I thought 'I'm not telling you anything', she shut me down, she stopped me from talking. Then I saw Dr. [name] and he'd say 'Are you anxious?' or 'Are you down?' but nobody, nobody once said to me 'What are you thinking about [name]?', it was all mood, high, low, like a robot, you know (23).

Constant change of service providers also made meaningful connection and development of trust difficult:

You see, the doctors change all the time, registrars change all the time, the consultant stays the same, but the trainee doctors come here, you know, and they don't really know much about you, they change around your tablets, that's all they do (19).

Stigma was perceived as preventing reconnection with a broader community. It required a lot of confidence and effort on the part of service users to resist the 'negative energy' caused by negative views on persons with mental health problems:

I think I'd socialize a bit more than normal people, just a bit more, but the trouble is you see in society whether we like it or not if you've a mental illness there is a lot of stuff about you... I mean the only reason I'm doing so well is because I don't give a damn what they think, and I behave proper when I'm out, I don't do anything strange or, I have a good name so everybody is very nice (23).

Some participants commented that overmedication and medication side-effects can make people look 'strange', which could lead to negative stereotypes and fosters disconnection of recovering persons from others in the community:

And I don't like the side effects of the medications... they're the only reason why people do look like they have mental illnesses, because they are pale, they put on weight, their eyes are zonked out, they are sitting around, they are not walking like, their speech is slurred (7).

But you see you have to realise that people are on tranquilizers, right, and sometimes people try their best but they forget, they're not as you'd say perked up, they might forget about what they've just been told (1).

Hostility and badmouthing can bring some 'negative energy' and could lead to emotional and spiritual disconnection from others, and in extreme cases, to aggression and further readmissions:

[What can turn a good day into a bad day?] If I got the idea that someone had said something about me, like that would put a bit of a downer on myself for an hour or two. I might let it play on my mind and just keep thinking about it. Yeah, even for instance I was going to work on the bus one morning and a guy I went to school with for five or six years and got on really well with, I was talking to him in general about work, and next thing out of the blue he says 'You're the schizo of the road, aren't you?' And you know schizo is the derogatory of schizophrenic, it's a horrible name, I hate that word, and I just said 'Excuse me'? And he said 'Ah I'm only messing.' I didn't even have the confidence to challenge him on it, you know, that put me on a downer for that day. Stuff like that, people bad mouthing you like (7).

I know what motivates people to get sick. People talking about them, and slugging them and calling them names. Then they get it into their heads that there's something wrong with them, you know what I mean, there's some bad people out there you know. What got me sick this time as well was a fellow bad mouthing me, he called me a paedophile. [Did he?] He did, and we had a row. He was a big fellow from [suburban town], I was in the pub and he called me a paedophile, which there's no truth in it, and I caught him by the throat and then [the fight] was broken up, he was a lucky man because I get

terrible if I get vexed. Well I think that triggered it off, triggered me getting sick, that row I had, I got sick after that (31).

Meaningful connection was experienced with somebody who reached out to the spiritual and other levels of self, accepted and validated a person in the here and now and believed in the positive future of the individual. Such connection could be triggered by accepting, calming, and friendly body language, listening, talking, eye-contact, sharing similar experiences or gradual development of trust. It led to or strengthened acceptance of self as a worthy human being capable of positive future, and helped the development of motivation to change and strengthening of the fighting spirit.

3.5.4 Coming to terms with the past

After getting a glimpse of positive future, making a decision to get better, and experiencing a meaningful connection with others a person feels the need to face the past, to explain what went wrong with the past, to come to terms with the past, to verify oneself against the past and to take responsibility for one's future life. Coming to terms with the past was essential for the process of active fighting for reconnection with the present and future life:

It was about facing myself, facing my own fears and, you know, moving from that kind of helpless child who took himself off in his head and really didn't take much responsibility for himself, to somebody who maybe would eventually take responsibility by facing his past, you know, so that was my kind of major advancement in recovery up to that point (9).

It is impossible to completely eliminate one's memories or experiences. In fact, they are a part of a person, and would always be there, even despite heavy medication or ECT:

I didn't mind getting it [ECT], if it was going to make me better, like I don't have a fear of the ECT. It doesn't do anything, except for the first hour when I wake up, I feel great, I can't remember anything and I feel great, and then it all comes tumbling back (2).

What we can't do is eradicate people's experiences, so you know these experiences to some extent will be with me, and I suppose that's the feeling I think anyway, in psychiatry, and the misunderstanding that it has that it should be eradicating all these things, whereas if these experiences are part of who I am, then to eradicate them would be to eradicate who I am (9).

Negative experiences and emotions were bottled inside as they had been viewed as something too scary, not 'normal', too risky to disclose, too dangerous and hurtful for one's self-esteem, low as it had been. Talking about one's previous experiences and emotions and validating them with others is the first step of releasing some 'negative energy' and gradually coming to terms with the past:

This is actually helping me now, talking about this now, you know just getting rid of some of the negative energy, you know talking is a great way of getting rid of negative

energy.... I mean it's an outlet... I mean even my stomach is feeling better talking to you (1).

Talk about it, don't keep it inside because I've done that for so many years and I think that's what happened, I kept everything in, never told anybody anything that had happened to me... It's all the hurt from childhood it's all, it's everything fighting to get out, you know and then kind of like a volcano it has to come out (6).

However in order to open up to somebody and to explain and confront the negative or upsetting past, one had to trust that the person would listen and accompany them in their journey back in time. In some cases the participants' past experiences were disregarded by mental health professionals and considered irrelevant to the current situation:

I'm just thinking about what I went through and... Like I'd just tell them [nurses], like I want to hang myself, can I talk to you for a few minutes but we'd be talking about like, that situation you know, so I didn't really talk to anybody about my past. [Do you think it could have helped to talk to somebody about your past?] Yeah it would have. I'm screaming inside, do you know what I mean? (28).

Re-living and explaining one's past in a non-judgemental setting was needed in order to come to terms with the past and to start moving through life with others. Reconnection with the past was sometimes gradual and could require repeated attempts over time with various audiences until fully remembered and explained:

And what happened with psychoanalysis, over a period of a year or more I was able to mention it in the [peer support] group, I was able to talk about the experience, the experience of what actually happened, to engage with the emotions and the feelings and the fears of what happened, in a group where people seemed to be listening to me, and... the normal feedback without analysing you or you know whatever... I came down off the cross, I was able to come down and out in a sense of that freedom to engage with people and to come into the world and to come out of that, that might have been the isolation that we spoke about, being on the side and not being to engage with ordinary things that people seemed to be doing (14).

Reconnecting with the past allowed people to feel, explore, explain and take control of one's emotions associated with the past experiences. It also allowed oneself to experience both negative and positive emotions in the present, such as fear, anxiety, anger, calm, joy, happiness, empathy and love:

But now what has changed is that I'm starting to kind of get in touch with these emotions and the time to kind of allow myself to feel, I suppose (9).

Explaining one's experiences to somebody helped persons to reconnect the past with the present and to see what had been missing in the past and what needed to be addressed in the future. One of the shared things from the past which was perceived as preventing connection with life was a lack of empathic, validating, emotional connection in childhood or adolescence. In addition, there was often bullying, violence, abuse and annihilation of their personality:

For many years I was bullied emotionally, denigration of my personality, withdrawal of affection, shouting. Shouting and silence. [Kind of, a lack of contact, is it? Or is it too

much contact?] Well deliberate withdrawing of emotional contact, I would call it emotional bullying... We had an emotionally compressed home, so there wasn't much emotion shown, the only emotion shown I'd say was anger from my father, so my mother was quiet, my father was angry (8).

My own mother and father had a very hard, very rough upbringing, you know, my father was an alcoholic. And he used to beat us and we used to have to hide the children everywhere... But he was the very same when he was sober, he was a very violent man, and so was my mother, she never hugged us or kissed us, never showed any love in her (6).

There was also a perceived lack of both positive and constructive feedback on life, advice and empathic encouragement:

My father was nice but distant you know, we didn't really connect, and I was kind of a sensitive kind of person, and the relationship with my father, he's a lovely man, but I'd perhaps be angry with him for not connecting more, and then, when he wouldn't respond, he'd respond in what would seem to be a reasonable way, but he didn't actually connect back, I would kind of go into myself and blame myself. [How should he have responded, what do you think would have been a good response?] Interesting one, yeah... I suppose, I just didn't build up a relationship with him, he wouldn't give me advice on everyday life as a young kid maybe (15).

The main damaging effect of annihilation, violence and lack of affection seem to be the loss of persons' confidence and belief in their own inherent capacity to move on in life:

I just got depressed and I went catatonic, my father was an alcoholic and he used to cause ructions in the house... Well I got well again, I was taking overdoses, fool, I think I just wanted attention. Just love and attention... [So what is recovery for you, how would you like to feel when you are fully recovered?] Confident, and I have no confidence. [Why do you think is that?] I don't know, must have been the way I was brought up. You see, we lived with an alcoholic, you know, and he wasn't very confident in himself, so we were just brought up with no confidence, because like if someone doesn't have confidence in themselves, how can they carry it on to someone else? (28).

Extreme fear caused by violence, or lack of accepting and encouraging connection affected courage to make decisions involving well-being of selves and others:

If child abuse happened in your life, you know, that terrible emotional crime, dreadful... I think only someone that's been through it really understands how it feels, and how it can really paralyse you, you know... When I'm out now, I'm in fear all the time, I'm kind of looking behind me a bit... I'm always kind of wary, you know, like I remember one time when my own daughter, she was only five or six and we were at the beach and she stepped on some stones and she was sliding deeper in, but I didn't go to her, I just froze, my niece was with me... You see, when you get a bad fright, you would like, you know...(6).

Talking about difficult times was also perceived as helpful as it 'released' some negative energy and made persons feel better physically:

[I'm sorry I'm asking all those questions about your difficult times...] No I don't mind, I like now to speak it out, I do yeah. It does help. It's a release of brain, instead of

throwing it back there, you know, there [pointing to the back of the head]. It's coming out now to the front. Yes, that's good now, yeah, that's better for me now (25).

Lack of friends with whom one could discuss one's feelings, doubts and questions about life was also retrospectively reported as contributing to disconnection from life. Moreover, participants felt that presence of friends during a life crisis could have helped to avoid complete disconnection and admission to hospital:

I think the intrinsic part of it was I felt kind of distanced or apart from everybody else, so in a sense there's a lack of a sense of where I was going in my life, why I was doing what I was studying, I was studying science and I had switched to arts, why I was studying that. All this kind of thing... Well socially I had some success with women, but with men I couldn't, I didn't have any friends that I could kind of talk about my everyday stuff with, we would discuss things that weren't part of my life, so I had a lack of real friendship, and I would be looking for that everywhere and when I didn't find it, I'd try harder and harder to find it and I couldn't find it. So basically if I had that friendship, if I had people to talk to about say simple things, what's really going on... (15).

When I look back at the mental health services, I actually can't think of what they did for me, does it make sense? Like they didn't do any harm, whatsoever... I've no grudge against them, but I still can't think of what they did for me, in the sense of I had company, but I could have had company somewhere else... I can't think of what they did for me, you know, in fact a good set of friends would have done more for me at the time, but a lot of my friends had actually moved away, and I kind of had lost a lot of friends through my bad time (9).

Talking about one's past, coming to terms with it and explaining one's emotions to someone added to understanding of self and others better. The establishment of meaningful connection, and reconnecting with the past was accompanied by recognition of own and others' feelings and emotions through talking and listening to others, and by gradual development of empathy:

[Do you think you've changed as a person since your most difficult time?] Yeah. I've learnt about my heart. [What do you mean?] I started to recover in my heart. Became more understanding. [And how did you do that?] Well you have to be able to talk (27).

I used to get the train, and this old lady, she sat down beside me, and started talking, and that was nice you know, because before, this is now after I had joined [peer support group], I would be kind of saying 'What does she want to sit beside me for?', but that's all changed, I can kind of talk to people... I'm kind of prepared to listen to people, and if somebody says something I could relate to it straight away (12).

Developing an understanding of others was associated with feeling gratitude for what services were doing, especially when somebody was potentially facing homelessness:

I mean they put a roof over my head, you know they're not the worst like, even the nurse that is in charge of me, he's not the worst, you know, and I'm only starting to see that now, you know only within a short period of time, I'm only seeing that these guys and women are doing their best. I mean there's nothing you can tell them that they haven't heard you know, I mean there's degrees to which they haven't heard it but basically that's their job like, you know that's their job, to understand (1).

Further reconnection with others was possible through realising that all people were equal, that they all shared some ground or humanity in general, and it was possible to understand everybody and make sense of their experiences:

[What about the next few years, what do you think will happen?] Well I would like to travel, I've always wanted to travel, and it does broaden the horizons, just travel, talk to people you know, you'll find that people are the same pretty much (1).

Another thing they teach you in [peer support group], in a subtle way without you realising that you're being taught it I suppose, is that everyone is equal. I mean, I believe that the President is as equal as the man on the street with the can of beer, because you know, they're both people of, if there is a God, I believe there is, but if there is, they're both people of some higher universe or God, you know, so who is to say one person is better than another? So like I do believe everyone is equal, you know, so that keeps everyone grounded, doesn't it? (11).

Coming to terms with the past entailed remembering and reliving the past with support from others through explaining, reasoning, explaining negative things which could have been handled differently, and developing better understanding of self and others in the present.

3.5.5 Fighting to reconnect with life: designing and executing one's own recovery

Fighting for recovery entailed designing one's own recovery by trial and error, and executing it by doing and changing. Coming to terms with one's past through meaningful connection with others, accepting oneself as a human being capable of positive change enabled persons to become better aware of what needed to be changed or developed in the future, and start actively fighting for this change.

Sometimes the beginning of active fighting occurred before coming to terms with the past. This could have happened in the absence of a trusting non-judgemental listener who could accompany them to their past, or if the past had been deeply hidden in memory and was only gradually reawakening during the active fight to get better:

Things from the past started coming back...I was seeing myself in bed, and all around me was red, I couldn't figure out what it was. And last Christmas my brothers and sisters all went out for drinks, just us, the family together. Talking about different things, and I said 'I don't know what it is, I am seeing myself in the middle of the bed, and it is all red'. And my brother said, 'Do you not remember Daddy splitting your nose open?' [Oh Jesus, that's terrible]. Yeah, and you know, they still, even now like, there is still things kind of coming back. Yeah, and I find it hard to cope with them... But I kind of made a vow to myself, 'I am not going to be in hospital anymore' (6).

Despite the recurrence of fears, bad memories or moments of unexplained anxiety, once the process of 'fighting' started and the decision to get better was made, participants felt relief, freedom, and confidence. Participants claimed that whereas 'giving up' could turn into fighting at some stage, the process of fighting was unlikely to reverse itself back into 'giving up':

[Some people told me that you have to fight to get better, not to give up, would you agree to that?] I would agree totally to that. I would agree with that yeah. [Explain this to me please.] It's hard to, you just feel like...you just want to get better in yourself, and you try everything to get better in yourself...Force yourself, it's like a brick thrown on you, and you try and get it off you, and you are relieved then, the heavy brick is off...And the same with your illness, you have to push it and fight it. Don't let it block you. [And can fighting turn into giving up?] No. Because if you are fighting, you know you'll get there (29).

First and foremost, it was also very important to listen to oneself, have confidence in oneself and act in accordance with one's inner beliefs:

I would say one thing that has helped when I was in hospital was a little four liner: 'Look inside yourself and see where you really want to be, listen to yourself, and you'll find that therein lies your piece of mind, and it won't go away'. In other words, what you really want, piece of mind, it is there and it won't go away... And not being able to see it is a type of blindness, and to ignore it, or to be hindered from acting upon it, brings on illness. I think achieving a recovery or a wellbeing is a specific as that (14).

Participants thought that professionals should allow them to have a dialogue and support them in designing their own recovery, rather than being treated as passive recipients of medication or available therapies:

I think patients should be given an option for what they want to do for your care plan. It involves them in the care plan, so they can do things they enjoy, not what the doctor thinks will work for them. Because everyone is an individual and everyone knows their own body and what works for them... Maybe at some stage you mightn't even know what you want, because you are really unwell. Then you might need some guide, someone to give you some options ... Then eventually you are going to know what will work for you (7).

That way of praying, that way of trying to express things, way of trying to engage with myself and with reality sort of helps me, but I am afraid to try and put that in front of a doctor and to see what he makes of it, whether he thinks it is a sign of illness and is debilitating, and I am afraid of this still with them. So there were things I never faced with them when I was in hospital because I didn't feel I was in a position to have a dialogue, so I submitted to whatever they were doing, OK (14).

Sharing ideas and seeking advice with their psychiatrists, nurses or peers was viewed as very helpful, when they could contribute to further reconnection with life:

The doctor I go to in [hospital name] is very good doctor... Because I go in and I'd say such thing and he'd say, 'Did you try it, did you try it that way or did you try it this way?' And maybe I wouldn't have thought of it, and you find yourself trying to do that and it works, you know, he's very good like that... Now I was with him last week and I have a wedding coming up, and I was saying to him, I'd like to lose a little bit of weight, and I was asking him was any of the medication I was on affecting my weight. And a sleeping tablet I was on, he's taking me off that, now I'm not sleeping that well but...(6).

By trial and error, people get to realise what strategies, medication, therapies are available, and what works and what does not work for them:

Well once I made the decision that I wanted to get better, I asked how could I get better, and so they spoke about CBT and they spoke about psychoanalysis and they spoke about psychotherapy, so I said okay, where is it, and it took a couple of weeks of me banging down the door to get an appointment with a psychologist. So I got an appointment with a psychologist and continued to see the psychiatrist and continued to, you know, speak with the psychiatric nurses, continued to engage with the other patients, continued to engage with the occupational therapists and I suppose I've designed my own recovery and I was very active (8).

Participants considered it very important to be able to choose activities of interest so that one could enjoy and get absorbed in what they were doing:

Give them [patients] choice and options like, because my choice would have been sports activities and them kind of things which I done myself on my own time after-hours. That's what got me better like (7).

Get something you like doing, work at something you like doing, don't work at something you're not happy at, work at something you're happy doing, you have an interest in (31).

When persons are doing things they not interested in, they may feel demotivated. The feeling of non-achievement, emptiness and meaningless can make a person feel disconnected from life:

I don't have great expectations, I don't enjoy coming here really [to the day centre], I'd like to get a job... I feel I'm not achieving, there's nothing to do like with the time you know, you're just hanging around all the time... (19).

Usually people knew what made them feel better once they have tried it before:

I love art now, and I think it was art actually that saved me that brought me out of the very deep depression. Because I used to colour an awful lot and draw and when I started off first there was all weird things animals and ghosts and monsters and... And I think something out of me, I don't know, it's hard to explain but I always loved it, but I've got rid of all that, horrible things, drawing horrible things. It's all flowers now and... I used to draw a lot of volcanoes. And you know, because that's what you feel when you're very depressed and you're angry you're like a volcano, and I used to draw a lot of those and then hid it, hid all, you know it make you feel better, like still wear the black but wear something bright with it (6).

If you can't sleep and your mind is wandering, write down what your mind is racing about and get it all out of your head and then you'll be able to sleep (19).

Different activities helped people to reconnect with the self on spiritual, emotional, cognitive and physical levels in the present. Reactivation of one or more aspects of self helped to get some 'positive energy' and feel connected with life, and get rid of 'negative energy' of disconnection. Persons knew which levels needed more activation depending on their interests and capabilities:

I have a physical recovery, I have an emotional recovery and I have a spiritual recovery and they're all different, they're all at different stages... I am a bit better emotionally than I used to be, and I would say that my recovery spiritually is the most consistent, so even on a bad day I would be spiritually okay with it, I'd be okay to have a bad day and recognise that having a bad day is part of the process... If I'm having a bad day physically I'm exhausted, I just have to sleep and even emotionally I'd be low, in a very

low mood... Obviously I want to get to about ninety in terms of physical, I want to go back and play rugby again (8).

Reconnecting with self cognitively involved consciously changing negative emotions into neutral or positive by self-talk, talking to others, and activating cognitive resources such as memory, concentration and reasoning through talking, reading, studying, or writing. Participants of GROW were encouraged to make a conscious effort to become aware of their negative emotions and try to change them by positive thinking:

The other aspect that I learned from [peer support group] is not to be controlled by your feelings, but to control your feelings (13).

Reconnecting with physical or bodily level of self entailed getting out of bed, walking, exercising, deep breathing, relaxation, improving diet and so on. First and foremost, one had to talk oneself into getting out of bed, and to do things during the day, which was often achieved by self-talk:

Actually my first big step towards recovery was, believe it or not, getting myself out of bed, talking myself out of bed. Now that sounds like a small step but it really was a major step for me, actually just to get out of bed... I still, believe it or not, quite often have to talk myself out of bed in the mornings. If I was driving into work for instance I would just kind of say to myself 'Right, it's okay, your day will be all right', self talk is a big thing for me (9).

I don't know whether it's the new medication but it's very funny, I'm always talking to myself lately. And I'd answer myself back and everything. I'd just say what I have to do next and then I'd say will I do that, or won't I. And then I'd say to myself 'ah sure I'll do it in a minute, ah no I better do it now', and all this. It helps to do things properly, you know (28).

Often when spiritual, emotional and cognitive aspects started to function in tune and the feeling of moving in time returned physical health improved too:

No, it was gradual, thinking back it was gradual, yes it was because I thought I was physically sick, I didn't realise I was mentally sick, I thought I was physically sick. I just felt in pain... So it's in my head and I've put down some expectations I'm achieving, but physically I feel well, I had hypertension and she [doctor] had me on tablets for the blood pressure, and the first time I went back to her after coming out of my own place, it was back to normal again, and she couldn't believe it.. Everything, the whole lot, the physical body, mentally and physically I'm much better (23).

My daily routine would consist of getting up at 7 AM, eating a good breakfast and then exercising... I decided to go into reading in a big way, so I started buying books and all... started using my brain a bit more than usual, and physically I started using my body a bit more than usual, so both are going in accordance, my recovery mentally, tackle a few things, physically tackling the size of myself and mentally exercising myself (22).

Whereas medication was sometimes reported to reduce anxiety and help emotional reconnection, it could do it at the expense of other levels of the self, such as physical, cognitive,

or spiritual. As all levels were intertwined and interrelated, could interfere with further disconnection with self on one or more of these levels and could lead to disconnection from life:

I'd like not to feel tired all the time, I'd like to have energy and interest in things, I can't concentrate on anything, I used to read but now I can't read, my concentration is really gone... [And why is that you think?] The medication I suppose... Well I don't know, they [tablets] interfere with a lot of things, take away your concentration and make you constipated, they dry you up inside (19).

I'm on an injection and I'm on a blood pressure tablet, I take it, and I've a stomach problem, I take it, but I have refused to take two of my tablets because, I'll tell you why, they interfere with my life, and I've been off them, I've been putting them down the sink for a month, and I feel in great form. I used to be feeling sleepy, stiffness in the legs and headaches with these two tablets, and since I gave them up I'm grand, so that's my life story... It's a good day if I'm able to get up in the morning and dress myself and get my breakfast and walk down to the bus and wait on the bus, and not be feeling tired or hardly able to stand up, and nowhere to sit down at the bus stop, my legs would be so weak and tired, I blame that on the two tablets, since I stopped taking them I'm grand (31).

Some participants gradually became aware that medication did not do anything for their reconnection with life, and it was possible to effectively function without it:

I was on medication for I don't know how many years, anti-depressants basically. One of them didn't particularly agree with me, so I was put on something else, but I can't think what the medication did for me... because I actually went to my GP at one stage and said 'Look, I'm going to go off this', and I said 'How do you do it?', and the GP said 'Well, you can do it yourself', so I did it myself and it didn't make me feel any better or any worse, if that makes sense to you (9).

Then the debate arises do I need the tablets to work, and since the beginning of this year the answer to that is no, because I'm functioning very well in work and I'm doing the work well, I'm doing everything I'm given to do... I haven't taken the anti-depressant for years, I don't think I've taken the anti-depressant except probably after I was discharged from hospital, I just don't like it (14).

The advice some participants gave to others was to fight for reduction of medication, but gradually and with supervision, as otherwise it may lead to relapse:

I'd fight against getting more medication off doctors. Because medication makes you very tired. Don't let the doctors give you too much medication. I'd say to them, here, listen, I'm staying in bed all day, so I can't take that, you'll have to give me something else that might be better, some smaller dosage. Don't go off your medication without your doctor's advice. Because you'll just end up in hospital again. Because that's what I did, and I ended up in hospital (28).

3.5.6 Synchronising self with others in time and giving back

Encouragement and support from others helped to maintain and strengthen fight for reconnection with life:

I want to get well and I was determined to get well and that was [what the nurse] was saying, 'You look better today', and I used to say 'Yeah, I'm getting better, you know,

great'... A bit of encouragement, oh you have to have that, just a word makes all the difference, just one kind word, it's amazing how it makes you feel, well, you know, when you want to make people feel good, you do say nice things don't you, you don't ask if your mood is up or down (23).

In addition to encouragement, people also needed some guidance and constructive feedback to help them find out what works and what could be done better. Some complained that service providers were not always forthcoming with their comments on what they were doing wrong and why:

Well I've always kind of tried to help myself as much as I can, but there are times I need help. There are times, I don't know whether it's a frailty of the human condition or something, I don't know, people, I much prefer people that tell me, you know, you're doing this wrong, you're doing that wrong, point it out, than you know, not suggest or not say anything like (1).

Positive feedback or support from other contributed to development of confidence and self-worth. The development of confidence and self-worth was seen as one of the major tools and tasks of reconnecting with self and thus with life:

[What does recovery mean to you?] Well I'll tell you, I'd like to feel confident about myself. I'd like to be able to get on a bus without getting full of anxiety; I start to shake, you see, when I get on a bus on my own. Like it's the confidence that's down a bit, my confidence, you know (18).

The GROW leadership program was specifically aimed at helping people to gradually develop their self-esteem and self-confidence:

I was doing the flip charts, they got me to get up and talk about the qualities of [peer support group], before that I wouldn't have even, I'd be 'Oh no, I don't want to do that', I mean I'm kind of more responsible, I have more confidence, and not as shy, I can be still a little bit shy, but I'm just learning all the time, you know, I have a lot to learn (12).

Peers were perceived as helpful and forthcoming with advice on how to do things better, communicate, or to behave in public:

Yeah the work ethic, socially going out, doing work has to be approached with a degree of intelligence, because if you don't have the intelligence, which is what [peer support group] can help you to find, if you don't have the intelligence to know that a certain situation really is not working out or that you need to change it...(15).

Yeah they're very good [peer support group]. People just talk, like new people come in, they suffer from this and they help you like, to get through things... Yeah, you see the way they got through their illness, you might copy them, see if it will help you. [Can you give me an example?] Like shaking my leg, they told me, I always shake my leg and they told me to leave my full foot on the ground (28).

One peer support group had a special system of individual tasks and provision of positive and constructive feedback:

We're all given tasks on a weekly basis, and so you feel, you've been given a task, and hopefully you'll achieve that by the following week... Then there're special activation reports, whereby after a period of time, say seven months, we get a report by at least two members of the group, who will tell us what they think of us. Mostly on a positive basis, seventy-five percent on a basis that would be positive. The other twenty-five percent on what we can improve on, to help us have a better state of mind (13).

Gradually becoming aware of one's progress helped to develop one's self-esteem and self-confidence and start enjoying life. Support of others facilitated self-discovery and the ability to give something back to others:

So they [peer support group] discovered I could play the guitar and sing, not through hearing me, just a friend of mine told them, so I couldn't sing in front of people, I didn't know what to do, so they got a get-together with the group, and they got me to sing one song and play my guitar with the light out, now who else in the world would understand that? So eventually, bit by bit, we practiced every week, and then I sang without the light out, and just to cut past that, I now sing voluntarily, solo (11).

Re-connecting with self and others brought some 'positive energy' to people and made it possible to start giving back something positive, which in turn helped to connect with life even more:

When I had my negative energy everything was black ... When the opposite happens, you know, when I realise I have a purpose here, when I can connect with other human beings, when I can use all of the talents that I've been given, when there's no cloudiness, when my head's not spinning from vertigo (8).

A good day would be when I'm feeling ok, feel like I'm enjoying life and doing things. I'd be helping out others, doing different things (19).

One can start feeling that they can make a difference by being a part of this world, by being there for somebody, by working, studying, helping others, creating something of practical or empathic use to others. Feeling that you are making a difference, helping others and the world helps to feel connected with self and something bigger:

[So how do you know it is a good day?] Well you kind of, I'm studying at the moment and if I get something done with my study, as you probably know yourself I'm sure... I mean it makes the whole world shift focus from one small little life of your own to something... [Bigger?] A lot bigger, a lot more varied and a lot more interesting (15).

[What would recovery mean to you?] Working, just filling in my day properly instead of walking around calling for friends and complaining... It makes me feel really angry like, makes me feel lazy. Working is good, because it's helping people. It makes you feel good about yourself (28).

In a peer support group helping new people provided a chance to give back to others and feel needed:

It's just like, because I know, that they're there for me, and hopefully I'm there for them, you know... I have a new member now, she's in my group, and I met her the other day, and we had something to eat, I texted her first to ask her how she was, and then I was talking to her and she said 'It's great, it's great getting these text messages from you.' Because like, I've been there, and I know what it's like (12).

Starting to understand other people and becoming aware of a possibility to give back led to developing new friendships. Friendship was perceived as a two-way thing: getting rid of negative energy of doubts and despair at the time of disconnection, and giving back some positive energy when somebody else was experiencing disconnection:

My husband and I separated, so I had to have somewhere to live. And then I got myself an apartment, we're great friends, my husband and I are great friends, we see an awful lot of each other, he's very supportive... I had dreadful agoraphobia for years, couldn't get out of the house, it was an awful burden on him really because I wouldn't, I just wouldn't go out, I was so afraid, but all that's gone now you know, so it's great (23).

Shared life experiences and moral values, as well as a sense of humour were perceived as key elements friendship:

Some of my friends I've had for years. We just seem to have similar interests, sometimes similar experiences in life. The same sense of humour, and I suppose in one sense probably the most important thing, is the same kind of moral standing, you know, don't totally agree, but we agree a lot on what's good and bad in life, what's right, what's wrong in life (9).

Inherent in friendship was shared experiences of accepting, non-judgemental and empathic meaningful connection, which created positive energy, reinstated meaning and purpose, strengthened spiritual, emotional, cognitive and physical resources, and helped to reconnect with life:

I get a sense of satisfaction, job satisfaction, seeing people get well... It's really great, you know, because when you see what friendship in a [peer support] group does to one person, and how they recover, because people are accepting them, you know, I mean it's fascinating to see, they're like a flower that's closed, and you see them nearly opening up, you know, and then six months later they're running a group, they're an organiser of a group, you know (11).

Conversely, feeling that you do not or cannot have any friends, not making a difference at all, or making a negative difference (being a burden, being useless, bringing nothing but trouble or distress to others) maintains disconnection with self, others, time and life in general:

I think I'm inevitably one of life's drop-outs. Well because I dropped out from society and I don't have anything to do with anything at all really... I'm just trying to eh... keep the status quo and not offend people (24).

Synchronising self with others in time could be achieved through talking, doing things with others, or for others and was associated with establishing or maintaining meaningful connection with others. Meaningful connection with friends, significant others, or family was a crucial part of fighting for reconnection with life, and was both facilitated by and contributed to development of understanding and empathy, and giving back positive energy.

3.5.7 Futurising and moving on: making active choices in life

Once a person explained the past to self and others, progressed in their fight for reconnection with life, and started to understand self and others better, they realise that it was possible to give something back and even plan one's future accordingly. Realising that one could give back to others added to further reconnection with life, further contributed to the feeling of staying in control of one's time, and opening up new possibilities and experiences in the future, and development of new friendships.

Futurising involved looking forward to experiencing new things, and thus becoming a part of life which is constantly moving and changing. It entailed comparing positive changes in self with the negative past, and finding positive things in the past which could be linked to the future:

Move on, put the experience behind me, so that if I meet these people [bullies from previous job] three or four years down the road, that I'm not kind of cowering in a corner, that I'm not getting palpitations, I'm not feeling anger and resentment, that I've risen above that, and I've moved on... Basically full recovery would be, for me, to put this traumatic experience behind me, by that I mean that I would like to be re-employed again, in a job which, monetary terms has never been a huge influence on me, more a satisfaction of going a job well, and it being recognised. To try and re-ignite my marriage, I have a great relationship with my children. I love my children dearly, and I get a great kick out of them growing up, and seeing how they're developing (13).

I spent ten years just in the house, so I want to be getting out now and enjoying it, it's like a new life, you know. And I'm thinking of going to Italy on my own at the end of May, but that's only a thought, it's not a definite, but the fact is that even if I'm thinking about it, it's good (23).

One of the main tools and goals of futurising was developing the ability to make proactive choices in life, rather than hesitating or doubting, or being afraid of the future. Making choices and then moving on with them made persons feel in control of one's life:

[How would you see yourself a 100% recovered, what would you like to be?] Not afraid of taking decisions on the spot and then following them through, rather than hesitating and thinking about this, that and the other (26).

It is beginning to try to make choices, day to day, I mean I do make choices obviously, but choices in relation to what makes me happy and what I want from here on. I mean how to manage my affairs, you know to take some sort of control, to take more control of my own life and in a healthy sense, overseeing to a degree (14).

Knowing that you have friends on whom you can rely in the future reduced anxiety about the unknown, and helped to feel more in control of own future:

If I can just handle life's problems, you know, say for instance if I went to my bank account now and found that I had no money left and my pay doesn't come in to the end of the month, now that could particularly distress me, but if I'm well recovered, I could logically think things through and think, well you know I have friends, I could lend some money, I could do this, instead of getting myself all tied up and particularly troubled and distressed and depressed and whatever... And that's important to me, this

kind of approach I could take with this life's challenges, if I had them under control, that would have been excellent, kind of, do something about it (9).

At the time of futurising and moving on, talking too much about negative experiences can slow down one's progress in reconnecting with life:

[Did you ever go to any support group?] It was up in [name of hospital]. [How was that?] It was OK, it wasn't very often, but it makes you focus on the illness all the time, you want to get away from the illness to do different things (19).

[Do you think talking helps recovery?] A certain amount but not too much, I find if you get, if you talk too much about it you go out in circles. And I do know a lot of people who will just talk all day about their mental health problems, I don't think it's a good thing, I think you need a certain amount of action as well... I would say, too much talking may not be a good thing. [Right. How do you know it's too much?] When you're pitying yourself too much, I suppose, and you go over and over it again, and you couldn't get anywhere (9).

Being around people who 'gave up' and do not change could also slow down one's progress of moving on with time:

[And have you seen people who 'gave up'?] Yeah. [How do they look?] Just still the same. Nothing changes. [How do they make you feel?] Well I feel I don't want to be around them, you know. Because you are getting better and they are not (29).

As one becomes stronger and more in control through repetition, doing things and feeling in tune with time, people start thinking about bigger chunks of time ahead, next day, next week, next month, next year. One can start projecting oneself in time, gradually reconnecting with the time flow and 'going on' with one's life:

[How would you know you're completely recovered?] Well I mean, a proper health, like be able to go to work, to be able to go out, to be able to deal with myself, you know, and just keep going, the way I'm going... When I get older, you know, to be able to cope, and hope I don't get any sickness that will stop me doing what I'm doing now, like does that make sense? Like I mean, life in general, just to be happy in myself, and content with what I've got (12).

It was very important to look forward to something positive in the future which could contribute to further development of self and giving back to others, and work towards this goal:

[So what are your expectations about recovery, and have they changed?] Yeah they have changed, because I'm actually doing an English course at the moment, I was good at English at school but I'm learning new techniques... I want to go over to somewhere where English is a foreign language like you know, that's what I'm hoping to get out of English course eventually you know. Teach English. So yeah I have something to look forward to, yeah I have something to look forward to (1).

I'm in here at the moment till a course comes up, and when that comes up it will give me the mood and the confidence and the energy then to do part time work, so I'm looking forward to that (22).

Futurising and moving one involved repeated cycles of formulation and execution of further plans for the future on the basis of new past achievements, opening oneself for new experiences and new friendships, and synchronising with self, others and time in the positive future.

3.5.8 Turning bad days into good days

An important step in one's recovery was accepting that there will always be bad days, as life can throw problems unexpectedly. Paradoxically, acceptance that anybody could be weak at certain times could help the individual to become stronger in order to face life problems:

But the bottom line is that we are strong because we know we're weak, we're kept afloat because we know we're weak, that's an aspect really of functioning, and we can be strong, but it is because of some sort of awareness within us, within ourselves, that we can be weak... It is a paradox (14).

Some participants felt that 100% recovery may not be achievable by everyone:

I don't think it's possible in this world, ever, ever, ever, ever, some people who are, say, susceptible to these things, even people who are happy, never ever, ever, ever, do you know what I mean? Well for me, I'm happy where I'm at (11).

Connection with time could sometimes be weakened or interrupted by internal or external factors, bringing some 'negative energy' associated with disconnection. Due to the fluctuating nature of disconnection and reconnection, some participants refused to accept the label of chronic, severe, or enduring mental illness:

I think there's very few people mentally unwell all the time, in fact I think I'd be better calling it partial mental illness. [Pardon?] Partial mental illness, I prefer that name on it. Because we're not mentally ill all the time. It's just a label, isn't it? It's just a label, to call somebody something. [So not to call it mental illness as such?] No, partial mental illness. There's very few people mentally ill all the time, I haven't met them... Like three-quarters of the time, I'd be grand (2).

The concepts of good and bad days emerged from participants as a personal measure of the process of recovering, being happy, or feeling connected with life on good days, and feeling disconnected from life on bad days:

I mean I know I'm not 100%, but I'm getting there you know, I mean I've a court case in the morning... I'm just feeling what anyone else would, you know, I'm feeling paranoid, I'm feeling anxious. Stomach upsets, you know... [Ok, let's say if we had a scale, right, from 0 to 100, now on this scale where would you be?] Right now? [Yeah right now.] Or normally? [Yeah, normally]. Normally around 75. There're days even you might push to 80 you know, right now I'd say about 30 with the court case. But then when I get down there tomorrow and bite the bullet, I'll probably be 60 for a while (1).

Good days were described as effortless, easy-going, joyful, whereby persons felt optimistic, energetic, proactive, confident and happy about themselves and their day:

On hard days lots of things are an effort, driving the car is an effort, you know, cooking the dinner is a real effort, everything is just dissipated... But on a good day...there's effortless about the day. It's effortless (8).

Good days were characterised by an unconscious feeling of dynamism and spontaneity when persons were involved into doing something meaningful and enjoyable, therefore bringing some positive change to both selves, others and life in general. Synchronisation, or reconnection with time and others entailed being 'in tune' with others on physical, emotional, cognitive or physical levels. Such connection could be achieved through experiencing simultaneous relatedness of feelings, thoughts, or experiences, and sharing the same moment of living time:

And sometimes, when I'm just going to play golf with a friend, it just takes away a lot of stuff, just by doing that, just being involved in something else, and being with somebody (9).

Bad days were characterised by the weakening of spiritual connection with the self, and slowing down of time. They brought low mood or anxiety, negative energy and tiredness, low self-esteem, lack of concentration. Multiple internal and external factors were suggested for the explanation of reoccurrence of bad days: bad weather, change of seasons, stressful events such as going to court or to a doctor for evaluation or prescription, judgemental or hostile interaction with somebody, sickness or death of somebody close, bad news on the radio or TV and other internal or external factors capable of causing sadness, worry, or anxiety. Whereas participants were not always sure about all the reasons behind the occurrence of bad days, most commented that they knew from waking up in the morning how they felt about the day and whether it was a good or a bad day.

Anxiety about some stressful events in the nearest or long-term future can weaken connection of self and time and lead to a frustrating feeling of 'bad days'. On 'bad days', time can slow down or become too fast, and the person may feel a lack of motivation or energy to 'move on':

A good day would be where I'm at peace with myself, and I'm at peace with the world, and that I am reasonably happy. A bad day would be where I would start reflecting on my traumatic experience, and dwelling on it too much, and not moving on, that would be a bad day, just going over my bad experience (13).

Sometimes there is too much going on in your life, you know, too much to do, sometimes you can kind of... get a relapse, you know, you are getting a bit higher, you know, a bit lower (5).

When service providers were perceived as focussing on just maintenance of the current state by medication rather than on moving on in time, it could cause a temporary disconnection from life even when such connection had been already achieved:

There haven't been bad days, I'll tell you recently when I was under, when the appointment at the hospital came up again and I had to begin to think about that, and maybe the fear of going down there and trying to articulate, you know, how I was, and what my hopes, if you want, towards a recovery were, rather than being maintained

with medication and just going on that way... I was trying to figure out whether that was a cause of anxiety, because I'm seeing that as something of a distraction at this stage. I see it as a distraction from a busy life (14).

Poor physical health also interfered with reconnection with time. It caused worries and threatened connection with life by curtailing physical or educational activities and increasing anxiety:

[Is there anything that is slowing you down you think?] Well at the moment there is because I've to go in for an operation... I'm having an operation on my foot... Yeah so I'll be off [day centre classes]... What's worrying me, what I'd love, someone to come up to the house and do the classes at that time you know. A tutor (18).

But physical illness, if you get physical illness, even if it's the flu, I think it sensitises you, and you get a little hit of it, you know, you get a little hit back of your original panics (11).

Bad days as such did not necessarily lead to complete disconnection, as long as one was aware of them and knew how to handle them. In fact, they could be viewed as a positive thing and even turned into 'good days'. A certain amount of dissatisfaction, unsettlement and discomfort can help a person realise that there is a need to change something, and make an active effort to 'move on' in life:

A bad day would be a day where I'm dissatisfied and I could see that I wasn't really going anywhere, I was unhappy with my lot basically... But again that raises a question, feeling unsettled, unsettled was a word that was used by one of the doctors, he said are you feeling particularly unsettled at the moment? And I could see where he was coming from, that if you're unsettled it is a sign of illness, but others would look at unsettled as a prelude to making change, to doing something (14).

Turning good days into bad days was achieved by positive self-talk, affirmations, thinking of something positive, moving on, doing something, exercising, writing a diary, praying, drawing, listening to the music, or having a conversation with somebody positive:

[So what would be a bad day?] When I'm worried about myself again. Sometimes the cancer and stuff like that, I'm getting over it. That is just the worst case scenario you know. I do my best to keep it minimised, the effect, I'll pray, I'll get in contact with my Christian friends and they'll pray, I'm able to talk to them about my problems (26).

Reconnection with the time flow on bad days can also be maintained and supported though futurising small units of present, i.e. living one hour or one day at a time. This helped to control continuity of time and not to allow interruption and 'negative spiral' of disconnection. The more vulnerable the person feels on a specific day, the more specific, short-term and structured the future needed to get. It may be helpful to think of things to do today, in one hour, or even in the next five minutes:

I did plan my day, and if it's a bad day, I said 'I'll get another shower', and then I'll clean my teeth, you know what I mean, and I had a very structured day and I found that it was the easiest way (23).

I have a few ways of coping, like I say to myself, if I'm happy for five minutes, nobody can take that time away from me (2).

Some participants of GROW mentioned that there were sayings 'don't get imprisoned in here and now' and 'let time pass' in the GROW Blue Book. These sayings helped to accept 'bad days' as they were, reconnect with the nearest future by planning small goals, and by executing them not to become 'imprisoned' in the worrisome here and now.

Some of the suggested reasons for a day becoming good were changing something about oneself, having a sense of achievement, making voices go away, losing weight, learning something new:

A good day would be if I done something right in the course and I'd go home happy (18).

Turning a bad day into a good day could come about by doing something despite the fear, being able to deal with anxiety, being proactive and taking risks:

But I was happy that day, because I've actually tackled this thing which I was afraid of, not only afraid of, but I didn't know much about, but I seem to have done a good job, that's kind of, satisfaction of it, and it's kind of given me a sense of, to do these things that I'm afraid of sometimes, you know (9).

The feeling of being connected with time was associated with doing things, being proactive, moving on, filling one's day rather than passively waiting for time to pass:

I just try and get on with it, and before I was just dwelling in the moment (28).

Activities that helped to get rid of the fear, panic or loneliness included conversation, joking, music, poetry, deep breathing, prayer, anything that had to do with interaction or rhythm, and thus strengthened reconnection between self and time:

That terrible fear, it used to be, you think you're having a heart attack, it's that bad, you know, your chest starts closing in, you can't breathe properly, that's before I learnt about the deep breathing, I used to do it in the hospital. [And is it helpful?] Oh very helpful, if you feel panic sweeping over you, I just count to ten, do my deep breathing and I feel myself calming down (6).

Exercise gave people energy and self-confidence, and helped to re-connect with self physically, emotionally and cognitively:

The physical ones like soccer, it gets you moving. Gets you physically fit and as they say healthy body, healthy mind (7).

Music helped to reconnect with self emotionally and spiritually, to reduce stress and anxiety, get rid of 'negative energy', and to control voices:

You see, I didn't know that music would take voices away from your head, till somebody said it to me. (28).

[What do you do to handle your stress?] Play music. Mouth organ and accordion (31).

Prayer or going to church helped to reconnect with self and others spiritually and emotionally during stressful times and to find some meaning in life:

Prayer I think helped me an awful lot... I used to pray hard, you know, when I was young, when I was about sixteen, I used to pray hard. I did pray, yes, I did pray, yeah. It got me through, it got me through (5).

[So what would be a good day for you?] Take my medication, go out, go to church, I'm going now tonight, you know bring the word of God to people, I don't know how you feel about it, but I just feel it is so real to have that in your life (26).

Not wanting to talk and not wanting to connect may be a sign of disconnection from life. A person may need to motivate oneself and push oneself to get out and reconnect with people:

I can't talk to those people, you note to yourself, a light goes off and says 'No, this is wrong, you need to go out and down to the pub or meet friends or something,' so it is essential that you have that kind of push (15).

Reconnection with others required a certain push or effort on one's part. However it became easier with practice, after it repeatedly led to improvement of mood and feeling connected with life:

I think it's to do with you as well though, you have to make an effort, you have to do it, it's no good expecting all those people to fall into, you have to put that message out to say, 'Look I'd like to speak to you, I'd like to talk to you', you know... I like to go on the bus every day because it's getting me out of the house and I'm keeping fine, but sometimes I might be a bit nervous, so I go and I say 'Ah this is madness', and I start smiling and I chat to somebody at the bus stop, do you know what I mean, not forcing my conversation on them but just smiling and then they talk and it goes away (23).

Sometimes you have to listen to others to become aware of the disconnection from life and accept that you need help:

At the moment I feel 100% recovered, and I plan on staying that way like. But if I ever do take a notch down and I get symptoms that I feel I'm getting unwell again, I know where to go and get the help. I accept help, I don't battle against it, because that's what happened last year when I had my breakdown. I didn't realise it was coming and the doctor said, 'People were saying, (Name), you're not yourself and you are battling against it, saying there's nothing wrong with me, it's not me, I'm fine'. It could be a sign you are getting unwell but you might not realise it (7).

Reflexivity, self-awareness and confidence that one can handle stress or negative feelings helped to find out how to take control of the self during moments of anxiety or panic:

I had an awful panic attack and these two old ladies came over to me and they were helping me and I said 'I know what it is, I just have to do the deep breathing and all' They thought I was having a heart attack. I went across that bridge and I got the pains in my legs, I thought I'd never get across, but got there, got to the shop, got the shoes for [name of son] and was grand coming back down. And from that day I kind of made a breakthrough in the panic attacks. I knew I could cope with them, like I still get them, but I know now I can handle them (6).

You get a little hit back of your original panics, but it's just that you've learnt to deal with them now, and you know they're not going to stay... you know that you didn't die, you didn't collapse and die, all the 'what ifs' that you're worried about, 'What if I drop dead, what if...' none of them happened you see, so you're now at a stage where you know (11).

When combined with spiritual connection with self and others, medication could help to get rid of fear of voices and hallucinations and to feel connected with life despite the occasional occurrences of voices:

I'm not as paranoid as I used to be, I'm not hearing voices, there has only been one or two episodes since I came here [day centre], and they were very weak, but before that they were a real attack, do you know what I'm saying? Very real, just heard voices, 'I'm going to kill you, I'm going to kill you'. Almost gone, about 95% gone. [And how do you react to them now?] There is not a whole lot you can do, you know, I'm taking the medication. Just disregard them... Take my medication, go out, go to church... I was talking to a pastor who had the exact same problem 23 years earlier, and he said not to worry about it, everything is in order, and not to worry about it (26).

Some suggested that as reconnection with life progressed, they encountered fewer bad days and they were not as 'bad' as they used to be. The more good days a person had in life, the more progress they had made in their recovery. Therefore reconnection with life could be evaluated by two factors: frequency of occurrence of bad days in the last year or month, and the degree of disability, or disconnection from life on bad days:

I had just six months of bad days, and the last six months have been nothing but good days. I'm fully recovered like, I don't have any bad days anymore (7).

No matter how difficult it was to handle and reverse bad days, once achieved, it became easier with practice. Eventually, the person had no or very few bad days:

[Some people told me that they have different levels of recovery on good days and bad days]. Yeah, well, you do have that alright, yeah, but I'll tell you what, when I started getting the good days, I didn't get the bad days ever again... I did have one bad day a few weeks ago, and I felt dreadfully lonely and all, but that's the only day I've had over the months (23).

If a person achieved good quality connection with self, others or time, even in the absence of perfect connection, it was possible to be happy and feel connected with life:

[So what would be your highest score of recovery on a good day?] I'd say we'll put down 80, will we? See if things have changed in my life, in terms of if I met somebody, in terms of if I had a relationship with someone, it might go up a bit, but some days like today, if I'm quite happy to be me today, it is not a bad day... You feel you're not different basically, you're a part of something, you're a connecting link or whatever in the community (15).

Turning bad days into good days entails an acceptance that bad days, or temporary disconnection from life are inherent in life, and may signify the need to change something. One can thus handle bad days and turn them into good days. Bad days can be turned into good days through various activities discovered as helpful during previous fighting to reconnect with life.

Key strategies of turning bad days into good days included short-term futurising and moving on in time, experiencing meaningful connection with others, and synchronising self and others in time.

3.6 Summary of theory

Reconnecting with life occurred in three interactive stages 1) reconnecting with self through getting back to oneself and accepting the self as a worthy human being capable of positive change; 2) reconnecting self with others through experiencing hopeful, accepting, non-judgemental and validating connection; 3) reconnecting self with time with support from others, or re-establishing the flow and coherence of the past, present and future, and actively shaping and executing one's present and future by synchronising self and others in the present and future. Specific processes involved that facilitated or slowed down reconnecting with self, others and time were not linear, but intertwined and iterative.

Through the 'fog' of disconnection, persons got a 'glimpse' of a positive future which re-awakened their hope for positive change and fighting spirit, or intrinsic motivation to get better, and got reconnected with selves spiritually. A glimpse of positive future was achieved either through a meaningful accepting and validating connection with others in here and now, or through believing that one can have a better life in the future. Occasionally, a glimpse of positive future could be triggered despite being told by others that it was not possible, or seeing others without a positive future and not wanting to be like them. Seeing positive future for oneself led to development of intrinsic motivation and a decision to get better no matter what, and to start fighting for reconnection with life.

Having experienced meaningful connection with somebody accepting and validating support of somebody whom they could trust (reconnecting self with others) persons felt ready to travel back to their past in order to explain and reconnect it with their present and future (reconnecting self, others and past). After re-establishing coherence of one's past, present and future, and realising they could give something back to others, persons started planning specific future goals (futurising) and making them real by doing and changing. Synchronising self and others in time was reported as an important goal and tool of reconnecting with life, and was achieved through talking, understanding, empathy and giving back (reconnecting self, others and present). Fighting for reconnection at the times of disconnection made it possible to turn bad days into good days. Key strategies of fighting for reconnection on bad days were reconnecting with others, futurising, and moving on.

This study shows that through non-judgemental and accepting connection with peers and service-providers persons can re-learn to respect and value themselves and others, come to terms with the past, develop understanding, empathy, and altruism, and to further reconnect emotionally, cognitively, spiritually and physically with self, others and time. This study

provides evidence that through constant re-establishing and maintaining a dynamic connection with self, others and time one can regain the feeling of meaningfulness of one's life, which was found to be crucial for physical and mental health (Urry *et al.* 2004).

On the other hand, hopelessness, seeing no future for oneself, lack of meaningful connection and somebody to talk to, and being pushed to do something against one's will led to a lack of motivation to fight to get better, and in extreme cases, to give up completely on one's recovery. Pessimism of diagnosis, side effects of medication, being treated as a disease rather than a human being, hostility and stigma in the broader community often created barriers to active reconnection and repeatedly caused disconnection from life.

4. Discussion of theory

The current chapter will discuss how the emergent theory fits into the findings of biopsychosocial research on mental health, mental illness, and the general health.

This chapter will discuss multiple definitions and overlapping constructs pertaining to spirituality, fighting spirit, hope, self-determination, self-esteem, self-confidence, empathy and some others mentioned or implied by the participants of the current study as relevant for their recovery. In addition, concepts emerging from classical physics and quantum theory considered relevant to the current study will be highlighted.

4.1 Relevance of the current theoretical framework to previous research and mental health practice

This study explored, documented and conceptualized the views of Irish persons with recurrent mental health problems on recovery, and built a coherent theoretical framework of recovering. Within the limitations of its sample, the study adds to both national and international in-depth understanding of what recovery is and how it can actually happen from the point of view of those recovering. The study also adds the voices of Irish service users to the international research on recovery. It is hoped that this study will facilitate understanding, promotion and implementation of the recovery vision and philosophy within the Irish mental health care in accordance with *A Vision for Change* (Department of Health and Children 2006).

The findings show that despite the multiplicity and variety of ideas about mental health, mental illness and recovery, there are many shared elements of recovery connecting international research. Such high-order complex concepts as hope, self-determination, and meaningful connection emerging from the current study are congruent with those identified in the previous recovery research. Moreover, viewing recovery as a process of gradual reconnection with life fits in and integrates diverse views on recovery and rehabilitation (Anthony 1993, Onken *et al.* 2007). It further expands the previously identified processes of spiritual reconnection of self and others (Higgins 2008), reconnection of spiritual, cognitive, emotional and physical aspects of self (Forchuck *et al.* 2003), and the importance of active coping and resistance in recovery, referred to in this study as fighting to get better (Ridgway 2001, Olason & Roger 2001).

In addition, the identified process of reconnecting with self and others in time adds clarity to previously coined concepts of growth, change, development, and transformation (Andresen *et al.* 2003) Non-linearity of the phases of recovery found by this study is in agreement with consumer views that stages of recovery are individual and should not be prescriptive or standardised (Deegan 1996) The view on recovery as reconnection with life is in agreement

with consumer definitions of recovery as a way of living a contributing life (Anthony 1993), living well despite disability (Deegan 1996), and taking control of one's life (Department of Health and Children 2006). As everybody's life circumstances and experiences are individual and unique, it is impossible to apply standard measurement criteria for recovery. However, it is possible to improve a person's connection with self, others and time through encouraging a person to tell their story and define their own goals of recovery depending on life circumstances, wishes and capabilities (Higgins 2008).

A view on recovery as reconnection with life also is congruent with the WHO definition of mental health. Mental health is defined by WHO as 'a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community... In this positive sense, mental health is the foundation for well-being and effective functioning for an individual and for a community. This core concept of mental health is consistent with its wide and varied interpretation across cultures.' (World Health Organization 2007).

This study adds support to the claim that 'subjectivity is not only a source of bias or distortion, but is itself an ordered and intelligible domain' (Davidson *et al.* 2008, p. 139). It can be argued that the view of recovery as reconnection with life is shared by many persons across the globe, whereas some descriptive concepts of life may be based on societal norms and values and therefore culturally specific. For example, work, independent accommodation, and family have been described as inherent in the Western system of values (Onken *et al.* 2007) and were present among the desired goals of reconnection with life in the narratives of this Irish study.

There are multiple probabilities and options on how reconnection with life can be achieved, and both service users and service providers face a challenging task of selecting the best suitable option in accordance with their beliefs and circumstances. The purpose of presenting such a wide choice of previous findings and constructs in the forthcoming sections is not to confuse and exhaust the already tired reader, but to demonstrate the complexity and irreducibility of reconnection with life to one specific theoretical framework. The aim of this discussion is to offer as many alternatives as possible which could help to understand and accommodate the specific circumstances of service users.

Nevertheless, one can argue that once reconnection with others is underway, the fighting spirit and self-confidence are strengthened, and the persons are better prepared to face their 'bad days' in the future, less relapses will occur, which will eventually save funds and time for the mental health services (Mead & Copeland 2000). In addition, it will add to better morale and job satisfaction of service-providers (Hazelton *et al.* 2006).

4.2 From disconnection to reconnection

We feel clearly that we are only now beginning to acquire reliable material for welding together the sum of total of all that is known into a whole; but, on the other hand, it has become next to impossible for a single mind fully to command more than a small specialised portion of it. I can see no other escape from this dilemma (lest our true aim be lost forever) than that some of us should venture to embark on a synthesis of facts and theories, albeit with a second-hand and incomplete knowledge of some of them - and the risk of making fool of ourselves (Schrödinger 1944, p.1)

The intertwined and multifaceted high order connection of spiritual, emotional, cognitive, physical, social and temporal elements of life seems to be taken for granted and go unnoticed until something disconnects from the whole. Due to the complexity of all aspects of health and well-being, disconnection from life may happen in many ways, either instantly or in a gradual fashion. Spiritual dissonance may be accompanied by emotional, social, physical and cognitive disconnection, until the seemingly stable building of life unexpectedly collapses like a house of cards in the wind.

Fortunately, as this study shows, the opposite can happen as well: individual life can be rebuilt and reassembled with own effort, help of others and time. However it usually takes more time and effort to rebuild than it took to destroy; and the new structure may need to be thoroughly propped, reinforced and intertwined with new skills and materials to avoid the previous catastrophe in the future. However once reinforced with previous knowledge and new skills, it may even withstand stronger tornadoes in the future.

But the crucial question seems to be not just how long or how much effort it should take to rebuild one's life. The crucial question seems to be: Why?

Why bother reconnecting with life that seems to be gone, why bother rebuilding the future, why not give up and stay in a temporal shelter of alternative reality instead of facing the ruins of here and now? Why bother resisting the seeming inevitability of the current order of things? Why go against the past and try to readjust the future? Where am I, where was I, and where will I be in the future? What's the meaning of it all? What is life about?

Judging by this study, trying to finding meaningful answers to some of these questions may be crucial to recovery from mental health problems. One should be highly motivated by the vision of the full building to undertake reassembling the unique order of its elements destroyed by the wind. The effort may require time, patience, labour, perseverance and support; but as they say, when there is a will, there is a way. In this chapter, I will try to tackle some of these questions.

4.3 What is life?

There is no agreement on the definition of life neither in sciences nor in arts, although most people feel that they know it when they see it (Chao 2000, p.245). The concept of recovering from mental health problems is similar to that of life, as it is very difficult to describe it and yet it is undeniable when one sees it:

I think some of my friends who had major mental health problems, I don't know how to describe this, you know, it certainly is, the place they are now, to me it would be 'recovered'. It's one of those things you can almost see in people, if that makes sense to you, particularly if you've been through it yourself (9).

During the final synthesis of the results of the current study, I asked several friends and colleagues how they would define life without much thinking. The only instant definition given to me was that life was the opposite of death. But then, what is death?

In a series of lectures delivered at Trinity College, Dublin in 1943, Erwin Schrödinger, an Austrian physicist, a Nobel laureate and one of the founders of quantum theory suggested a definition of death as maximum entropy (Schrödinger 1944). Entropy as the natural tendency to equilibrium, disorder and decay of all material things was defined by the Second Law of Thermodynamics (Greene 2007, Schrödinger 1944). Schrödinger's definition of entropy reads as follows:

When a system that is not alive is isolated or placed in a uniform environment, all motion usually comes to a standstill very soon as a result of various kinds of friction; differences of electric or chemical potential are equalized, substances which tend to form a chemical compound do so, temperature becomes uniform by heat conduction. After that the whole system fades away into a dead, inert lump of matter. A permanent state is reached, in which no observable events occur. The physicist calls this the state of thermodynamical equilibrium, or of 'maximum entropy' (Schrödinger 1944, p. 24).

Schrödinger argued that living organisms, in contrast to the physical matter, have an amazing inherent capacity to evade the decay to equilibrium, i.e. entropy. Thus, Schrödinger defines life as negative entropy. Despite the fact that the material, or physical structure of a living organism is subject to increasing entropy and disorder, by continually drawing order from the environment and freeing itself from its own disorder, it seems to be able to delay, resist or evade the dangerous state of maximum negative entropy and disconnection.

Pending further discoveries on Earth and beyond, Schrödinger's definition of life is still considered most useful in biology, astronomy, and physics (Chyba & Hand 2005). It echoes Aristotle's definition of life as the capacity for self-induced alteration, attributed to the soul (*anima*) of the living body (Chyba & Hand 2005, Aristotle 1941, Byers 2006).

Descartes denied the Aristotelian view, comparing the body to a self-propelled machine which motions could be explained in terms of self-sustaining properties of the matter (Byers 2006). One can argue that the Cartesian view of the living body as a ‘self-propelled machine’ which motions can be explained through chemistry, genetics, brain circuits and other observable phenomena may still dominate psychiatry, cognitive psychology and neuroscience.

The view of Descartes on life of the body as a ‘self-propelled machine’ does not adequately address the question of ‘why’. Why do some things metabolise and change to sustain themselves, and some do not? (Byers 2006). Is there something more to me that allows me to be both a passive witness, and an active decision-maker of my life (Dennett 2003), or is the latter just an illusion? (Wegner 2004).

While the jury is still out on the last question in cognitive psychology, neuroscience and some other disciplines (Wegner 2004), the narratives of the participants of this study suggest that there may be indeed something more to one’s life than just being its passive witness. Moreover, this study presents empirical evidence in the form of personal narratives that it may be the perceived loss of this human capacity to decision-making and self-induced change, and the feeling of being reduced to a passive witness that lies at the epicentre of emotional distress. Conversely, self-discovery and reactivation of an inherent human capacity to change helps to reconnect and improve functionality of other observable physical and neural resources, as well as some physical body movements such as getting out of bed, going out, and doing physical, artistic, or intellectual work. At the core of the process of reconnection with life in this study was an active, self-induced, and self-sustained effort labelled as fighting to get better, which can be further defined as fighting against entropy and the seeming irreversibility of the state of disconnection from life.

4.4 Reconnecting with self

The current section will discuss previous findings relevant to the stage of reconnecting with self and its underlying processes.

4.4.1 Giving up and fighting for recovery

The categories of fighting to get better and giving up were relevant for all participants of the current study. The category of ‘giving up’ was associated with accepting the hopelessness of diagnosis and the label of mental patient, and handing over control to mental health service provision, medication or their carers for their life. Giving up was also associated with a lack of hope that recovery or better life was possible, and lack of self esteem and self-confidence.

Subjective experiences and representations of physical illness has been studied much more extensively compared to those of mental illness (Fortune *et al.* 2004). A concept of ‘Giving Up

– Given Up’ similar to the one emerging from this study was coined by Engel (Engel 1967). It was associated with hopelessness and helplessness, and usually appeared before the onset of physical illness. One of its characteristics was slowing down of bodily functions (e.g. heart rate). The complex of ‘Giving Up – Given Up’ was sometimes triggered by loss of a significant other and was also observed in the context of mental illness (Adamson & Schmale 1965).

A construct similar to ‘giving up’ was described by Frank as ‘demoralisation’, which typical features were feelings of impotence, isolation and despair (Frank 1974). Frank believed that demoralisation was one of the major underlying causes of anxiety and depression, and the main reason why people sought therapy. In Frank’s description, those demoralised ‘are conscious of having failed to meet their own expectations or those of others, or of being unable to cope with some pressing problem. They feel powerless to change the situation or themselves and cannot extricate themselves from their predicament (Frank & Frank 1993, p.35). The core features of demoralisation were described as ‘a feeling of being trapped, not knowing what to do, becoming helpless’ (Clarke & Kissane 2002, p.734) and are very similar to the feelings of being ‘trapped’, ‘stuck’, or unable to ‘move on’ emerging from participants of this study.

The concept of ‘giving up’ was also found to be closely associated with an inability to commit an action found inherent in persons with schizophrenia (Lysaker *et al.* 2006). Inability to commit an action was interchangeably labelled as ambivalence, demoralisation, or avolition. The authors describe the experiences of two persons undertaking psychotherapy as a progression from ‘volitional paralysis’ to ‘the gradual recovery of a sense that one is capable of action’ (Lysaker *et al.* 2006, p.81). The restoration of inherent capacity of making decisions and following them through was also voiced by participants of this study as a necessary constituent of reconnecting with life.

The concept of fighting to get better identified in this study had elements of confrontation with the pessimistic prognosis, chronicity of their illness and deterministic attitudes of service providers. It was also associated with a return of energy, spirit and intrinsic motivation to get better. Whereas it is hard to generalise on the basis of our findings if fighting was something inherent in a person from birth or it developed gradually, all participants commented that fighting started with getting hope and energy, and the belief that recovery was possible. In a few cases, fighting started from as a negation or a revolt against being seen as a disease or seeing other patients who gave up and not wanting to be like them.

It is worth noting that only one person in the study self-identified himself as the closest to giving up, commenting that he was probably the only one among the other people he knew. The rest were identified and self-identified as fighters, trying hard to get better and using any available tools including medication, talking, physical and intellectual activities. It may not be

surprising in the context of the inclusion criteria of the study: self-nominated persons who felt they were in improvement and were willing to talk about recovery.

The *in vivo* concept of fighting for recovery identified in this study was very similar to the concept of ‘fighting spirit’ emerging from studies in psycho-oncology (Morris *et al.* 1992). The concept of ‘fighting spirit’ in oncology contained four dimensions: a highly optimistic attitude; a search for more information about the illness; a wish to fight, defeat, or conquer cancer; not being taken over by emotional distress (Greer *et al.* 1979). Persons with higher scores on the first three dimensions also scored lower on emotional distress.

In psycho-oncology, compliance and the tendency to suppress negative emotions or anger was found to lead to chronic helplessness when faced with the ‘finality’ of cancer diagnosis, and to influence prognosis (Temoshok 1987). Seeing cancer as a severe and enduring threat of all aspects of life significantly reduced survival of patients (Morris *et al.* 1992). The latter study suggested that there was a conceptual overlap between stoic acceptance, fatalism, and helplessness. The view of such persons of the future was described as ‘Life can never be good as it was before’ (Morris *et al.* 1992, p.113). Conversely, the attitude of patients with higher levels of fighting spirit was summarised as ‘I will live as I lived before, maybe better’ (p.112).

The construct of fighting spirit was included into a new scale entitled the Positive And Negative Expectancy Questionnaire (PANEQ) which yielded three distinct factors labelled negative affect/pessimism, fighting spirit, and positive affect/optimism (Olason & Roger 2001). Fighting spirit contained such concepts as expectation of success, determination and endurance. The authors argue that the discriminant validity of the three-dimensional scale was better than previous bipolar optimism/pessimism scales due to the inclusion of the dimension of the fighting spirit scale which captures persistence in emotionally and cognitively challenging settings.

The concept of fighting spirit may be essential for persons recovering from mental health problems. It may explain why some persons did not accept the finality and pessimism of their diagnosis, especially if it was schizophrenia generally associated with chronicity and hopelessness. Moreover, it may be considered as a necessary prerequisite of reconnection with life. Fighting spirit can serve as a predictor of successful reconnection and therefore needs to be supported and encouraged by the mental health services.

4.4.2 Intrinsic motivation and self-determination

As suggested by the participants, the initial decision or desire to start fighting for one’s recovery had to come from within the person. A lot of participants of this study felt that their inner

interests and goals were not taken into consideration by service-providers, which sometimes interfered with their reconnection with selves and taking responsibility for own recovery.

The concept of intrinsic motivation as opposed to controlled motivation is based on self-determination theory (Deci & Ryan 1985) and learned helplessness theory (Abramson & Seligman 1978). Learned helplessness theory of depression is based on behaviourism and was first coined after experiments with animals which were subjected to mild but prolonged stress and developed depressive symptoms and amotivation. Learned helplessness theory was then transferred to a hypothesis about human behaviour.

If persons had been exposed to offensive, forcing or highly unpleasant events outside of their own control, they may acquire learned helplessness, leading to amotivation, and cognitive and emotional difficulties. Such persons may exhibit impaired curiosity, lack of learning skills, and depressive mood (Abramson & Seligman 1978). Some of the previous experiences of the participants of the current study included violence, sexual abuse, bullying, parental neglect, parental alcohol abuse and other unpleasant or stressful events. It can be hypothesised that unpleasant experience in the past could have negatively affected self-determination, intrinsic motivation, and decision-making in the long term.

Learned helplessness theory was further reformulated to include attribution theory of the causes of events to various factors (Abramson *et al.* 1978) and association between explanatory style and illness (Peterson & Seligman 1987). Attribution of negative events to global, stable and internal factors such as lack of ability, negative personality, or the general impossibility of finding a solution to a problem could lead to 'catastrophizing' of negative events, which could make an individual more prone to depression and pessimistic outlook on the future (Abramson *et al.* 1978). For example, being diagnosed with mental illness in a way which implies that some internal, stable and non-modifiable factors caused such illness (such as inevitable genetic, personality, upbringing ones and so on) can further contribute to learned helplessness which could already have been triggered by some previous highly negative events in a person's life. Whereas self-blame may be partially removed by means of the global, internal and stable biological causal explanations of mental health problems, the uncontrollability of mental health problems implied by such explanation can contribute to further development of learned helplessness and loss of intrinsic motivation. Conversely, interpretation of negative events as stemming from external, dynamic and context-specific factors such as being temporarily subjected to external family-specific or work-specific negative factors may partially remove the effects of learned helplessness and increase the estimated probability of positive outcomes in the future (Abramson *et al.* 1978). However will the effects of learned helplessness be removed completely by dynamic external causal explanation?

The theory of depression as the product of learned helplessness in humans was originally based on the notion of an internal versus external locus of control (Rotter 1966). Depression was seen as stemming from an individual's stable internal characteristics, such as attribution of outcomes of events to the internal (self) or external forces (other people, events or circumstances). Persons with higher internal locus of control were seen as less prone to depression and helplessness as they perceived themselves as inherently capable of controlling external forces, and *vice versa* (Peterson & Seligman 1984).

However some studies failed to establish whether the cause of helplessness was a belief in an external or internal locus of control (Ozment & Lester 2001). Whereas helplessness scores were positively associated with depression, the role of internal or external locus of control in helplessness was less important. The authors suggested that the learned helplessness theory needed to be reformulated, as the concept of locus of control does not provide a sufficient explanation of either risk factors leading to depression or its positive outcomes.

The current study suggests that it may be impossible to completely separate external and internal locus of control, due to the dynamic entanglement of self, others and the moving time of one's life. Shifting the 'blame' from the self to others for the occurrence of negative events or the non-occurrence of positive events may be also unproductive and promote passive expectation for others to change direction of one's life. It may be only through acknowledging the wholeness of the interaction of internal and external, controllable and uncontrollable factors, and searching for a context and time-specific solution that a person can synchronise with one's life and reconnect fully with self, others and time. Biological, psychological, internal, social, context-specific, and time-specific factors may all play their role in the shaping of motivation to find solutions notwithstanding the seeming magnitude of a problem. Moreover, multiplicity of causal explanations may contribute to the emergence of multiplicity of possible solutions, which in turn can increase hope and intrinsic motivation to try out as many solutions as possible, and find out which works better in each individual case. An exploration of multiple interactions of internal, external, dynamic, stable, global, and specific causal explanations of events, and their relationships with positive well-being can highlight further directions for the development and application of the learned helplessness theory to mental health.

In self-determination theory, human behaviour is described as resulting from intentionality, which refers to the conscious or spontaneous formulation of future behaviour which this person will attempt to perform. Amotivation can be regarded as behaviour not regulated by one's intentionality, either due lack of self-confidence or some environmental barrier such as arbitrary control of authority. Due to the lack of own intentionality amotivated persons may experience the feelings of frustration, fear, or depression.

Self-determination theory may provide a better explanation to development of intrinsic motivation, than the learned helplessness theory relying on the notions of external versus internal locus of control. Self-determination theory takes into account both internal and external circumstances of a person, and their change over time. Control-determined behaviour, though regulated by one's intention, is not a result of free choice and is considered to be extrinsic motivation (Deci & Ryan 1985). A person's control-determined behaviour may be dictated by either internal or external controls, or coercion, perceived as something that one has to do out of fear or self-preservation, and may be accompanied by the feelings of pressure or anxiety. Some participants provided examples of coercion and control inherent in their treatment experiences. Obviously when intrinsic motivation, or freedom of choice was not facilitated, the persons were not intrinsically motivated to comply with the treatment suggested by others, be it pharmacological or other.

Contrary to extrinsic or control-determined behaviour, intrinsically motivated behaviour is initiated by choices based on personal interests and goals. When persons were asked about their preferences or choices in this study, they felt more interested in the outcomes of their own actions and more motivated to try new things. It may be crucial to support intrinsic motivation in recovery, by asking persons about their interests and finding out their capabilities, as opposed to expecting them to benefit from activities previously shown as beneficial to other persons.

4.4.3 Conation as fighting spirit in psychology

Participants of this study spoke about the importance of will, will-power, and wanting to get better for the emergence and sustaining of their 'fight' for reconnection with life. Another psychological concept highly relevant to the process of fighting to get better identified in this study is that of conation.

The traditional view on constituents of mind in psychology included three components: cognition, affect and conation (Gerdes & Stromwall 2008, Tallon 1997). Whereas cognition can be as the process of getting to know and understand, i.e. the process of encoding, sorting, processing and retrieving information, affect refers to emotional processing of information and can be associated with positive and negative feelings about people, information, experiences, or events (Gerdes & Stromwall 2008). Conation can be described as a personal, striving, goal-oriented aspect of motivation that translates cognition and affect into proactive, as opposed to habitual behaviour (Tallon 1997).

Conation is very close to the concept of volition, or the use of will, and freedom to make choices about what to do (Snow & Jackson 1994, Mischel 1996). The four major components of conation could be described as proactive, directional, energizing, and persistent (Huitt 1999). The directional component of conation is in agreement with hierarchy of needs theory, specifically, the need for self-actualization (Maslow 1954). The directional component of

conation also involves setting goals and an awareness of a 'possible self' which provides the bridge between goal and reality (Markus & Nurius 1986). The importance of a vision of future self emerged as vital for the decision of participants to either 'give up' and accept the passive identity of a mental patient, or to start their 'fight' for the better future. Such fight entailed proactiveness in designing own recovery, directionality of futurising and moving on, and persistency of on-going and sometimes risky effort of fighting. In addition, fighting to get better required a lot of energy. All the four characteristics of conation seem to be inherent on the process of fighting to get better identified in this study. Conation may therefore play a vital role in reconnecting with life, and should be explored in this context.

Some argue that one of the reasons why researchers failed to identify strong predictors of behaviour in the areas of cognition and attitudes was omission of the construct of conation from research (Bagozzi 1992). As overt behaviour and cognition received more attention, interest in conation subsided whereas before both emotion and conation had been considered central to the study of human behaviour (Amsel 1992). The existence of free will, self-determination and spirituality has been gradually disputed and ousted from psychology by scientific determinism and the march of experimental empirical research (Gerdes & Stromwall 2008).

Another possible reason why the study of 'conation' was neglected in favour of studying behaviour, cognition and emotion is that all these concepts are intertwined and are difficult to separate (Snow 1989). Conative components are inherent in the measures of cognition and emotion. Similarly, conation has cognitive, affective, and volitional components which are highly correlated (Snow & Swanson 1992).

However as this study shows, all aspects of the self, such as physical, emotional, cognitive and spiritual could be highly correlated and inseparable. An exploration of one element of the self may not be as productive and enlightening as studying the interrelations of elements representing the whole. Re-introducing the concept of conation in psychology may highlight new directions for research of psychological health and well-being and recovery from mental or physical illness.

4.4.4 Embodiment: bodily intentionality

As shown by the results of this study and by previous research, mental health may interact with physical health in multiple ways. In this study, improvement in spiritual or emotional aspects of self was often followed by improvement of physical health. Blood pressure, weight problems, asthma, and stomach pain were reported to improve or disappear upon improvement of mental health. Conversely, physical exercise was giving energy and positive emotions, which in turn improved self-confidence, self-esteem and perceived quality of relationships with others.

Whereas it is beyond the scope of this study to lay out an exhaustive argument in favour of a holistic view of self as a complementary unity of mind and body, the current findings supported by some previous research definitely point in this direction. There is already a large body of evidence suggesting the link between physical and mental health. Physical and mental aspects of the self seem to be highly correlated and interconnected, and improvement of physical health can lead to improvement of mental health and *vice versa*. The concept of embodiment has been recently proposed as useful for epidemiological and health research (Krieger 2005). After all, living beings are not constructed piece by piece as machines or buildings are, but grow and develop as wholes from embryonic forms with already inherent and interrelated processes of feeling, thinking, perceiving, wanting and doing (Shotter 2004).

Merleau-Ponty originally developed this concept to highlight the concordance, or agreement of an individual's lived body with the individual's consciousness (Merleau-Ponty 2002). The main feature of embodiment is 'bodily intentionality', or the 'intending' quality of a living body. The concept of conation or volition may be the driving force behind the reconnection of physical, emotional and cognitive resources of embodied self.

In this study, spiritual reconnection with the self, involving hope, self-determination and intrinsic motivation to change seemed to be the driving force of emotional, cognitive and physical reconnection with self. Similarly, some (Ryff *et al.* 2004) identified correlations between the six dimensions of positive well-being scale (autonomy, environmental mastery, personal growth, positive relations with others, purpose in life and self acceptance) with diverse biomarkers (cardiovascular, neuroendocrine, and immune). Those scoring higher on purpose in life had lower inflammatory markers compared to those scoring lower on this dimension. Personal growth and purpose in life scores were also positively correlated with the levels of 'good' cholesterol (Ryff & Singer 2006).

Moreover, the findings of neuroimaging studies suggest that the subjective intentional content of thoughts, feelings, beliefs, and volition can significantly influence the observable levels of brain functioning such as molecular, cellular and neural (Paquette *et al.* 2003). Neuroimaging studies of the effects of psychotherapy on brain metabolism of patients with obsessive-compulsive disorder (OCD), panic disorder, major depressive disorder, and spider phobia showed that psychotherapy aimed at increasing patients' capacity to choose how to respond to intrusive, depressive, or fearful thoughts and feelings showed significant positive changes in brain activity and brain metabolism (Beauregard 2007). Some argue that by intentionally changing one's mind a person can change one's brain processes and psychological states (Paquette *et al.* 2003).

Emotional self-regulation is defined as a set of cognitive processes with which persons can influence which emotions they have, when they have them, and how they express them (Gross

1999). Such strategies can include rationalisation or suppression. A study of emotional regulation in schizophrenia found that individuals with schizophrenia did not differ from controls with regard to their use of suppression and reappraisal (conscious alteration of emotional significance of the stimulus) as methods of regulating emotion experience and emotion expression (Henry *et al.* 2008). Moreover, both controls and participants with schizophrenia demonstrated the same correlation pattern between reappraisal and well-being, whereas greater use of reappraisal was associated with better social functioning. The reported increased use of reappraisal by participants diagnosed with schizophrenia was associated with significantly reduced depression. The results of Henry *et al.* (2008) study suggest that persons diagnosed with severe mental illness use similar mechanisms to regulate or to suppress emotions as those undiagnosed. Suppression of emotion in itself may not be a maladaptive strategy for persons with schizophrenia, as had been previously hypothesized, and can be interpreted as a protective self-regulation of negative emotions (Henry *et al.* 2008).

These findings are congruent with the narratives of some participants of this study on how they gradually learnt to control and change their negative emotions with positive thoughts and self-talk. In case of those participating in GROW, one of GROW's healing principles, 'be reasonable', was reinforced through group discussion and repetition. In other cases, reconnecting with and reflecting on one's emotions was achieved through psychotherapy or counselling. Finally, those who did not have access to GROW or psychotherapy learnt some strategies of emotional self-regulation from their peers or found them out themselves through trial and error.

Overwhelming negative emotions such as anxiety, fear or sadness may cause suffering and aggression when not cognitively controlled. However constant suppression of negative emotions and inability or unwillingness to express emotions or to speak about them can also be detrimental to one's mental health (Gross 1999). Emotions appear to be inherent in normal conscious experience and are necessary for language fluency and memory (Duncan & Feldman Barrett 2007). Some argue that the positive contribution of emotions to mental health has been neglected in Western culture and psychiatry (Williams 2000). Emotion can be seen as 'woven into the very fabric of our reasoning; from scientific observations and the generations of hypothesis, to moral understanding' (Williams 2000, p.66). Some suggest that goals must have emotional components in order to be effective and turn into performance (Epstein 1990).

Participants of this study felt that allowing themselves to feel, speak about their emotions with others, or express their emotions through arts or writing helped them to release negative emotions, learn to control them in the future, and create space for positive emotions. Encouraging a person to tell their story could facilitate a quicker cognitive-emotional reconnection and help to overcome negative emotional states previously considered unavoidable

and unbearable (Jackson *et al.* 2003). Critically, people need to work out the best strategies for reconnecting and activating their available resources and apply them with support and encouragement from others. This leads us to the importance of others in the process of reconnection with self on spiritual, cognitive, emotional and physical levels, and reconnection with life in general.

4.5 Reconnecting self with others

This section will describe relevant research findings pertaining to the processes of reconnecting self and others, considered as a crucially important phase of reconnecting with life.

4.5.1 Meaningful connection: acceptance, validation and empathy

Accepting oneself as a worthy human being in most cases arose from meaningful connection and being accepted as such by others, which helped to develop one's intrinsic motivation to change, to reawaken one's fighting spirit, and to further reactivate and reconnect one's own emotional, cognitive and physical resources. Some suggest that suffering of those demoralised can be relieved by health professionals through establishing empathic relationships aimed at 'a restoration of self-esteem and self-efficacy that comes through increased competence and human connectedness' (Clarke & Kissane 2002, p.740).

Simulation Theory (ST) holds that people use their knowledge about themselves to understand others (Goldman 1992). ST has been recently supported by the discovery of mirror neurons which are activated both when an individual is acting with a specific goal in mind, and when they see another individual carrying out the same action (Gallese 2001). Such neurons produce a form of brain activity which simulates the behaviour of others and makes it possible for the observer to imply the goals of others' actions. The discovery of functions of mirror neurons underlines the importance of meaningful connection in therapy. It may be only through such meaningful empathetic connection that a better understanding of self and others can be achieved.

A study on empathetic abilities such as emotion recognition, emotional perspective taking and affective responsiveness among persons diagnosed with schizophrenia and controls found worse empathetic performance of persons diagnosed with schizophrenia compared with undiagnosed controls (Derntl *et al.* 2009). According to the latter study, emotional perspective-taking was the most difficult task for persons with schizophrenia which worsened with increased symptomatology. The authors suggested that remediation of such 'deficits' may improve patients' daily life, reduce personal distress and improve social functioning.

The views and experiences of participants are congruent with this recommendation. Through talking to others persons whom participants knew and trusted, participants started to understand

and to accept themselves. By understanding and accepting themselves, participants in turn started to understand others better. With practice, instant relatedness of feelings and thoughts became easy to establish even with persons seen for the first time, e.g. met on the train or in public.

Acceptance and validation has been developed as the key starting principles of dialectical behaviour therapy (DBT), designed for persons with borderline personality disorder (BPD) considered as most problematic of all patients (Lynch *et al.* 2006b). Whereas no participants of the current study reported that they had been diagnosed with BDP, acceptance of persons as they were in the here and now, and validation of current and previous experiences were mentioned by all participants when describing meaningful connection with nurses, psychiatrists, psychotherapists or peers as crucial in re-awakening of hope and will for positive change.

In DBT, a purely change-based approach was found inefficient as persons with BPD often dropped out of treatment in response to being invalidated (Linehan 1993). Similarly, participants of the current study reported their unwillingness to communicate with some psychiatrists or nurses when they felt their experiences and personality were not accepted and validated. Acceptance and validation of a person as they were was found to facilitate commitment to positive change in the future (Lynch *et al.* 2006b).

The theory underpinning causality of BPD is based on biosocial theory, whereby a biological tendency towards emotional vulnerability is affected by an invalidating rearing environment characterised by punishing, ignoring, or trivialising the person's communication of thoughts and emotions, as well as possible sexual, physical and emotional abuse (Wagner & Linehan 1997). Most of participants of the current study reported social and environmental problems they faced either in their childhood or adulthood, including sexual abuse, physical abuse, neglect, lack of emotional or spiritual connection in the family, loneliness, and stigma.

The principle of mindfulness in DBT involves reducing the patient's attempts to control their personal experiences including emotions, thoughts or bodily states but learning to control the focus of attention, i.e. observing a thought or emotion in a reflective, neutral fashion without trying to suppress the experience. Mindfulness may therefore facilitate emergence of alternative responses to unpleasant thoughts or feelings by creating internal context which can be applicable to a variety of external contexts where such thoughts or emotions can occur. It may therefore help with the accumulation of alternative responses which may be selected in a new situation, and help to get control of unpleasant thoughts and feelings. For example, a study on influence of mindfulness training on subjective experiences of voices and hallucinations found that mindfulness training allowed participants to accept voices and hallucinations as they were, rather being scared of them or judging them as wrong, which contributed to their subjective well-being and improved clinical functioning (Chadwick *et al.* 2005).

A study on the influence of self-reflection and autobiographic narratives on the capacity to understand the thoughts and emotions of others suggested that changes in the levels of self-awareness through personal narratives may lead to changes in levels of awareness of others in persons diagnosed with schizophrenia (Lysaker *et al.* 2007). This finding is especially important concerning the fact that some studies show patients with schizophrenia appear to recall less self-defining memories about past achievements and more memories regarding hospitalization and stigmatization of illness (Raffard *et al.* 2009).

Affirmative intimate social relationships characterized by self-disclosure of negative feelings and perceived responsiveness, whereby individuals felt that they were understood and appreciated by others, were found to positively influence both physical (Kelley *et al.* 1997) and emotional well-being of individuals (Reis 2001). It is argued that such understanding and appreciation of others can only stem from establishing meaningful connection on a spiritual level, whereby a person is accepted as an equal human being no matter what their external and internal condition could be at that moment. Moreover, other research shows that establishing such connection may positively influence a broad range of individual cognitive and emotional processes (Reis & Collins 2004).

A three-country study of patient perceptions of physician responsiveness has shown that GPs perceived as listening, trustworthy, and responsive to emotional needs significantly predicted both patient satisfaction and subjective health (Reis *et al.* 2008). Those knowing their physicians longer also perceived them as more responsive to their needs. The importance of continuity of care for the development of trust and meaningful connection with service providers has been underlined by the current study and confirmed by previous findings (Reis *et al.* 2008).

In this study, participants did not feel comfortable to start talking about their previous background at the beginning of the interviews, until they established trust in the interviewer. One can also hypothesise that some could not recall their experiences until they spoke about other things for a while. Speaking about short term-past and present could have triggered their long-term memory which then reconnected them with some meaningful parts of the past. However more studies are needed to verify this hypothesis.

The findings of the current study showed that often due to the lack of time and a constant change of service providers, the participants did not always have a chance to either develop a trust in their service providers, or speak about their experiences after having established such trust. However they felt that talking about their negative experiences would have been helpful for the development of a positive view on themselves and better understanding of others. Moreover, participants complained that sometimes they were not listened to by service providers, not involved in a dialogue and not empathised with.

As can be seen from the findings of this study, achieving empathic, meaningful, humane connection may be a challenge in the modern mental health services. Empathy requires seeing first and foremost a shared humanity in a person as opposed to depersonalised illness. Participants of this study complained that they themselves and their experiences were often disregarded and devalued by psychiatrists, nurses or other health professionals in favour of diagnostic categorising and answering standard questions about mood and cognition. Service users were often denied dialogue, talking, and being listened to.

When acceptance, validation and dialogue did not occur, patients had little trust in the service-provider or motivation to comply with the suggested treatment. No matter how effective suggested medication could have been considered by the practitioner, the patient who did not trust the practitioner, may not have expected treatment to be effective and was not motivated to comply with it. Re-introducing meaningful, non-judgemental and empathic connection through listening, emphasising and encouraging dialogue is vital for recovery-oriented services.

4.5.2 Giving back to others: altruism

Development of an understanding of others and the ability to give back to others were voiced by the participants of this study as important needs and tools of reconnecting with life. Those who had children, grandchildren, significant others, or even pets found it easier to start and sustain their fight to get better. This finding is congruent with the concept of relational self in interpersonal-cognitive theory (Andersen 2002): ‘Our central argument is that the self is relational – or even entangled – with significant others and that this has implications for self-definition, self-evaluation, self-regulation, and, most broadly, for personality functioning, expressed in relation to other’ (p. 619). Andersen (2002) argues that motivational and emotional patterns of behaviour are also shaped by the relational self.

Some claim that becoming more human represents a continuous process of becoming more altruistic (Morrison & Severino 2007). The authors describe altruism as arising from realization that everybody is interrelated: ‘When altruistic, we do not just love the other for who the other is; we love because we know that we are part of the other and the other is a part of us’ (p.26).

Similarly to the interpersonal-cognitive theory, Morrison and Severino (2007) describe altruism as arising from realization that self and others are interrelated: ‘When altruistic, we do not just love the other for who the other is; we love because we know that we are part of the other and the other is a part of us’ (p.26). The authors introduce a further useful distinction between nepotism, which limits unconditional love to specific groups of people (e.g., love of relatives only), and an altruistic recognition of interrelatedness and interconnectedness of all human beings. It is this recognition of universal relatedness that distinguishes those ‘fully human’, who can realise their existential meaning through giving back something positive to the world of others who share the same humanity with self.

A grounded theory study of how mental health nurses work with suicidal patients identified a core category of reconnecting the person with humanity (Cutcliffe *et al.* 2006). The first stage of the process included experiencing intense, warm, care-based human to human contact allowing the patient to gain trust in the nurse and humanity in general. Both participants of GROW and service users reported how they developed realisation that people were equal and shared the same humanity with each other, which contributed to a sense of belonging somewhere. Such realisation developed gradually, starting from a feeling that you were not alone in a small circle of peers, friends and gradually extended to include people in general. True friendship with others was defined as a 'two-way thing': others 'being there' for you, and you 'being there' for others. Among friends there were peers, neighbours, and nurses. Inherent in definitions of friends were shared experiences, shared educational backgrounds, shared sense of humour, and shared moral values of 'good' and 'bad'.

The potential and willingness to give back to others were considered by participants as crucial for their reconnection with life. The ability to do voluntary or paid work was viewed as very important, as it meant helping others and thus made a person feel good about self. Not being a burden on the others, being useful, having a reason or purpose to be here, making some difference and bringing some positive change to the world contributed to motivation to change and learn new things, and brought a sense of achievement and joy to the day. Conversely, believing that one was unrelated to anybody or anything in the world, was a burden on others led to giving up one's fight for partial or complete reconnection with life.

This study argues that believing in the one's ability to give back something positive to life was a driving force behind reconnection of one's spiritual, emotional, cognitive, and physical resources. However at the beginning of the process of reconnection, with self-esteem and self-confidence still being weak, persons needed frequent validation and verification from others that they were going in the right direction. Participants needed somebody to believe that reconnection with life was possible, even when they could not believe it fully themselves.

4.5.3 Reconnecting self, others and something bigger: spirituality

The concept capable of embracing the process of re-connection of self, others and something bigger is spirituality. Three factors of a holistic spirituality scale were identified in a study of spirituality among persons with chronic illness (Delaney 2005). The three factors were self-discovery (intrapersonal, or self), relationships (interpersonal, or self and others), and eco-awareness (transpersonal, or self, others and the universe).

The existential aspect of spirituality is associated with search for meaning and purpose, and the questions of 'Why? What for?' which encompasses both interpersonal (self and others) and transpersonal (something bigger) aspects of existence. The search for meaningfulness in life may be central to the human experience and in this sense is similar to conation (Frankl 2000).

Being reaffirmed that there is some reason for a person to be in this world can trigger the will to start fighting for further reconnection with life.

The search for meaning and purpose leads to growth, healing and transformation (Delaney 2005). This is especially vital in recovering from mental health illness. Studies on health effects of spirituality or religious activities identified positive significant links with reduction of depression and anxiety, increased longevity, and other multiple physical and psychological health benefits (Ellison & Levin 1998, Mueller *et al.* 2001, Costanzo *et al.* 2009). Spirituality underlies the continued growth of 12-step programmes for substance abuse (Hopson 1996), and was found to be a unique and core predictor of quality of life in hospice care and psycho-oncology (O'Connor *et al.* 2007, Whitford *et al.* 2008, Costanzo *et al.* 2009).

In this study, spirituality emerged as one of the key aspects, or levels of reconnection with self and others through reawakening of hope, fighting spirit, meaning, self-acceptance, empathy, and altruism. Participants of this study mentioned the positive influence of their religious beliefs, going to church with others, and prayer. Prayer helped reconnection with self through meditation, self-acceptance, and finding purpose, whereas church attendance helped reconnection with others through joint activities, interaction, tolerance, and understanding.

As recent U.S. research shows, psychiatrists are more likely to encounter religious or spiritual issues in clinical settings than other practitioners (Curlin *et al.* 2007). Ironically, several studies also established that psychiatrists are significantly less religious than the general population, their patients, and other practitioners (Galanter *et al.* 1991).

There has been a historical tension between religion and psychiatry, with Freud equating religion with psychosis and even equating religion with an enemy of mental health (Freud 1964a, Freud 1964b). However the tension may be waning currently due to the recognition of positive effects of spirituality on mental health. Some evidence shows that symptomatic outcomes improve with incorporation of discussion of spirituality issues congruent with patient beliefs in the therapy (Curlin *et al.* 2007).

One of the biggest strides in U.S. psychiatry was the recognition that religious/spiritual beliefs are not inherently pathological per se, whereby a diagnostic category for religious and spiritual problems was included into DSM-IV (Turner *et al.* 1995). Some suggest that the growing clinical importance of spirituality/religion in psychiatry requires renegotiation with a view of addressing religion and spirituality issues in their clinical practice (Curlin *et al.* 2007).

Judging by the narratives, spiritual beliefs are not often discussed in the Irish mental health settings. The reasons for this need to be further explored. Some argue that a search for meaning may be especially challenging in the 21st century, due to existential vacuum associated with consumerism and the predominance of physical/bodily matters over the spiritual/moral.

4.5.4 Role of positive and constructive feedback in development of self-esteem and self-confidence

Self-esteem and self-confidence were viewed as vital for one's reconnection with life by participants. These concepts were reported important for mental health rehabilitation (Griffiths 2009). However participants felt that it was very difficult if not impossible to develop self-esteem and self-confidence in isolation, without support from other people, and getting both positive and constructive feedback. In fact, self-esteem was strengthened through empathic acceptance and validation by others, and self-confidence through getting positive and constructive feedback. The ability to give back to others, be it through working or providing emotional support, led to development of self-worth and self-confidence.

Some suggest that the links between self-esteem and resilience have been previously underestimated because of the unidimensional model of self-esteem as self-regard, or self-worth (Miller & Daniel 2007). Mruk provides a two-dimensional model of self-esteem: as the integrated sum of self-worth and self competence (Mruk 2008). In order to have a positive self-esteem persons must both feel confident about their sense of worth as a good person entitled to respect from others, and their self-competence, or the ability to face life challenges (Mruk 2008, Miller & Daniel 2007) According to the two-dimensional model, if a person has low self-esteem in either dimensions (self-worth or self-competence), they may exhibit defensive, or pseudo self esteem which can lead to anti-social behaviour/aggression, narcissism, or depression (Mruk 2006, Mruk 2008).

The helping nature of GROW programme aided some participants in the development of their self-esteem and self-confidence. They were encouraged and praised for their courage, but also advised what could be done better, which they considered helpful for their personal development which could in turn contribute to others through working, creating arts or just emphasising with others, thus improving something in the lives of others. Persons felt that sometimes they needed to verify with others if they were moving in the right direction, if they were doing things right or wrong, and why. Both positive and constructive feedback was considered important for the development of self-esteem as a sum of self-worth and self-competence.

4.5.5 The role of humour in reconnecting self and others

Participants of the current study considered humour and their increased ability to make others laugh and laugh at jokes of others as both powerful tools and goals of their recovery. Jokes shared with peers, psychiatrists or nurses were highly valued, as they were providing some 'positive energy' which enabled persons to further reconnect with life. One participant recalled that even when being in a catatonic state in an in-patient ward he was able to react and smile at funny faces his fellow patient was making at him, which helped him to get through the difficult period. Joke and laughter can facilitate reconnection others and even turn a bad day into a good

day. The importance of humour was also underlined by GROW participants who commented on the atmosphere of joy and play during the meetings despite the seriousness of the problems discussed.

Use of humour can help to overcome anxiety in the face of adversity, contribute to the feeling of acceptance and belonging, and should not be neglected by recovery-oriented mental health practice and research (Bell & Malhi 2009). The authors argue that humour as a positive resource and an effective means of establishing meaningful connection has been disregarded in psychiatry. Instead of being used as a therapeutic tool, in psychiatry it was usually routinely measured when conducting a mental state assessment or initiating treatment for anxiety disorders or depression.

The research on the influence of positive emotions and humour on mental health is relatively new (Taber *et al.* 2007). A review of recent research identified multiple mechanisms by which pleasure, play and positive life events can help consumers to take an active role in their recovery (Davidson *et al.* 2006c). A recent study found that having clown-led sessions in an in-patient ward twice a week during 83 days significantly decreased incidents of self-injury and fighting (Higueras *et al.* 2006). In another study, a significant reduction in negative symptoms, anxiety and depression was found in persons with schizophrenia who watched comedy movies in a long-stay ward five days per week for three months, compared to patients who watched a mixture of film types with only 15% being comedies (Gelkopf *et al.* 2006).

Appropriate use of humour may facilitate empathic reconnection with others and self-healing, and should not be disregarded in the mental health care. It can contribute to positive energy and optimism, reported by participants as essential for reconnection with life.

4.5.5 Environment: positive and negative energy

If it is difficult for professionals to see a person behind the disease, it may be even more challenging to the general public. The effects of stigma associated with mental illness can be quite pronounced in the Western society (Vogel & Wade 2009). The lack of clarity about what are mental health problems, and how one should react when meeting a person with mental health problems in public, is natural and unavoidable in the historical context when everybody strange or irrational had been viewed as potentially dangerous and therefore institutionalised, i.e., kept away from the sight and the mind of the public.

The stories told by the participants of the study highlight the lack of understanding, empathy, and normal interaction with service users in the community. In a lot of cases, bullying, teasing, and 'badmouthing' led to exacerbation of mental health problems. However negative these experiences are, some argue that it is not the presence of negative interaction *per se*, but an

absence of positive, accepting relationship that may be most detrimental to the feelings of belonging and meaningfulness of life (Lefley 2001).

Day centres provided space for peer interaction and joint activities where a person could feel they were not 'the only one' and could exchange views and narratives with accepting and validating others. Peer support groups served the similar function of understanding, accepting and supporting community. For church-goers, prayer and discussion of spiritual issues with others filled lives with meaning and hope and sometimes made the reality feel more 'real'.

It is interesting that in this study not many issues arose about the aesthetic nature of the environment. Environment was first and foremost seen in terms of people, social connectedness, ill- or well-meaning and thus either contributing to or slowing down one's reconnection with life. If the beauty of surrounding or facilities was important at all, it was viewed as secondary and complementary to the social atmosphere of 'goodness' or 'badness', friendliness or hostility. A good environment was where people smiled and asked 'how are you'; a bad environment was a lack of interaction, loneliness, and bullying. The concepts of negative and positive energy which emerged from participants may be worth further exploration.

The Framingham longitudinal study on the dynamic spread of happiness found that happiness seems to be a collective phenomenon, depending on the happiness of people with whom an individual is connected. The study found observable clusters of happy and unhappy people within social networks (Fowler & Christakis 2008). People surrounded by happy people and central in the social 'happy' network were more likely to become happy in the future compared to those on the borders or outside the network. The authors concluded that the clusters of happiness result from the geographical spread of happiness and not just a tendency to associate with similar individuals. Therefore, providing better care for persons who are sick or recovering in the community may not only increase their happiness but also the happiness of others living nearby (Fowler & Christakis 2008).

One can hypothesise that the opposite may also be true: unhappy or lonely people may affect happiness of other people in the area. In fact, a study on neighbourhood variation in incidence of schizophrenia found evidence for person-environment interaction (Os *et al.* 2000). Both the neighbourhood proportion of single persons and the degree of neighbourhood social isolation seemed to have an influence on the development of psychosis. The higher was the proportion of single people in the neighbourhood, the less socially isolated single persons felt and their odds of developing psychosis were lower. Similarly, the study of the impact of unemployment on mental health found that the risk of suicide among unemployed was higher in areas with less unemployment, with those unemployed being somewhat different and standing out (Platt 1986). Social connectedness and a sense of belonging may buffer and modify personal vulnerability associated with adverse life events or genetic factors.

The latter findings provide at least partial explanation of the cultural and geographical variation in the incidence and outcomes of mental illness found in different countries (Gupta 1992). The attitudes and views on mental illness and recovery may modify the risk of incidence, severity, and outcomes of mental health problems. If mental health problems are viewed as dimensional and something that any individual can experience and overcome in the face of adversity, social exclusion may not be so pronounced and such persons may experience social support and connectedness beneficial to their recovery. Conversely, if mental illness is viewed as a genetic, internal, and environmentally non-modifiable disorder alien to ‘normal’ population, there is a high chance that this person would be feared and avoided rather than socially supported, and reconnection with others and self in the community will be very difficult if not impossible. The influence of the views of others on self may be impossible to separate from the process of reconnection with self in the present and future.

The concepts of negative and positive energy which emerged from participants as inherent in life may be worth further exploration. If happiness and positive energy can transcend non-locally, so can unhappiness and negative energy. Kindness and good will may have beneficial consequences to both physical and spiritual aspects of our existence. ‘Giving back’ may influence both the recipient and the ‘giver’. Maybe there is logic in the end in treating others the way one would like to be treated, as a means of spreading global happiness which may in turn come back to one’s own household.

By helping persons with mental health problems to feel accepted, respected and valued, and helping them to start ‘giving back’ to others, mental health services and the general public can help these persons to regain hope, directionality and meaning, and to take control of their reconnection with life. Conversely, hostility, aggression, badmouthing, bullying, and discouraging from doing things can trigger disconnection from self, others and time, which can in turn increase the risk of self-harm or aggression among persons trying to reconnect with life in the community.

It is hoped that this study will help to spread some ‘positive energy’ by informing the Irish mental health services and the public of the benefits of viewing mental illness as a temporary disconnection from life, which could be overcome with support and encouragement from others, and is open to all human beings.

4.6 Reconnecting self, others and time

The next sections will describe the third interactive phase of reconnection with life identified by this study: reconnection of self and others with time which was essential to feeling fully connected to one’s life.

4.6.1 Good days, bad days: interruption versus immersion

Temporality, or the sense of time, is an essential dimension of human experience which is often taken for granted and remains under researched and under theorised (Hodges 2008). The temporality aspect involves the subjective experience of time as it flows, the continuity or disruption of time during turning-points, or life-changing events, and the subjective perceptions of the pace of time (slow, fast or unnoticed) (Biley & Galvin 2007).

The concepts of good and bad days emerged from participants of this study without original prompting, and proved useful for describing the recurrent, fluctuating, and cyclical nature of the process of reconnection and disconnection. In addition, quality and quantity of good and bad days emerged as possible measures of the personal recovery progress. Good and bad days were generally perceived as inherent in life due to certain level of unpredictability of internal and external environment, expected and unexpected reoccurrence of stressful and joyful events, bad or good weather, sad or happy memories, or physical illness which was not always possible to control.

However acceptance that bad days were inherent in everybody's life rather than symptomatic of one's chronic biological illness made it easier to view them as passable and modifiable.

Whereas one could not stop bad days from happening, one could change something within oneself not to allow bad days to dominate one's life. With some effort, practice and repetition one could even change bad days into good days. Strategies found successful for such change were self-talk, affirmation, prayer, talking to others and other activities aimed at maintaining spiritual connection with self and one's life in general.

The concepts of good and bad days similar to the findings of the current study emerged from studies of subjective experiences in chronic physical illness carried out by Kathy Charmaz (Charmaz 1991, Charmaz 1995, Charmaz 1983, Charmaz 1989). Charmaz found that there were three ways of viewing the illness in time: as an interruption, as an intrusion, or as an immersion into one's life (Charmaz 1991). Persons who viewed their illness as an interruption denied its chronicity. Seeing illness as a temporary interruption of one's life meant having hope for full recovery. Viewing illness as an intrusion meant acknowledging that illness can reoccur, dividing time in good days and bad days, which allowed individuals to somehow stay in control of their life. Finally, those fully immersing oneself in illness gave up hope for recovery and went with the flow of ups and downs of illness which was now controlling self and one's life (Charmaz 1991).

Charmaz' work on subjective perceptions of time have some similarities with this study. Participants of this study disagreed with the chronicity of their diagnosis and despite sometimes pessimistic attitudes of service providers hoped for partial or complete recovery. Not everyone believed that full recovery was possible; bad days were viewed as inherent in life which could

reoccur. The description of 'giving up' was somewhat similar to the concept of 'immersion' in illness suggested by Charmaz (Charmaz 1991). However as hope reappeared and reconnection with self progressed, bad days either disappeared or became non-significant, with good days reigning in life. One can suggest that the views of participants on their mental illness gradually progressed from immersion into disconnection (giving up) to intrusion of disconnection in reconnection only during bad days, and to an insignificant interruption of connection with time. Viewing mental illness as chronic, intrusive and incurable seems to be unproductive and indeed incompatible with the concept of recovery as reconnection with life.

4.6.2 Reconnecting past and future in the living present

Representation of self as an entity extended in time is closely associated with the ability to remember one's past and project oneself in the future. The unconscious living present always contains orientation towards the future in the form of expectation, or hope (Fuchs 2005, Deleuze 2001, Biley & Galvin 2007) However this future orientation is only possible when the living present is also in synthesis with the past. Normally, such synthesis occurs implicitly, without a conscious effort. Therefore, the living present at the peak of happiness, or well-being can be described as an unconscious and spontaneous continuity, or coherence of one's past, present and future.

When an expectation is not realized, or something shocking happens, people can experience time as a moment of shock, disquiet, or stumbling (Roberts 2005, Williams 2003). Fuchs (2005) describes this as a 'gap... between need and satisfaction, desire and fulfilment, or plan and execution' (Fuchs 2005, p.195). The continuity of the past with the expected future may be disturbed, and the person feels disoriented and desynchronized with time. The person needs to explain and store the unexplained shocking experience in the past for it to become subconsciously available in the present and future. Such explained experience can prepare a person to manage it in the future.

Some shocking, embarrassing, frustrating, or fearful past experiences were reported by all participants of the study. When perceived as unexplained and confusing, they were reported to slow down their reconnection with the moving time. Participants reported their inability to 'move on' in time due to being 'stuck' in the negative past and not seeing any positive future. They reported a sense of confusion, a lack of clarity, and inability or unwillingness to remember experiences perceived as important for the re-establishment of coherence of their life. Some felt that they needed to go back to the point of the shocking events associated with the interruption of the continuity of their time, and to explore and explain these events. By remembering and explaining the events and associated emotions persons could reconnect again with the flowing time.

According to the narratives of participants of the current study, it may be the feeling of making sense of what was, is, and will be happening that helps a person to become synchronised with one's time. Exploring and explaining to self and others the meaning of the unfolding events and experiences may be a crucial prerequisite for reconnecting with the moving life.

4.6.3 Coming to terms with the past

A coherent sense of self could be constructed by telling stories about themselves to others (Gallaher 2000). In this sense, the time dimension of self can be gradually reconstructed through telling personal stories, self-reflection, and explanation of the meaning of the experiences.

Participants who had a chance to tell their story to peers or psychotherapists and relive their emotions and fears felt that telling the story gave them a chance to move on not only in terms of re-creating a coherent self but also in the sense of synchronising themselves with others. Telling a story somehow helped to understand oneself better and feel alive, and thus to regain a right to move on with others.

However some participants never had a chance to tell their story in their own words. If given a chance, participants mostly discussed their current feelings with service providers. Such brief discussions were taken out of the context of their full life, and represented disjointed bits of self not linked to the past, present and future. Some lost all hopes about talking to service providers, as their stories had not been taken seriously and they had not been given time or support to speak out in their own words and at their own pace.

In addition, participants were not always ready to talk about their past from the very beginning, or to a person they did not trust. They needed to gain trust in the person who could accompany them into their journey through time. The establishment of meaningful connection with others described in the previous chapter could have been crucial for reconnecting with the past and linking it to the present and future. Persons also needed to regain some amount of self-esteem, self confidence and acceptance of self in here and now prior to travelling back to the unpleasant or fearful past.

4.6.4 Futurising: turning bad days into good days

The distinction of implicit (unconscious), and explicit (conscious) temporality was suggested as useful for phenomenological psychiatry (Fuchs 2005). Living time is implicit, or unconscious time; being engaged in something purposeful and interesting can make the perception of time disappear (Wylie 2005). The feeling of a 'flow experience' when we are absorbed in something that we enjoy doing (Csikszentmihalyi 1988) coincides with a feeling of spontaneity and positive well-being when the concept of time as such is lost and the person just feels 'alive' (Fuchs 2005).

Feelings of effortlessness, lightness, spontaneity, positive energy, and smooth ‘sailing’ through life were characteristic of ‘good days’ described by the participants. On bad days, time was felt as explicit, effortful, desynchronised, or empty, and somehow separated from the person. Both acceleration and slowing down of time were mentioned in this study when there was either too much or too little ‘happening’ in one’s life, and the persons could be overwhelmed with their negative past and did not see the way to ‘move on’ with the future.

The importance of intentionally structuring own time on bad days strongly evolved from the interviews. The persons somehow knew from the early morning how they felt about the day. If they felt that they were stressed, fearful or sad and the link with the flowing time was weak they needed to consciously thicken their connection with here and now. This was done by planning a routine, building a structure to the day, breaking time into small fragments of ordinary, mundane, neutral things to do, such as having a shower, brushing teeth, reading a book or going for a walk. Sometimes it was better not to think too far ahead and just live in one hour, or one day at a time. Once some of the small goals were achieved, further reconnection with time was easier and the feeling of temporal flow and spontaneity gradually returned. Often warm, empathetic or humorous exchange with others helped the feeling of explicit difficult time to disappear.

The importance of intentional structuring of own time has also been identified by a phenomenological study of mental health patients’ experiences of hospital treatment (Borg & Davidson 2007). Participants often described their outpatient activities and therapies as fragmented due to long time spans between them. Some participants reported that when they did not take the initiative in structuring and filling in their time, they often experienced ‘idle time’ which was perceived as meaningless, which slowed down their recovery. Similarly, some participants of the current study complained that activities of day centres were sometimes aimed at just passing the time, rather than getting involved in something meaningful which would help to ‘fill in the day’ and bring the feeling of an achievement or doing something useful.

Physical exercise, arts, learning, work, especially in conjunction with social interaction, were reported to contribute to the positive feelings of moving on, doing something, making people feel better about themselves and doing something with their time (Crone & Guy 2008, Biley & Galvin 2007). Music was mentioned by some participants as a means of self-meditation, relaxation, and re-synchronisation with time, and in some cases diminishing the disturbing effects of voices and even making them stop.

Some suggest that conversation, poetry and music can provide a sense of time coherence through dialogical rhythm and percussion, which establishes meaningful connection between past, present and future (Bohm 1996, Freshwater 2007). Green argues that ‘not only does music raise expectations for what might be going to happen next, it also causes us to make

retrospective connections between present and past events, so that the present makes the past meaningful; and the musical past colours the present just as much the present raises expectations for the future' (Freshwater 2007, Green 2005, p.78). Activities such as music, singing, poetry, dancing, exercising were mentioned in this study as helping to reconnect with time and to take control of it on bad days.

4.6.5 Synchronising self, others and time

An individual can be synchronized or desynchronized with others and time on either physical or cognitive levels, or both (Fuchs 2001). For example, a human being can go through states of physical needs such as food, sleeping, or doubts during decision-making process which require taking a 'break' from others and time in order to resynchronize oneself (Fuchs 2001). As this study shows, a short stay in in-patient units can help a person to take a break and resynchronise self in time. However it may not be possible to feel connected with self and time in the long-term without being connected to others.

Reconnection, or resynchronisation with time could be fostered by getting 'in tune' with others on spiritual, emotional, cognitive or physical levels. Such connection could be achieved through experiencing simultaneous relatedness of feelings, thoughts, or experiences, and sharing the same moment of living time. In this study, dynamism and spontaneity were characteristics of good days, when persons were involved into doing something meaningful and enjoyable, therefore bringing some positive change to both selves, others and life in general. This study provides evidence that through constant re-establishing and maintaining a dynamic connection with self, others and time one can regain the feeling of meaningfulness of one's life, which was found to be crucial for physical and mental health (Urry *et al.* 2004).

Meaningfulness is also inherent in the sense of coherence theory (SOC) (Antonovsky 1987). Antonovsky argued that one's general orientation in life should have a sense of coherence, a global forward orientation 'that expressed the extent to which one has a pervasive, enduring though dynamic feeling of confidence' (Antonovsky 1987, p.19). SOC is associated with comprehensibility of one's internal and external environment, manageability of internal and external resources, and meaningfulness of engagement with the demands and challenges of the environmental stimuli (Antonovsky 1987). The meaningfulness and worthiness of efforts may be the crucial driving force in people's quest for health and mental health. Antonovsky's sense of coherence proved to provide inner strength when dealing with adversity or chronic physical illness (Griffiths 2009). Developing a sense of coherence may be a useful constituent of reconnecting with life.

Some argued that the SOC construct per se only indicates emotional calm and serenity and does not fully capture active resilience in the face of illness or distress (Watson *et al.* 1988). Without the fighting spirit, the sense of coherence may lead to permanent calmness and homeostasis,

thus not motivating change and active re-synchronisation with life, when something inevitably changed with the moving time. Fighting spirit may be necessary to sustain the effort of reconnection at the times of temporary disconnection from self, others, or time. A recent study found that while fighting spirit correlated significantly with SOC, it was not a significant predictor of SOC in students (Johnson 2004).

Illness and disorder may represent a natural tendency, as bodies consist of physical, material parts which are subject to entropy over time. However the fighting spirit and human intentionality reinforced by others can not only stop but even reverse entropy. In this sense, the state of unsettlement, dissatisfaction and emotional turmoil may have a positive influence on human existence as it may subconsciously signify the need for change in order to adapt to the changing circumstances of life. Mental health problems *per se* may not be physical disorder, but they may indicate the presence of some disorder in a person's spiritual, emotional, physical or social aspects of life and the need to change something within oneself or one's circumstances.

This view is also congruent with the philosophy of the Tidal Model whereby mental health problems *per se* may be viewed as a potential for positive change in one's life (Buchanan-Barker 2009). Participants commented that his feeling of being unsettled, rather than being associated with a sign of illness, could be interpreted as a prelude of making change and an opportunity to face life challenges.

In fact, self-concept theory of subjective change suggests that perceived improvement in mental health should increase both negative and positive feelings about self, because it violates self-consistency standard but satisfies self-enhancement standards (similar to the double-dose effect of self-worth and self-confidence discussed earlier). Therefore reconnecting with life may be accompanied by both the negative feelings of uncertainty and unsettlement and the feeling of achievement and self-development (Keyes & Ryff 2000).

It may be due to the feelings of unsettlement and uncertainty which accompany any major change in life that it is necessary to stay connected to others and from time to time validate your direction with others. Shared hope, empathy, and humanity help to synchronise self and others in time and to stay connected with the moving life.

The core category of reconnecting with life and its constituents of self, others and time intertwine with some dynamic and interconnected phenomena described by quantum physics.

Scientific developments in modern physics and quantum theory (QT) show that matter and mind in this universe are far more interactive than some psychological and psychiatric models of mental health and illness generally assume (Satinover 2006, Stapp 2009).

The next section will highlight some key concepts of classical physics and quantum theory (QT), such as relativity, timespace, dual nature of quanta, complementarity, uncertainty, and entanglement considered useful for better understanding of the core category of reconnecting with life emerging from this study.

4.7 Reconnecting with life through the lens of science

Today, thanks to the ingenious work of biologists, mainly of geneticists, during the last thirty and forty years, enough is known about the actual material structure of organisms and about their functioning to state that, and to tell precisely why, present-day physics and chemistry cannot possibly account for what happens in space and time within a living organism (Schrödinger 1944, p.2).

In the quantum theory we are encountering something that potentially is far more revealing of the depth of the universe that we presently recognise. I believe that the investigation of consciousness will bring us into contact with something more (Helrich 2006, p. 564)

Until the beginning of the 20th century, the scientific Newtonian view of the world was similar to that of the Cartesian ‘self-propelled machine’. The role of human intentionality was reduced to passive witnessing of causally unfolding reality (Stapp 2009). Time, space and matter were considered absolute, separate, and unrelated. Such view was extremely positivistic, implying that there was the absolute truth, and that we can gradually get to know all the truth, by robustly and repeatedly measuring the material phenomena by means of empirical, objective, neutral and therefore scientific observation (Greene 2007).

Isaac Newton himself acknowledged the ‘problem’ of free will, whereby the existence of human intentionality was incompatible with a mechanistic picture of the universe (Park 1988). Similarly, in the biomedical model of health and illness, health outcomes are largely predetermined by genetic, physical, chemical and other observable characteristics of a human being. ‘Chemical imbalance’ of the brain could be modified by chemical interventions; intentionality is thus reduced to accepting such interventions, i.e., compliance.

The development of special (1905), and later general (1916) **relativity** theories by Einstein departed from Newtonian static picture, by introducing the notion of interconnectedness of space and time in relation to a current location (Greene 2007). ‘Absolute’ space and time, previously thought as separate ‘objective’ entities existing independently from each other, proved to be relative, dynamic, and interconnected in a broader unified dimension of **timespace**.

The introduction of timespace dimension cancelled the universality of the concept of ‘here and now’, making it relative to the location of a person or object within a timespace unit. For example, if two people are moving in the same direction but their speed is different, e.g. when one person is travelling long distance by plane and another one by train, the two persons’ hand

watch would show slightly different times; but each person's watch will be right in relation to this person's location (Greene 2007). Thus, complete reconnection with time viewed as desirable by participants of this study can only be achievable through synchronising one's time with the time of others, who are moving within the same dynamic timespace unit of life. Compliance grows beyond the impassive acceptance of a remedy by a person, but must be accompanied by a physical presence of another person delivering a remedy in the same timespace. Such presence may entail not only being in one room at the same time, but also being aware of each others' presence through perceptions, body language, and dialogue.

However Einstein claimed that in this material universe it was still possible to predict what would be happening in the future by observing what was happening in the past. By knowing where an object had been before (location), and with what speed it was moving relative to the speed of light (velocity) it should be possible to predict the object's new location (Greene 2007). The speed of light was shown to be constant and unsurpassable in the universe. If we apply the relativity theory in this sense to recovery from mental illness, one would be able to predict somebody's future outcome of recovery by knowing some determinants of the person's mental health at the current moment (e.g. degree of symptoms, or degree of reconnecting with self, others and time) and the progress of improvement in symptoms over time (velocity) established by longitudinal studies.

Developments in the studies of micro-world rendered the determinacy of location and velocity inapplicable to quanta including photons, electrons, molecules and neurons, and other tiny constituents of matter, energy and human brain (Maltonado 2009). Multiple experiments in quantum physics proved that some empirically observed changes occurring in the material micro-world cannot be explained without taking into account the effects of the observation *per se*, or the interaction of the observation with the observed 'matter' (Koch & Hepp 2006). Moreover, it may be only through resorting to subjective human experiences that such quantum 'weirdness' could be explained (Stapp 2009).

The key quantum phenomenon which so far has been impossible to disprove or even fully explain is the outcome of the **double-slit experiment**, originally labelled as the double-slit interference pattern (Brida *et al.* 2002). The double-slit experiment demonstrates the **dual nature** of photons, electrons, and other tiny constituents of the matter. Such micro constituents can act either as particles, or as waves. However, wave-like appearance cannot be directly observed, and can only be described by mathematical calculations. However wave-like quantum state does exist, as its imprint can be witnessed *post factum* as the outcome of double-slit experiment (Greene 2007). For the clarity of further deliberations, the gist of the experiment is presented below.

The ray of light which can exhibit properties of tiny particles called photons (or other quanta such as electrons or neurons) goes from a projector through a plate with two slits towards a black screen. If each photon were a particle, as would be expected by the laws of classical physics, it would have to go through either one or the other slit of the plate, which should in turn result in two bands of brightness forming on the black screen immediately behind the slit.

However instead of just two bright bands, there appear several of them on the black screen, suggesting an interference pattern consistent with a wave-like behaviour. Instead of going through one slit only, some photons seem to go through both of the slits, somehow interfering with themselves and other photons. The interference pattern indicates wave-like behaviour, which is incompatible with either location or velocity characteristics of a particle. However, despite the appearance of many bands of light on the black screen, each photon produces a microscopic traceable bright spot on the black screen, meaning that after going through the slits as a wave, it is arriving at the black screen as a particle.

In order to determine what exactly happens when photons are going through the slits, special detectors are put into place, either in front, or behind the double-slit plate. But as soon as the detectors are switched on, photons instantly 'drop' their wave-like behaviour and act like particles according to the laws of classical physics, going either through one or the other slit. The particle-like behaviour is confirmed by the appearance of two bright bands on the black screen. When the experiment is repeated with detectors switched off, several bands of light appear on the black screen suggesting wave-like interference behaviour. However when the detectors are switched on at any time, either before or after the photons passing through the slits, the interference pattern disappears again, and only two bands of light reappear on the black screen.

In short, when the photons (or electrons, or neurons) somehow 'find out' about the observation which occurs or is due to occur, they instantly start behaving like predictable particles, each of them going through one and only slit. The speed of this change is untraceable by any detectors and must be quicker than the speed of light. When unobserved by technology, photons behave like waves with many probabilities of how they could pass through the slits, which is confirmed by an interference pattern on the black screen. Thus it becomes impossible to determine *post factum* which slit they had gone through. In quantum physics, such statistically unstable cloudy appearance of photons, electrons or other quanta is referred to as 'probability waves'. The 'wave' of many probabilities of passing through the slits materialises into a certainty of one specific pathway only when the photon is subjected to, or is about to be subjected to observation (Greene 2007). It is thus impossible to separate the observer from the observation *per se*.

Using the language of quantum theory, it can be hypothesised that reconnection with hope, as in growing 'probability waves' of new possibilities of escaping the 'trap' of disconnection, and

selecting the best one among the many, can only happen through unobtrusive, accepting and hopeful presence of others. As discussed previously, the principle of mindful observation of thoughts and feelings in DBT may help accumulation of probabilities of alternative responses from which to select in a specific situation. If one had to apply the language of quantum theory to DBT, mindful non-judgemental observation may help a person to rebuild ‘probability waves’ of their desirable future and learn how to intentionally select the best suitable option, as opposed to following a habitual response pre-determined by previous experiences.

The concept of probability waves in quantum theory echoes the definition of human creativity (Arieti 1972). Arieti (1972) considered creativity as one of the means by which human beings escape ‘fate’ of pre-conditioned responses and produce new pathways in addition to existing ones. One of essential characteristics of creativity is divergent thinking which does not follow the norms but seeks extraordinary solutions (Guilford 1959). Cropley (2006) further defines divergent thinking as the ability to produce ‘multiple or alternative answers from available information’, and ‘recognizing links among remote associates’ (Cropley 2006, p. 391).

However, divergent thinking can be also viewed as thought disorder in schizophrenia (Nettle 2006). There is a danger that by labelling creativity as mental illness persons will be stripped of multiple possibilities of their ‘escape’ from the trap of disconnection. Reconnecting with life requires resourcefulness, considering multiple options and thinking ‘out of the box’, which should be nurtured and supported by mental health practice.

Conversely, ‘forcing’ the person to go through a slit of diagnostic categories in the context of impersonal and judgemental observation disregards other probabilities leading to recovery. In fact, by observing only selected behaviours of ‘pathology’, service providers may force service users to go through the one and only slit of the identity of mental health patient.

The impossibility of determining the exact path of an unobserved photon until the observation actually takes place led to the formulation of Heisenberg **uncertainty** principle, whereby certain physical characteristics, such as location and velocity, cannot have precise values at the same time (Heisenberg 1930). Moreover, the more accurate is the knowledge of one value, the less accurate is that of the other. Therefore, uncertainty is built in any experiment, no matter how robust and objective it claims to be. Knowledge of location of a person in relation to a specific stage of recovery does not guarantee knowledge of when the next stage will occur and in fact which stage will occur next, until the stage actually occurs and could be finally observed and described.

The notion of **complementarity** of wave and particle states was formulated by Bohr in 1927 to denote a relationship between mutually exclusive and contradictory aspects, which can give a complete view of the phenomenon only when combined (Atmanspacher *et al.* 2006). Some argue that the notion of complementarity could solve the problem of Cartesian duality of body

and mind, by looking at them not as separate entities but as inseparable extensions of each other, two sides of the same coin, which itself belongs to some broader third reality (Bishop 2005). This broader third reality cannot be empirically observed. However it could be described through subjective experiences of human consciousness, which can navigate the unobservable reality. Human consciousness is not subject to the laws of classical physics (Helrich 2006). Subjective experiences of recovery and healing can reveal unique unobservable processes essential in mental health and well-being, and should be utilised in health practice and research to complement observable physical processes.

Fighting for recovery may entail a substantial effort to go against time and 'escape' the irreversibility of previous negative experiences, and to find new ways of reconnecting with life in the future. In fact, the state of unsettlement and dissatisfaction preceding any major change in life is somewhat similar to the resonance state of nuclear growth and decay. The resonance state can be with a shaping and growth of a major life-changing decision: the bigger change is envisaged, the longer is the resonance state preceding time-reversal and moving in a new direction leading to growth (Bishop 2005). However the duration of each resonance state and the specific direction of such change can never be predicted with certainty (Bishop 2005). Similarly, it may be impossible to fully describe, separate and predict the duration and order of specific stages of reconnecting with life.

One of the many suggested explanations of this phenomena is quantum decoherence, i.e. interaction of quantum micro-world with classical macro-world (Greene 2007). Though macro-world appears solid and static, on a mini-scale it consists of uneven surfaces, materials and particles of energy, which can easily penetrate, or be penetrated by other 'matter' or substance. Thus, micro and macro worlds interact in many known and unknown ways, which produces unpredictable results. On a physical side, there is always a dispersion, or a micro 'leak' of substances in any interaction, which can affect any seemingly solid and separate classical structure (Greene 2007). One can hypothesise that such 'micro leak' of energy and other substance is also present in human interaction, as human bodies and brains consist of molecules, neurons, and lumps of energy which were shown to behave like quanta (Maltonado 2009). The 'positive' and 'negative' energy of human interaction mentioned by the study participants may well exist both inside and outside the human body, and may influence not only thoughts and feelings, but also physical, chemical, and energy assets of the body and brain. Being subjected to the 'positive energy' of accepting and validating connection could release some 'negative energy' of distressing thoughts and feelings which had been 'bottled' inside, and clear space for positive thoughts and feelings, as well as activating and strengthening of emotional and cognitive resources. Conversely, 'negative energy' of hostility and disconnection can damage reconnections with self and others which can negatively influence emotional and cognitive assets of a person.

Einstein, Podolsky and Rosen (1935) (EPR) opposed the uncertainty principle and argued that quantum physics presents only a partial explanation of reality (Einstein *et al.* 1935). In an attempt to minimise the effects of possible ‘local’ interaction between micro quanta and macro technology, they suggested measuring velocity of a twin particle of a pair, and to infer the location or velocity of another particle. The emergence of twin particles is based on a phenomenon in subatomic physics when a particle disintegrates into two twin particles of equal mass, moving in opposite directions. The velocity of the two constituents is equal and opposite, and the position of one particle is therefore determinable by the knowledge of the position of the other. The logics behind the EPR experiment was that if one measures the position or speed of one particle, one can infer information on the position or speed of the other twin particle without disturbing it. The two particles are spatially distinct and thus unconnected entities, which can be meters, kilometres, or light years apart (Einstein *et al.* 1935).

However further experiments did not only fail to disprove the uncertainty principle, but led to discovery of another yet fully unexplained phenomenon of ‘quantum weirdness’, i.e.

entanglement. When measured, the properties of one twin particle instantly correlate with the properties of the other twin particle, demonstrating some instantaneous connection, surpassing the limits of space and time. This led to the formulation of the entanglement principle by Schrödinger (Schrödinger 1935). When two open systems enter into temporary interaction and then separate again, they somehow change and start sharing some characteristics of each other:

Another way of expressing the peculiar situation is: the best possible knowledge of a *whole* does not necessarily include the best possible knowledge of all its *parts*, even though they may be entirely separate and therefore virtually capable of being ‘best possibly known,’ i.e., of possessing, each of them, a representative of its own. The lack of knowledge is by no means due to the interaction being insufficiently known — at least not in the way that it could possibly be known more completely — it is due to the interaction itself (Schrödinger 1935, p.555).

The subcategories of self, others and time identified in this study may be impossible to fully separate and describe due to their entanglement evident in the underlying processes of reconnection with life. It may be only through describing the effects of progressive interaction between self, others and time that one can gain an understanding of reconnection with life. Positive energy and hope triggered by meaningful connection with others further interacted with an inherent human capacity to move on in time, in order to give back some positive energy to others. It may be this positive energy of life, good will and self-induced change which can in turn bring positive change to others, which makes the whole of human body and mind ‘tick’ and feel happy with their lot, despite unavoidable decoherence and irreversible entropy.

Light exposure therapy has been shown to interact with neurotransmitters on subtle levels consistent with quantum mechanics, or quantum brain dynamics (Curtis & Hurtak 2004). Weak quantum theory has led to the formulation of the concept of entanglement between patient,

practitioner and remedy (PPR) (Milgrom 2006); therapeutic relationships (Hyland 2004), and correlation of consciousness and intentionality in neuroscience (Maltonado 2009). Some neuroscientific studies discussed in the previous chapter suggest that by changing our mind when being observed we are changing our neurological brain processes, possibly becoming entangled with the observer or the observation *per se* (Paquette *et al.* 2003).

Some argue that randomised control methodology used in pharmaceutical trials may be similar to double-slit experiment, whereby introducing double blinding for controls may lead to entanglement between remedy and placebo effects, which may in turn contaminate the outcome of the experiment (Milgrom 2006). Placebo effects produced metabolic changes in the brain comparable to the effect of SSRI fluoxetine in persons with major depressive disorder and lifted the mood and diminished dysphoria associated with major depression (Mayberg *et al.* 2002). The effectiveness of medication may depend on both the internal and external contexts of its delivery, such as acceptance and validation of self by others and trusting that medication delivered by the other will be of help to the self.

The use of forced, closed-ended techniques such as impersonal observation or standardised questionnaires aimed at capturing subjective experience may 'contaminate the experiment' and lead to the outcome which would not have occurred without such observation. In fact, close and detached observation of patients considered suicidal can lead to further disconnection of those observed from the self and broader humanity (Cutcliffe & Barker 2002). The same refers to the use of coercion, or forcing a person to comply with a specific behaviour considered beneficial without taking the person's view into account. Routine outcome measurement in psychiatry can be damaging and disempowering for persons striving to reconnect with life, as it reduces their experiences to only observable ones. Viewing a person as a 'particle' with determinable location and velocity may prevent the growth of 'probability waves' of reconnection with life by this person, and strip them of hope, personal resourcefulness, and willingness to move on. In fact, awareness of being at psychometric risk for schizophrenia was associated with a significant negative impact on mental well-being of the general public, especially among those with lower risk (Linscott & Cross 2009). Insight into mental illness as understood in psychiatry was found to negatively impact on the quality of life of persons diagnosed with schizophrenia, by reducing their hope of recovery (Hasson-Ohayon *et al.* 2009).

Judging by the outcomes of this study, the reawakening of fighting spirit can be positively influenced by others who believe that a positive change is possible, and can help the person to find out and select the best available pathways of such change. Another important and challenging task of service-providers is to try not to interfere in the natural process of reconnecting with life, and not to force it prematurely into a specific direction predetermined by some previous outcomes, such as specific medication or therapeutic activity which could have

worked for some persons but may not necessarily work for others. It may only be individuals themselves who can determine what is working and what is not.

The unavoidable shaping role of the observer in the double slit experiment, and the quantum phenomenon of entanglement between two interactive particles can provide a deeper understanding of the roles of a service provider and a service user in therapeutic connection. Ivor Browne suggests that the role of a therapist has a dual function (Browne 2008): one of a participant who empathises with and relates to the person as another human being (as in entanglement), and another one as a reflective observer of what is going on with the person and with the therapist (as an observer in a double-slit experiment). The role of the observer is to provide and guide context in which the person can find their own way of reconnecting with life, which may not become visible without non-judgemental and empathic help from others. The wave function may remain hidden from technology, as can hope; however a hopeful presence of an observer can help a person to make their own choice between the two slits of giving up, or fighting to get better: 'Perhaps the most important thing of all is simply to provide 'hope', to let the person see that you believe change is possible and that they can do it, if they are ready to work for it.' (Browne 2008, p. 275). Other than that, uncertainty and multiplicity of outcomes are inherent in any experimental or human undertakings.

Another hypothetical explanation of the outcome of the double-slit experiment is that each step of acquisition of knowledge about the world occurs in a conjunction with a collapse of a 'probability' state. This in turn opens up new probabilities for acquisition of new knowledge. Therefore, with each step of knowledge acquisition, the physical state of the universe slightly changes and opens up 'a new set of potentialities for future psychophysical events' (Stapp 2009, p.11). Such interpretation grants human beings the role of co-creators of the universe, which is partially shaped by conscious thought and the development of the new knowledge. The influence of free will and human intentionality on the empirical, actual and real domains of reality cannot be disproved by the scientific laws of this universe. There is space for both positivism of physical structures and processes, and constructivism of interaction of the observer with the observed in the complementary dual nature of quanta which seem to operate on different levels of bigger stratified reality of life.

The importance of hope, intentionality and the spiritual realm for health and well-being has already been proved by previous health research, and should be reinstated in health research and practice. Hope, will, fighting spirit, and creativity, which drive human beings to reconnect with life and resist entropy in the face of adversity should be nurtured through meaningful connection by all health services.

4.8 Limitations to the study

The theoretical framework of recovery built up by this study cannot claim to represent the full truth about recovery. The study framework of recovery is based on 32 interviews and can be explored and modified through further research. Other interviewees may have identified additional issues or concepts pertaining to recovery.

Other researchers could have viewed the data from a different angle and could have arrived at a different theoretical framework. As in any study, subjectivity and previous background of the researcher could have influenced the design, data collection and the analysis. The thorough working guidelines of classical GT, frequent discussions of the analysis with supervisors, verification of identified concepts by further participants and in the previous literature may have helped to reduce subjectivity and to improve theory building.

I did not have direct control of recruitment procedures as some participants were invited to the study via representatives of peer support groups and mental health services. However distribution of information letters and personal communication of specific selection criteria at various stages of the study may have helped to ensure consistency of theoretical sampling.

The next chapter will discuss specific implications of this study to mental health practice and research.

5. Study Implications and Recommendations

The findings of this study have some important implications for mental health policy, practice, education, research and health promotion, some of which have been alluded to in the discussion chapter. The following chapter will present study implications for the mental health field.

The contribution of the theory generated by this study is its new language and a new way of looking at mental health recovery. The study provides a deeper level of understanding of what recovery is (reconnection with life) and how it can happen (through an active reconnection with self, others and time). The identified underlying processes, strategies, facilitators and barriers of reconnecting with life can equip mental health stakeholders with new tools and understanding necessary for effective and efficient evaluation and development of recovery-oriented policy, education, practice, research and mental health promotion. Specific implications for these areas are presented in the next sections of this chapter.

5.1 Implications for policy

As mentioned in the Introduction, *A Vision for Change* (Department of Health and Children 2006) defines recovery as a belief in the possibility of recovery and regaining control of one's life. It is hoped that this study will help to make this belief a reality in the Irish mental health services by clarifying what recovery means and how it happens in an Irish context.

This study provides further clarification to the concept of person-centred care highlighted by *A Vision for Change* as one of the key characteristics of recovery-oriented services. Person-centred care requires a paradigm shift towards re-focussing on aspirations and goals of those recovering, and the vital importance of their input in care. Personally defined life goals should map the starting point of one's recovery journey, as opposed to being mapped according to the views of service providers. In short, once the views of every service user on their recovery are sought and given priority, the service-provision can be viewed as recovery-oriented (Connecticut Department of Mental Health and Addiction Services 2006, Noordsy *et al.* 2002, Oades *et al.* 2005, Onken *et al.* 2007). Development of a will to change and motivation to get better should come from within the person, and should be nurtured, encouraged and supported by the services through meaningful connection, involving acceptance and validation of individuals and their life experiences.

The view on recovery as reconnection with life reiterates that recovery extends beyond in-patient facilities into the broader community. As can be seen from the results of the study, reconnecting with life involves multiple aspects of spiritual, emotional, cognitive and physical

functioning and therefore requires multidisciplinary efforts and supports. Development of multidisciplinary teams and community services as recommended by *A Vision for Change* is therefore vital for recovery oriented services (Department of Health and Children 2006).

Judging by this study, contribution of peers to individual recovery is invaluable, and should be welcomed and utilised by the services where possible. Voluntary and semi-voluntary peer support groups provide excellent services for recovery and their work should be financially supported where possible. Recovering service users could be consulted by services, as they can provide help to both community rehabilitation services and in-patient clinical settings.

Day centres were highly valued by participants for providing space for development, education, training, and peer support. Day centres can assist with reconnection with self, others and time by providing talking therapies, cognitive and physical activities and socialising. The work of public community rehabilitation services should be supported, funded and further expanded to make reconnection with life in the community possible and consistent for those recovering.

The study showed that peer support and advocacy groups such as GROW or IAN are not readily available in most rural areas, with most of them located in urban or suburban areas. It may be helpful to explore geographical distribution of peer support groups and community services in order to identify areas where both, either, or neither are available. To avoid duplication, public funding can be redistributed to support voluntary groups where no public community services are available.

The work of service providers should not be focussed on risk prevention but on reconnecting of service users with life in the broader community. Taking into consideration that a certain degree of unsettlement, uncertainty and anxiety may accompany any major change in life, recovery-oriented services should be open-minded, flexible, tolerant and supportive. Services should encourage the person to try out new choices and experiences necessary for recovery, sometimes at the expense of their own comfort (Connecticut Department of Mental Health and Addiction Services 2006, p.63).

An exception to this could only be 'those rare circumstances in which the impact of the illness or addiction contributes to their posing imminent risks to others or to themselves' (Connecticut Department of Mental Health and Addiction Services 2006, p.66). In all other cases, service providers have to actively support the person's decisions and respect their 'dignity of risk', even if they suspect that the persons' judgement is impaired (Connecticut Department of Mental Health and Addiction Services 2006). This will add to the development of intrinsic motivation, fighting spirit and self-confidence, which could be crucial for reconnection with self, others and

time.

Quality of recovery-oriented services can be monitored through independent and anonymous audit of service users' and their carers' satisfaction with a specific service or therapy. Such audits could employ mixed methods approach aimed to elicit both quantitative satisfaction scores and qualitative reasons behind such satisfaction or dissatisfaction.

Most of the study participants were generally satisfied with services and support from others provided to them throughout their experiences with mental health problems, with less than one third being neither satisfied nor dissatisfied. However our general satisfaction question did not distinguish between professional services or other resources. One can argue that most of the study participants were generally satisfied with their reconnection with life. After all, the inclusion criteria of the study were persons who considered themselves to be in improvement and wished to talk about their recovery. If recovery is viewed as reconnection with self, others and time, the influence of all these three constituents may be important in service user satisfaction with professional services, and could be further explored and evaluated.

5.2 Implications for mental health education

The view on recovery from recurrent mental health problems as reconnection with life, defined as a self-induced effort directed towards establishing and maintaining meaningful connection with self, others, and time is suggested by this study as helpful for recovery-oriented services and education. Familiarisation with this study could be recommended for mental health professionals and educators, service users, researchers, policy makers, legal professionals and the general public.

Judging by the narratives of the current study, elements of person-centred, recovery-oriented care already exist in the Irish mental health services, at least in the community public mental health care. Participants complimented psychiatrists, nurses, psychotherapists and other professionals for their understanding, empathy, encouragement, sense of humour, tolerance and listening skills which facilitated their reconnection with self, others and time. Such qualities need to be further reiterated and expanded by mental health education, and used as positive examples of recovery-oriented care. In some cases, intuitive carers and therapists may already employ therapeutic entanglement; facilitate fighting spirit and intrinsic motivation and the accumulation of multiple probabilities of alternative responses to stressful situations in the future. Self-reflection combined with subjective experience of service users may guide and maintain effective reconnection with self, others and time of service users and self-confidence

of service providers that they are actively assisting such reconnection.

Despite the existence of recovery-oriented care in Ireland, this study also provided qualitative evidence that diagnostic and pharmacological medical models of recovery generally dominate over a person-centred, empathetic and accepting therapeutic approach within the Irish Mental Health Services. Control over recovery needs to be handed over to all persons accessing the services, with service providers acting as partners in care. Individuals should be seen as capable of self-management of their recovery.

As some studies suggest, modern mental health training and practice may not devote much space and time to developing empathic skills of service providers. Some argue that psychiatric trainees are still told during their training: ‘You can’t talk to a disease’ (Fisher 2003). Some of the practices of modern mental health care, such as impersonal observation of patients, make meaningful and hopeful connection impossible and lead to further disconnection of persons with mental health problems from others, self, and the broader humanity (Cutcliffe & Barker 2002).

Some argue that as elsewhere, person-centred care is under threat in Ireland (Kelly 2007). Following the developments of scientific knowledge and technology, the general provision of services have changed direction from the comfort of caring to diagnostics and therapeutics (Kelly 2007). Some argue that the Irish health service provision ‘has adopted the reductionistic, mechanistic and dehumanising medical model’ which is hardly compatible with the caring essence of the art of healing (Kelly 2007, p. 29). As elsewhere in the world, a more business-like, consumer oriented approach to health care has evolved in Ireland, following the Western world globalisation, fast pace and quick profit (Kelly 2007).

As shown by research, a business approach to medicine and healing may bring disillusionment, low morale, burnout, cynicism and resistance to change for health care providers (Castledine 2003). Putting the spirit of compassion and empathy back into health care may not only help patients to reconnect with their lives, but help service providers to do so as well. It may be only through realising the interconnectedness of self and others that person-centred care can be re-established. The double role of a service provider as 1) a human being and friend entangled with a service user as a human being and friend, and as 2) a self-reflective observer of reconnection with self, others and time of service user need to be reinstated in health care.

To be able to nurture and support individual recovery, service providers may need to question some biomedical assumptions acquired during their previous training, and paternalistic relationships with patients prevailing in the past (Mead & Copeland 2000). Development of empathy, spirituality, self-esteem, optimism, and self-confidence may be needed for both service users and their service providers to make recovery possible. Curiosity, benevolence and

self-reflection can also help this joint development (Buchanan-Barker 2009). Discussion of feelings, ideas and concerns with service users and other service providers can also help to verify directionality and effectiveness of care provision.

5.2.1 Developing and maintaining meaningful connection

The importance of therapeutic meaningful connection with others in recovery from mental or physical illness is not new. Indeed, most therapies utilise some form of meaningful connection or therapeutic entanglement between patient and practitioner (Lynch *et al.* 2006a, Hyland 2004). Some argue that therapeutic empathy should be an essential feature of any therapy (Thwaites & Bennett-Levy 2007). It is time to reinstate the importance of meaningful connection at all levels of mental health education and practice. The important constituents of establishing meaningful connection are acceptance and validation, empathy and spirituality.

5.2.2 Acceptance and validation

One can argue that the key principles of DBT can be also applied to persons with other diagnoses such as schizophrenia, depression, or bipolar disorder. Principles of DBT such as acceptance and validation could be applicable to all levels of mental health service provision.

A discourse analysis study of training Australian nursing staff on basic principles of DBT for patients diagnosed with BPD showed that the training programme, which was aimed among other things at seeing personhood in patients, had a positive and beneficial influence on the nursing staff (Hazelton *et al.* 2006). As a result of the training, a pervasive therapeutic pessimism was replaced with a more optimistic understanding and moral stance. In addition to improved relationships with the patients and perceived quality of caring, staff unexpectedly reported a positive impact on their own personal development and relationships. Staff spoke about how this training developed their patience, motivation, and empathy and helped them not only in their job but in their personal life as well.

Most of nursing models are also based on acceptance, validation, and development of empathy and understanding of self and others. Whereas training service-providers on specific skills related to various cognitive-behavioural therapies may be time-consuming and costly, training on their shared elements, such as empathy, acceptance, and validation could be much more achievable and desirable at all levels of mental health service provision.

5.2.3 Facilitating intrinsic motivation and fighting spirit

Facilitating intrinsic motivation is suggested as useful for persons with mental health problems (Wu *et al.* 2000). The latter authors provide therapeutic guidelines on how to facilitate intrinsic motivation in persons with mental illness. The first is to support client autonomy by acknowledging the client's ability to make decisions and solve problems, and to encourage them to take actions based on personal choice as opposed to expectations of others. The second has

to do with structuring occupational therapy services so that short-term therapeutic activities lead to success, with a view of extending these activities in the future based on the outcomes and the client's wishes. The involvement of others such as partners or family members in encouraging client's intrinsic motivation outside the therapeutic setting is also advisable.

The Collaborative Recovery Model (CRM) adopted in Australia underlines the need for a working alliance between the patient and the practitioner and the autonomy support of the recovering individual (Oades *et al.* 2005). The term 'autonomy support' is also based on self-determination theory and consists of three major components: primacy of service user perspective; providing choice for service users; and explaining what is happening in the therapy. The authors argue that motivational enhancement should be one of the main guiding principles of recovery-oriented services (Oades *et al.* 2005).

The Tidal model of nursing was developed in the 90s, on the basis of what patients and their families needed from and valued in nursing (Stevenson *et al.* 2003). The Tidal Model views compassionate caring as providing the conditions for growth and development (Buchanan-Barker 2009). The Tidal model views mental illness as stemming from problems of human living and underlines people's capacity to change. Among the 10 Tidal commitments viewed as necessary for genuine compassionate caring, are the importance of valuing the person's story and language as opposed to the 'colonial language of the professionals who have diagnosed them (Buchanan-Barker 2009 p. 685), developing genuine curiosity about the person and his life story; and becoming the apprentice rather than master of healing, learning from the person what needs to be done.

The Tidal model supports what people are saying about recovery in this study: that they had to design their recovery themselves, but needed the support from other people to formulate their specific needs and goals and to follow them through trial and error. Therefore the Tidal model can be seen as recovery-oriented and should be considered for adaptation in recovery-oriented services.

Solution-focused therapy (SFT) has been found successful in US and UK inpatient facilities (Stevenson *et al.* 2003). In SFT, a service user is seen as the main driver of change with a service provider encouraging and supporting such change, and providing positive and constructive feedback. SFT is also in line with the theoretical framework of the current study, whereby designing and executing of the own reconnection with life was supported by others in care. Use of SFT can be recommended for recovery-oriented mental health services.

The concept of active and self-sustained effort inherent in fighting to get better emerged from this study as an important prerequisite of reconnection with life. Fighting spirit can serve as a

predictor of successful reconnection and therefore needs to be supported and encouraged by the mental health services.

5.2.4 Development of empathy of service providers

The importance of empathy and understanding for reconnection with others and self strongly emerged from participants. Some argue that empathetic knowledge per se does not make an empathetic therapist, unless it becomes genuine and unconscious (Thwaites & Bennett-Levy 2007). In order to successfully support the development of empathy and mindfulness of service-users, there may be a need to develop empathetic abilities of service-providers. Thwaites and Bennett-Levy (2007) propose four key elements of therapeutic empathy essential for successful psychotherapy practice: empathetic attitude/stance, empathetic attunement, empathy communication skills, and empathetic knowledge. An empathetic stance includes benevolence, curiosity and interest in the patient as a person and a helping attitude and can be described as helping to establish spiritual connection with the person.

Empathetic attunement is similar to some elements of mindfulness and refers to an on-going effort on the part of the therapist to stay attuned on a moment-to-moment basis with the client through non-judgemental awareness. The importance of being genuine and human in accepting and validating the person's experience was underlined. From the perspective of findings of the current study, empathetic attunement can be described as establishing emotional and temporal connection with the person by synchronising with the shared flow of the emotional experience in here and now.

Empathetic communication skills refer to the verbal and non-verbal bodily behaviour of communication of empathy to the client. Listening, validating, acknowledging behaviour, such as eye-contact, nodding, paraphrasing and even providing relational feedback from own experience can be crucial for establishing therapeutic relationships. This type of connection can be helpful for establishing both cognitive and emotional connection with the person.

Finally, empathy knowledge refers to cognitive professional education and training on therapeutic relationships and empathy which may be explicit/declarative (knowing that empathy is important in therapy) and implicit/procedural (unconscious awareness of the need for empathy that can guide being empathetic).

Olsen suggests a theory of empathetic maturity to specify the structure of nurses' sense of caring concern for the mental health patient (Olsen 2001). There could be three hierarchical levels of empathetic maturity whereby inclusiveness of others increases with more education, caring experience, and moral development. These three levels are interpersonal, intrapersonal, and transpersonal.

At the first interpersonal level, mutuality with other person is based on how well the patient meets the needs of the nurse/service provider, whereas the patient's needs are not the primary objective. As a result intuitive, humanistic, creative care is not likely.

As one participant of this study noted, he expected nurses to call him by his first name as opposed by his surname, as his parents and friends called him. However some nurses continued calling him by his last name which sounded very cold and impersonal and therefore they did not become his 'friends'.

At the second level of empathetic maturity, the perception of common humanity with patients is based on the mutuality of meaning, e.g. nurses or doctors experience mutuality with patients only when the patient's meanings and rationales coincide with theirs. Therefore, positive regard for a patient with 'negative' or 'strange' behaviour is difficult at level 2: 'Either the negative behaviour must be explicable in terms the nurse can understand and accept as human, or the patient cannot be seen as a person like the nurse' (Olsen 2001, p.41). In this case, previous history of the patient can help to explain the current behaviour and in turn, develop positive regard for the patient. Spiritual interpersonal relatedness with the patient may or may not be achieved and depends on the context of communication and shared previous experience.

For example, in this study, one participant recalled that he was lucky enough to share a background in philosophy with one nurse, which significantly improved his quality of care: the nurse stopped by him and involved him in conversation every time he was feeling low. But what about other patients, who may not share philosophical or religious background with any of other nurses?

At the highest, third level of caring, mutuality is based on one's perception that the other person can create their own meaning that is valid but independent of one's own meaning. Therefore, the feeling of mutuality based on shared humanity with the patient comes prior to the consideration of meaning created by patient: "At level III the patient's humanity is conferred prior to a judgement of the patient's actions or rationales" (Olsen 2001, p.42). In this situation, the patients can reveal and discuss all their feelings and concerns without the fear of being judged, misunderstood or disconnected from the service provider. This level may require development of the transpersonal level of spirituality, i.e., seeing a shared human and universal moral standing with the person, or empathetic attitude or stance.

Therefore, meaningful connection should involve connectedness of all levels of patient and practitioner entanglement: spiritual, emotional, cognitive, physical, and temporal.

5.2.5 Developing spirituality

Due to the benefits of spirituality for mental health and well-being, mental health service providers may need to be prepared for discussion of religious or spiritual matters, should service

users consider them important for their recovery. The construct of spirituality is a helpful concept which is under researched or underreported in the Irish mental health area. More clinical and population research is needed in the Irish context on the influence of spirituality and religion on mental health and recovery.

As can be seen from the current study and previous research, philosophical and religious questions are inherent in reconnection with self, others and time on a spiritual level (Miovic 2004). There may be a big difference between a patronising statement ‘It sounds like that is important to you, so tell me more about your religious beliefs’ meaning they are just beliefs, and a more empathetic statement such as ‘Maybe your husband is talking to you, so tell me more about your spiritual life’, meaning that the beliefs are potentially valid (Miovic 2004, p. 106). The author argues that the only way to avoid patronising behaviour in therapy is for the service-providers to think about the ‘big questions’ pertaining to humanity and spirituality themselves. Whereas specific religious beliefs and practices are a matter of personal choice, cultural traditions and individual conscience, the concept of spirituality does entail a belief in ‘something bigger’ which cannot be disregarded in therapy. After all, the existence of a spiritual realm has neither been proved nor disproved even by scientific research developments (Satinover 2006).

A study of Nurse-Patient Relationship (NPR) found that connection between the nurse and the patient has to address the spiritual needs of the patient on top of biopsychosocial. The crucial spiritual need of the patient was found to be recognition of personhood, which was only possible in an atmosphere of trust and openness. Some of the skills necessary for promotion of spiritual connection were mindfulness, thoughtfulness and a motivation to be fully engaged in case (Miner-Williams 2007).

The phase at which the spiritual needs were addressed was described as unfolding. Unfolding was characterised by a mindful interaction between nurse and patient, which involved reciprocity, melding of roles and exchange of energy (similarly to quantum entanglement). The phase of unfolding marked the beginning of a co-journey, whereby the nurse did not direct the persons, but encouraged them to formulate their needs and activate self-healing.

Development of spirituality can be recommended for both service-users and service-providers. Delaney provides specific recommendations on how to improve any ‘weaknesses’ associated with lower scores on any of the three dimensions of spirituality: intrapersonal, interpersonal, and transpersonal (Delaney 2005). For those scoring low on the intrapersonal self-discovery scale, activities developing self-knowledge and self-awareness could be recommended, such as meditation, relaxation, deep breathing, self-reflection, listening to music or doing arts.

For those scoring low on relationships, or intrapersonal dimension, participation in peer support group and counselling could help if they aim at active listening, empathy, and presence, as well as narratives. The author also recommends energy therapies such as Reiki which could bring into consciousness interconnectedness of life and human beings.

The transpersonal, or eco-awareness dimension of spirituality could be reinforced by creating caring environments, gardening and artwork, prayer, meditation, church attendance or referrals to clergy for discussion of transcendental matters.

5.3 Implications for mental health practice

The process of reconnection with life started from the state of disconnection from life, inability to make decisions and escape the ‘trap’ of demoralisation. Recovery-oriented mental health services should aim to help the person to find reasons behind being ‘stuck’ or ‘trapped’, and to become aware of what needs to be changed in order to reconnect with life. For example, the initial assessment can start with simple yet powerful questions such as ‘What happened? And what do you think will be helpful? And what are your goals in life?’ (Connecticut Department of Mental Health and Addiction Services 2006, p.11).

Encouraging a person to tell their story when they are ready and willing to do so could facilitate a quicker cognitive-emotional reconnection and help to overcome negative emotional states previously considered unavoidable and unbearable (Jackson *et al.* 2003). Empathy, understanding, encouragement, openness and helpfulness are vital ingredients of joint travel to the past of service users and service providers.

Standardised questionnaires should not be dominant over person-centred sessions. As both previous research and this study show, routine outcome measures may not be productive in mental health recovery as they ‘cannot capture individual differences with any clinically useful sensitivity’ (Lakeman 2004, p. 214). Service users should be encouraged to talk at length, narrate their story, voice their concerns and aspirations towards recovery, and participate in a dialogue with service providers. As shown in the discussion chapter, forcing persons to go through the one and only slit of psychiatric diagnostic may manage their ‘wave function’ of hope and will to get better and decrease their multiple probabilities of reconnecting with life.

A similar recommendation is provided by the Yale University Programme for Recovery and Community Health. The programme which reiterates that goals of recovery should ‘not be defined by staff based on clinically-valued outcomes (e.g., reducing symptoms, increasing adherence)’, but by the person, and should be focussing on ‘pursuing a life in the community’ (Connecticut Department of Mental Health and Addiction Services 2006, p.10). Moreover,

service providers should ‘avoid using diagnostic labels as a means of describing an individual, as such labels often yield minimum information regarding the person’s experience or manifestation of the illness or addiction’ (Connecticut Department of Mental Health and Addiction Services 2006, p.12)

More time needs to be allocated for person-centred sessions with service users in order to achieve and nurture meaningful connection, hope and intrinsic motivation. The findings show that trust, empathy, altruism, listening skills and dialogue are vital in recovery-oriented services.

Empathy and spirituality can be incorporated into primary care visits through empathic listening, expressing concern, self-disclosure and establishing equal common ground with the patients (du Pré 2001). The author argues that such visits can be conducted during the same average amount of time, with the first visit being the most crucial and slightly longer than subsequent visits. The advantages of ‘biopsychosocial’ as opposed to biomedical visits are patients’ satisfaction, self-disclosure, and adherence to treatment through commitment to collaborative decisions.

Participants needed somebody to believe that reconnection with life was possible, even when they could not believe it fully themselves. Belief in recovery needs to be shared by both service users and professionals at all stages of reconnection with life of service users.

Constructs such as hope, spirituality, fighting spirit, intrinsic motivation, meaningful connection emerged as most relevant for reconnection with life in the current study. However there may be other relevant constructs not identified in study. The relevance of specific concepts should be identified, negotiated, and further renegotiated to match aspirations of each individual for their recovery.

Multi-level activities such as arts, learning, meditation, or sports need to be available to all persons recovering from mental health problems. It is only the individuals themselves who can decide which activities will work for them, which can facilitate the development of intrinsic motivation to get better. However others are crucial for providing the context where individual aspirations are encouraged and listened to, and the possibility of positive outcomes for everyone is constantly promoted irrespective of previous causality.

As shown by this study, educational activities and occupational therapy are crucial for developing self-confidence. Analysis of needs and capabilities could be carried out in community settings so that aspirations and training needs of service users can be matched with existing training and educational resources or adult learning centres in the community. Service users should be encouraged to lead some training sessions and share their expertise in various

areas of reconnecting with life as reconnecting with self, others and time.

The importance of intentional temporal structuring of activities emerged from the study. The advice of service users shall be sought on how and when such activities should be structured, and incorporated into training schedules where possible.

The contribution of other expertise beyond the specialised professional knowledge should be welcome. Such multiple expertises could include peer support groups, religious groups, primary care providers and others supports available in the community. As stated previously mental health services should be encouraging the use of other community services and supports , (Connecticut Department of Mental Health and Addiction Services 2006).

5.4 Towards recovery-oriented pharmacology

Recovery-oriented psychopharmacology should be based on shared decision-making and aimed at agreed goals of reconnecting with daily life of service users (Noordsy *et al.* 2002). In addition, the Hippocratic approach to psychopharmacology, summarised as: ‘to cure sometimes, to heal often, and to console always’ may be more helpful for recovery than aggressive pharmacology viewing symptom reduction and compliance as the main focus of treatment (Noordsy *et al.* 2002). Recovery-oriented pharmacology should be aimed at maximising reconnection with self, others and time and minimising cognitive impairments or sedating effects preventing such reconnection (Noordsy *et al.* 2002). A guide for service users, carers and practitioners on medicine management published by the UK Department of Health can be a useful reference for person-centred approach to psychopharmacology (NIMHE National Workforce Programme 2008). One of the recommendations of the guide states that ‘Generally, good practice suggests starting at the lowest dose of a medicine that is effective and discussing any planned increase or decrease with the service users or carer’ (NIMHE National Workforce Programme 2008, p. 5).

If both service users and service providers agree that the use of medication would be helpful, desirable and concordant with the process of reconnection with life, most suitable medication should be offered with all side-effects discussed (NIMHE National Workforce Programme 2008). Subjective experiences of service users concerning the positive, negative, or neutral effects of medication on their reconnection with self, others and time should be explored, reported and taken into consideration for further planning.

Furthermore, findings showed that in some cases recovering service users may not benefit from on-going use of medication. Therefore supervised reduction or cessation of use of medication

should not be dismissed from person-centred, recovery-oriented care, but should be discussed and negotiated with service users to suit each individual case.

5.5 Implication for research

In 1977 George Engel, professor of psychiatry and medicine suggested integrating and synthesising knowledge of medical and social sciences into the Interactive Biopsychosocial Model (IBM) (Engel 1977). Engel argued that biomedical model of research, education and practice should become reoriented towards: 1) addressing health in addition to illness; 2) addressing interaction of biophysical, psycho cognitive, and social processes in health and disease, rather than looking for single root causes; 3) take into account the role of social interaction of an individual with their significant others, and society in maximising health and well-being (Lindau *et al.* 2003). On the basis of his own research and clinical practice, Engel came to conclusion that the psychiatric model of disease was no longer adequate, either for scientific tasks or for social responsibilities of medicine. Until recently the biopsychosocial model remained on the margins of biomedicine. Some suggest that one of the reasons for that is that ‘professional and research institutions are often structurally rooted in the biomedical model’ (Lindau *et al.* 2003, p.3).

This study supports and enhances biopsychosocial model suggested by Engel. Recovery as reconnecting with self, others and time is more about becoming and staying mentally well, rather than becoming or staying mentally ill. A most appropriate approach to understanding and supporting recovery is therefore salutogenic (Antonovsky 1987). Studying mental health and resilience may be more revealing than studying only mental illness and distress (Ryff & Singer 2000). It is even more crucial at the times of global economic crisis. Mental health and resilience can contribute to a wide range of positive health outputs and protect from some negative consequences of financial downturn (The European Commission 2009).

The ‘dual nature’ of health and well-being manifesting itself in both observable physical, chemical, genetic and biological ‘particle’ factors, and directly unobservable but nevertheless existing and influential ‘wave-like’ properties of subjective experiences and feelings requires viewing these properties as complementary rather than separate. Studying both observable body and brain dimensions and unobservable subjective experiences and their interactions is essential for introducing and promoting biopsychosocial model in health care and research.

The shift to biopsychosocial research in the area of mental health requires more qualitative investigations of the lives of people with and without mental health problems (Davidson *et al.* 2008, Ryff & Singer 2000). Recently, the importance of qualitative studies for improvement in evidence-based medicine and health policy has been growing. Qualitative research of subjective

experience of both service users and service providers can broaden and improve evidence beyond experimental research in order to better suit specific clinical local contexts (Goering *et al.* 2008). ‘Quantitative methods are particularly well-suited to providing context-free guidance and universal truths, whereas qualitative methods are needed to understand what works and how to implement appropriate care in real-world contexts (Goering *et al.* 2008, p. 146). Qualitative research findings may lead to new creative ideas and innovations within health care practice and should be more actively included into evidence based medicine and systematic reviews, on a par with randomised control trials and experimental research. In addition, narrative formats of qualitative studies are ‘highly persuasive means of swaying the public’ and could be useful in health promotion campaigns (Davidson *et al.* 2008, p. 138).

The synthesis of studies of subjective experiences of human existence with modern science has been advocated by modern physicists who view it as a necessity rather than luxury in further exploration of broader reality of this universe (Helrich 2006). There is also tendency among both physicists and doctors to become multidisciplinary, whereby physicists acquire a second education in psychology, and some psychiatrists turn to quantum physics as it welcomes creativity and new approaches to acquisition of knowledge about the world (Satinover 2006). Though acquiring a second profession may be challenging and time-consuming, curiosity, self-reflection and quest for combining knowledge of various disciplines could be beneficial for all professionals. Quest for new knowledge should not be restricted by professional boundaries of specific disciplines. Both researchers and practitioners need to stay open to and ready to accommodate new views and perspectives of seeing the world, and look for ways of collaborating with professionals from other disciplines. The research into interaction of flesh, structure and energy of physical ‘matter’ with subjective experiences of consciousness can move us towards better understanding of the living universe.

Research into correlation of diverse biomarkers and positive health outcomes could be combined with that of subjective experiences of persons recovering from illness or addiction. In addition, multimethods research into benefits of positive emotions such as humour, play, friendship, and achievement on mental and physical health can advance us in better understanding of interactions and entanglement of body and mind.

Research into positive and negative energy which emerged from participants as characteristic of human interaction may be worth further exploration and benefit mental health, psychology, psycholinguistics, pragmatics, intercultural communication and other health, language and communication studies.

Re-introducing the concept of conation in psychology on a par with cognition and emotional may highlight new directions for research of psychological health and well-being and recovery

from mental or physical illness. The importance of intentional structuring of own activities and the relationships between intentionality, performance and learning need to be further explored.

Subcategories and processes of reconnecting with time revealed by this study, such as futurising and moving on, coming to terms with the past and synchronising self and others in time need further qualitative and quantitative investigation and elaboration. They can serve as a useful starting point of exploration of the role of subjective experiences of temporality in mental illness, mental health and reconnection with life.

Research into subjective experiences of the effects of medication on reconnection with self, others and time can improve and develop recovery-oriented pharmacology. Open-ended, qualitative methodology can provide better understanding on how various medications interact with multiple processes of individual reconnection with life.

Further research into applicability of the sense of coherence scale (SOC), fighting spirit, spirituality and conation to the mental health area should be carried out. These constructs proved to be useful and enlightening for studying recovery from chronic physical illness and addictions and may prove so for mental health.

Similarities and differences in recovery from mental and chronic physical illness need to be further explored. Such exploration may yield a broader theoretical framework of recovering of one's health and well-being. One can hypothesise that integration, strengthening, and rebalancing of one's physical, spiritual, emotional, and cognitive resources may be at the heart of reconnecting with self after or in any illness, addiction, life change, or adversity. However more studies need to be carried out in order to confirm or disprove this hypothesis.

5.6 Implications for mental health promotion

The findings of this study suggest re-focussing of mental health promotion on recovery and dismantling the stigma of an incurable mental illness. The dimensional view on mental illness as a temporary disconnection from life which could happen to any person under various circumstances, and the importance of others in both reconnection and disconnection needs to be specifically addressed by mental health promotion.

It is hoped that this study will aid mental health promotion by informing the Irish public about the possibility of recovery, and the de-stigmatising benefits of viewing mental illness as a temporary disconnection from life, which could be reversed with support and encouragement from others, including mental health services, carers, peers and the general public.

Current research shows that either pure social or pure biomedical view on mental illness and recovery is incapable of removing stigma associated with mental illness from public perceptions

(Schnittke 2008). Whereas biomedical view currently dominant in mental health promotion partially removes the blame for the occurrence of mental health problems from the person by allocating causality to biological or genetic internal factors, it further reinstalls fear and mistrust associated with the uncontrollability and unpredictability of mental health problems. On the other hand, purely social view on mental illness in health promotion may install hope for recovery as a personal responsibility, but however may blame a person for non-resisting external social circumstances and not initiating and controlling own recovery. It is only through incorporating biopsychosocial model of mental illness and recovery in mental health promotion, with all interactive factors given equal emphasis and recovery viewed as possible despite any genetic or social circumstances, that public can start seeing multiple possibilities of how both disconnection and reconnection with life can occur. Such interactive and multidimensional view may remove blame associated with either internal or external circumstances in mental illness and recovery, and promote acceptance and social inclusion of persons with mental health problems in the community.

Notwithstanding the influence of biological, genetic, social, family or other factors, mental health problems can affect anyone during difficult times. Disconnection from self, others and time can occur to any professional or population group. The services and attitudes to mental health should therefore be refocused on viewing persons experiencing mental health problems as part of 'us', rather than the genetically or socio-economically predetermined 'them'. Services and supports should be therefore designed to be able to accommodate any of 'us', as opposed to some of 'them'.

The good news about seeing mental health problems as a temporal disconnection from life, and recovery as reconnection with life is that with proper support, reconnection with self, others and time is open to all. I would like to conclude this study with a message from one of the study participants:

It's good to be recovered. And everybody will recover sooner or later [...]. It's very important to believe.

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Appendices

Appendix A: Information letter for the participants



Health Research Board

Improving health through research and information

Yulia Kartalova O'Doherty
Researcher
Mental Health Research Unit
Health Research Board
Third floor, Knockmaun House,
42-47 Lower Mount Street, Dublin 2

T 01 2345144
F 01 6611856
E ykartalova@hrb.ie

Date: April 04, 2007

Recovering from recurrent mental health problems:

What does it mean to you?

Dear Sir/Madam,

The Health Research Board is carrying out a study to find out what 'recovery' means for different people who have experienced recurrent mental health problems. '*Recurrent mental health problems*' for our study means that a person has experienced mental health problems *more than once* over a period of two or more years. An example of recurrent mental illness could be serious depression or schizophrenia.

Please note that you do not have to be a user of mental health services in order to participate in this project. We are looking for any persons who have experienced mental health problems more than once over a period of two or more years prior to the study, consider themselves to be in improvement and feel relatively well to tell us about their experience in a confidential interview.

What has this got to do with you?

We would like to hear about your personal experience of recovering from mental health problems, what difficulties you have had at different times, and what helped you to get through them. Such information will help to make recommendations to service providers and policy

makers and combat stigma by letting the public know real stories about mental health difficulties and recovery.

How do you tell us about your experiences, needs and recovery?

You are invited to have a private interview with Yulia Kartalova-O'Doherty, who is an HRB researcher. The interview will be completely *anonymous*, this means that no-one else will find out what you have said, and no personal information (e.g. personal names, addresses, organizations, etc) will be included in the study report. Please also note that participation in this study does not form part of your treatment. If you take part in this study you are covered by an approved policy of insurance in the name of the Health Research Board. It is also entirely *voluntary*, so if you feel like stopping at any stage you can do so.

To be involved you need to contact us:

If you want to find out more or are willing to help with this study, or even if you have questions or comments, please phone *Yulia Kartalova-O'Doherty*

- Phone 01 2345144 or 087-6704312.
- E-mail ykartalova@hrb.ie.

What will be involved in the interview?

- The interview will take between 45 and 90 minutes.
- It will be arranged in a place that suits you.
- The information you share with us during the interview will be available to the researcher only and no identifying details will be disclosed.

If you know any other persons who have recurrent mental health problems and who might be interested in the study, please feel free to give them the contact details.

With your help, the findings of the study will be published by the HRB and made available to the public. We appreciate your time and effort, your experience is very important to us.

Yours faithfully,



Yulia Kartalova-O'Doherty
Researcher

Appendix B: Consent form for the participants



Yulia Kartalova O'Doherty
Researcher
Mental Health Research Unit
Health Research Board
Third floor, Knockmaun House,
42-47 Lower Mount Street, Dublin 2
T 01 2345144
F 01 6611856
E ykartalova@hrb.ie

Recovering from recurrent mental health problems: A modified grounded theory study in an Irish context

Consent for Participants (Interviewees)

Please tick boxes

- I have read the information letter on the above project
- I understand why I am being asked questions
- I agree to answer questions about my experiences and support requirements
- I understand that only the Health Research Board and Dublin City University research team will know the answers I give
- I understand that participation in this study does not form part of my treatment or rehabilitation programme
- I agree to allow the interviewer to audio tape the interview
- I understand that the notes and the tape of the interview will not be disclosed to anyone other than the HRB/DCU research team
- I know how to contact the research team if I need to, as provided in the information letter
- I understand that participation in the research is voluntary and I am free to withdraw at any time

Date _____

Signed _____

Print _____

Appendix C: The first interview schedule



Yulia Kartalova-O'Doherty
Researcher
Mental Health Research Unit
Health Research Board
Third floor, Knockmaun House,
42-47 Lower Mount Street
Dublin 2
T 01 2345144
F 01 6611856
E ykartalova@hrb.ie

Recovering from recurrent mental health problems: A modified grounded theory study in an Irish context

Interview schedule

1. First of all, tell me a bit about yourself. Basically, what is your background, where did you grow up, how many people in your family – that kind of thing.

2. Tell me about your experience of with mental health problems. When and how did you experience mental health difficulties for the first time?

[prompt only if needed: What happened then? What kind of support you had and needed at that time?]

3. Would you remember when you first felt that your mental health and well-being have improved? What happened? What kind of support you had, what else would have helped?

4. What are your expectations now of your treatment and recovery? Have they changed? How and when?

[prompt if needed: What does recovery mean to you? How would you measure the success of treatment and recovery?]

[if never used mental health services: What are your expectations of your recovery? Have they changed? How and when? Have you ever considered using mental health services? Why? What kind of support do you have and need at the moment? How would you measure the success of your individual recovery?]

5. How would you describe your current stage or level of improvement? How close are you to your desired destination? What do you need to help you move along? Is there anything that slows you down?

6. What were the most difficult period (or periods) of your experiences with mental health problems? What helped you to cope? What made you feel better and why? What could have helped even more?

I only have a few more questions left to ask, so we'll start to wind down now.

7. What advice would you give to somebody who is experiencing mental health problems for the first time? [prompt if necessary: mental health problems similar to yours]

8. What about the next few years: what do you think will happen? Do you have any future plans for yourself?

9. Is there anything else you want to add? Any issues you feel we haven't touched on?

Thank you very much for the interview, it was very helpful.

Appendix D: The second revised interview schedule



Yulia Kartalova-O'Doherty

Researcher
Mental Health Research Unit
Health Research Board
Third floor, Knockmaun House,
42-47 Lower Mount Street
Dublin 2
T 01 2345144
F 01 6611856
E ykartalova@hrb.ie

Improving health through research and information

Recovering from recurrent mental health problems: A modified grounded theory study in an Irish context

Interview schedule

1. Thank you again for participating in this interview. I would like to ask you about your personal experience with mental health problems and recovering. When and how did you experience mental health difficulties for the first time? How did you know that you were experiencing mental health problems?

[Would you remember when you first felt that your mental health has improved? When did you start to improve? What happened? Was there a turning point of some kind which started your road to recovery?

What do you think helped you to improve further? What else would have helped?]

2. What are your expectations now of your recovery? Have they changed? How and when?

3. What does recovery mean to you? How would you like to feel, what would you like to experience or to be able to do when fully recovered? How would you know that you are fully recovered? [How would you measure your individual recovery?]

[If never used mental health services: Have you ever considered using in-patient or other mental health services? Why have you never used them? Why? What kind of support do you have and need at the moment? How would you measure the success of your individual recovery?]

4. Several interviewees told me that they can have different levels of recovery on good days and bad days. Would you agree with that?

So what would be your good day? How do you know it's a good day? What do you do on a good day? What are your experiences? What are your emotions? How do you think good days impact your recovery? Is there anything that can spoil a good day?

What about your bad day. How do you know it's a bad day? What do you do on a bad day? What are your experiences? What are your emotions? When and why can they stop? How long would they last? What can turn a bad day into a good day?

Now I will ask you to rate your own level of recovery on a good day, on a bad day, and where you would like to be in the future. [Give three scores here.]

5. What do you think helps your recovery?

How do nurses help? How do doctors help? How does medication help?

How do inpatient services help? How do they not help?

Have you ever participated in peer support groups? How do peer support groups help/not help?

What activities help with your recovery and why? What else?

What about friends, do you think having friends is important for your recovery? What do friends do? Who would be your friend, how do you know they are your friend? What would be their impact on your emotions, energy levels?

Do you think talking helps recovery? How does talking help recovery?

A couple of interviewees told me that talking helps them to get rid of some negative energy. Would you agree with that?

What is negative energy? Where do you think it comes from, what can cause negative energy? How does it affect your recovery?

Do you think there is such thing as positive energy? Where do you think it comes from, what can give you positive energy? How does it affect your recovery?

Do you talk to yourself sometimes? When and what do you say? Does it help? How does it impact your recovery?

What would most help your recovery at the moment? At the moment, is there anything that slows down your recovering?

6. What were the most difficult period (or periods) of your experiences with mental health problems? How did you cope? What helped you to cope? What made you feel better and why? What did not help at all?

7. Some of our previous interviewees mentioned that you had to fight to get better, and not to give up.

Do you think it is important to fight for your recovery? Have you ever "fought" to get better?

How and when? What would you fight for, what would you fight against? What can motivate you to fight for your recovery? Have you seen other people that were "fighting" to get better?

What were they doing, how did you know that they were "fighting"? How did it make you feel?

What about “giving up”? Have you ever “given up”? When and how did it happen? Why? Have you seen other people who “gave up”? Where and when? How do you know that they “gave up”? How did they look like, what did they do? How did it make you feel?

Can “giving up” turn into “fighting”, and the other way round? When and how? What do you think comes first: giving up or fighting? What could be the consequences of “giving up” and “fighting” for recovering from mental health problems?

I only have a few more questions left to ask, so we'll start to wind down now.

8. What advice would you give to somebody who is experiencing mental health problems for the first time? [Prompt if necessary: mental health problems similar to yours]

One of the pieces of advice given by interviewees to other people was to remember that it is not the end of the world. Do you think it's helpful advice?

What do you think makes you feel that it is the end of the world?

How can you resist the feeling that it is the end of the world? What helps you to overcome this feeling, to come to the conclusion that it's not the end of the world?

9. What about the next few years: what do you think will happen? Do you have any future plans for yourself?

10. [If not spoken about during the interview]: Finally, tell me a bit about yourself. Basically, what is your background, where did you grow up, how many people in your family – that kind of thing, anything that you think is important.

Do you think your background can impact mental health and recovering in any way?

If yes: How can background influence mental health? Recovering from mh problems?

Do you think environment can influence mental health and recovery? How? What is good environment? Bad environment?

Do you think past events can impact your mental health and recovery? Which events and in what way?

11. Is there anything else you want to add? Any issues you feel we haven't touched on?

If you had one thing to say about recovery, what would it be?

Thank you very much for the interview, it was very helpful.

Appendix E: The third revised interview schedule



Yulia Kartalova-O'Doherty
Researcher
Mental Health Research Unit
Health Research Board
Third floor, Knockmaun House,
42-47 Lower Mount Street
Dublin 2
T 01 2345144
F 01 6611856
E ykartalova@hrb.ie

Improving health through research and information

Recovering from recurrent mental health problems: A modified grounded theory study in an Irish context

Interview schedule

1. Thank you again for participating in this interview. I would like to ask you about your personal experience with mental health problems and recovering, anything that you think is important.

[When and how did you experience mental health difficulties for the first time? How did you know that you were experiencing mental health problems?]

Would you remember when you first felt that your mental health had improved? When did you start to improve? What happened? Was there a turning point of some kind which started your road to recovery? What do you think helped you get on the road of improvement?

What about later, would you remember more of such turning points in your improvement? What happened, when and why? What do you think helped you to improve further?

2. What are your expectations now of your recovery? Have they changed? How and when?

3. What does recovery mean to you? How would you like to feel, what would you like to experience or to be able to do when fully recovered? How would you know that you are fully recovered? [How would you measure your individual recovery?]

[If never used mental health services: Have you ever considered using in-patient or other mental health services? Why have you never used them? Why? What kind of support do you have and need at the moment? How would you measure the success of your individual recovery?]

4. Several interviewees told me that they can have different levels of recovery on good days and bad days. Would you agree with that?

So what would be your good day? How do you know it's a good day? What do you do on a good day? What are your experiences? What are your emotions? How do you think good days impact your recovery? Is there anything that can spoil a good day?

What about your bad day. How do you know it's a bad day? What do you do on a bad day? What are your experiences? What are your emotions? When and why can they stop? How long would they last? What can turn a bad day into a good day?

Now I will ask you to rate your own level of recovery on a good day, on a bad day, and where you would like to be in the future. [Give three scores here.]

5. What do you think helps your recovery?

How do nurses help? How do doctors help? How does medication help?

How do inpatient services help? How do they not help?

Have you ever participated in peer support groups? How do peer support groups help/not help?

What activities help with your recovery and why? What else?

What about friends, do you think friends are important for your recovery? What do friends do? Who would be your friend, how do you know they are your friend? What would be their impact on your emotions, energy levels?

Do you think talking helps recovery? How does talking help recovery?

A couple of interviewees told me that talking helps them to get rid of some negative energy. Would you agree with that?

What is negative energy? Where do you think it comes from, what can cause negative energy? How does it affect your recovery?

Do you think there is such thing as positive energy? Where do you think it comes from, what can give you positive energy? How does it affect your recovery?

Do you think talking to oneself can help recovery? Do you talk to yourself sometimes? If yes, when and what would you say? How does it impact your recovery?

Is there anything that slows down your recovering at the moment?

6. What were the most difficult period (or periods) of your experiences with mental health problems? How did you cope? What helped you to cope? What made you feel better and why? What did not help at all?

7. Some of our previous interviewees mentioned that you had to fight to get better, and not to give up.

Do you think it is important to fight for your recovery? Have you ever "fought" to get better? How and when? What would you fight for, what would you fight against? What can motivate you to fight for your recovery? Have you seen other people that were "fighting" to get better? What were they doing, how did you know that they were "fighting"? How did it make you feel?

What about "giving up"? Have you ever "given up"? When and how did it happen? Why? Have you seen other people who "gave up"? Where and when? How do you know that they "gave up"? How did they look like, what did they do? How did it make you feel?

Can "giving up" turn into "fighting", and the other way round? When and how? What do you think comes first: giving up or fighting? What could be the consequences of "giving up" and "fighting" for recovering from mental health problems?

I only have a few more questions left to ask, so we'll start to wind down now.

8. What advice would you give to somebody who is experiencing mental health problems for the first time? [Prompt if necessary: mental health problems similar to yours]

9. What about the next few years: what do you think will happen? Do you have any future plans for yourself?

10. [If not spoken about during the interview]: Finally, tell me a bit about yourself. Basically, what is your background, where did you grow up, how many people in your family – that kind of thing, anything that you think is important.

Do you think your background can impact mental health and recovering in any way?

If yes: How can background influence mental health? Recovering from mental health problems?

Do you think environment can influence mental health and recovery? How? What is good environment? Bad environment? Do you think past events can impact your mental health and recovery? Which events and in what way?

11. Is there anything else you want to add? Any issues you feel we haven't touched on? If you had one thing to say about recovery, what would it be?

Thank you very much for the interview, it was very helpful.

Appendix F: Questionnaire for the participants



Yulia Kartalova-O'Doherty
Researcher
Mental Health Research Unit
Health Research Board
Third floor, Knockmaun House
42-47 Lower Mount street, Dublin 2
T 01 2345144
F 01 6611856
E ykartalova@hrb.ie

Recovering from recurrent mental health problems

Questionnaire for the participants

Gender: Male () Female ()

Age: _____

Marital status: Single () Married / cohabiting () Separated / Divorced ()
Widowed ()

What is the nature of your mental health problems? (diagnosis if known)

What is the approximate duration of your experience with mental health problems in years? _____

Education (please tick all that apply):

Some primary () Completed Primary ()
Some Secondary () Completed Secondary ()
Some Post Secondary () Certificate / Diploma ()
One or more University Degrees () Other _____

Current employment status:

Employed full-time () Employed part-time ()
Unemployed () Homemaker ()
Study () Retired ()
Sheltered employment () Training ()
Other _____

Current occupation (if unemployed or retired what was previous occupation)

Where do you reside at the moment?

- In your own accommodation ()
- In an in-patient unit ()
- In your parents/relatives' home ()
- In a community residence ()*

*if in a community residence, do you know if it is high (), medium (), or low () support? (Please tick one only)

Other (please specify) _____

What mental health services have you used in the last 12 months? Please tick all that apply.

- In-patient care () Out-patient care ()
- Respite care () Day care ()
- Day hospital () Day centre ()
- Nurse () Psychiatrist ()
- Psychologist ()

Other (please specify) _____

Have you participated in any peer support groups or programmes in the last 12 months?

Yes* () No ()

*If yes, what are they?

What other mental health services have you used previously? Please tick all that apply.

- In-patient care () Out-patient care ()
- Respite care () Day care ()
- Day hospital () Day centre ()
- Nurse () Psychiatrist ()
- Psychologist ()

Other (please specify) _____

Have you previously participated in any peer support groups or programmes?

Yes* () No ()

*If yes, what were they?

Do you have a Medical card? Please tick Yes or No.

Yes () No ()

Do you have a private medical insurance cover?

Yes () No ()

Are you in receipt of a disability allowance?

Yes () No ()

In general, how satisfied or dissatisfied are you with the services and support provided to you throughout your experience with recurrent mental health problems? Please tick one only.

- Very dissatisfied ()
- Dissatisfied ()
- Neither satisfied nor dissatisfied ()
- Satisfied ()
- Very satisfied ()

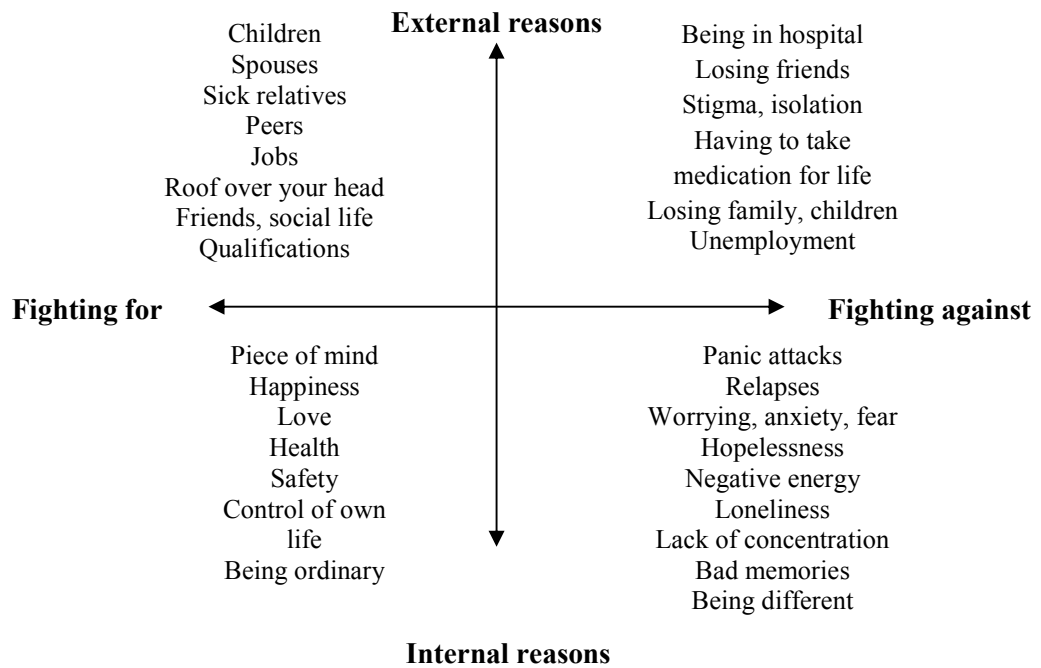
Appendix G: Example of open coding of the first six interviews on Excel

Tentative category/property	Theme /Chronology	In vivo code	Inter-view	pp
Talking to others	start of recovery	talking to patients	1	3
process of recovery	progress	learning	1	3
process of recovery	progress	Getting my memory back	1	3
manner of process		gradually	1	3
lack of friends, change	onset	I was unhappy there [in college], the only friends I had were my friends from school	2	2
to be well for life	first improvement, expectations	I got well there, I thought I was well for life	2	2
Not helpful	ECT treatment	I don't have a fear of ECT, but it doesn't do anything for me	2	2
comes tumbling back – past memories	ECT treatment	the first hour I feel great I can't remember anything, then it all comes tumbling back	2	2
	disagree with diagnosis	I don't think I have schizophrenia myself, I am kind of in limbo	2	3
Self-definition of problems		OCD, and depression, and anxiety	2	3
relationships with others	first improvement	in hospital: a girl asked me to a coffee shop	2	4
Recurrent vs chronic	manner of illness?	sick a quarter of the time and well the other 3/4	2	4
cope with fear	role of OCD	I'm afraid of something happening, and I just start that to prevent something happening	2	5
Current medication does not help	not the best medication	I think I might be better off on different pills	2	5
Not there when needed	psychiatrists	I like some of them, but they're so busy, you're in and out	2	6
Informal, warm relationships	Looking for friends	some of the nurses are among my best friends	2	6
Too formal, distant?	nurses who are not friends	I don't like to be called by my surname	2	6
Cognitive	barriers to recovery	concentration is bad	2	8

Appendix H: *In vivo* themes and concepts emerging from narratives about the past and current experiences, and future aspirations of recovery of the first six participants of the study

<i>Past</i>					<i>Present</i>			<i>Future</i>		
Past events	Feelings	Change in definition of mental illness	What helped	Past barriers	Current state	Current barriers	What helps	Recovery goals	What would help	Barriers to recovery
Trouble Crime Violence Physical abuse Sexual abuse Alcohol abuse Mental illness of a parent Death of a parent	confusion, feeling unsafe, anxious, unable to relax, hiding, running away, paralysed, trying to forget, getting into yourself, apprehensive (something is about to happen), angry, fearful (afraid to ask), shy (with girls), negative energy, panic attacks	Disagreement with prognosis that mental illness is for life Mental illness is like a volcano, I used to draw lots of volcanoes, now I draw flowers Long, long way to recovery I have been through some very bad times but thank god I've come through them	Change of medication; Reduced medication; OCD for a short while; Self-harm: do something to distract yourself Something to fight for (goal?) own motivation own willpower Self talk Prayer Friends Wife Children Friends from work Getting a roof over my head (hostel) Breathing: controlling panic attacks	Hospital: Very easy to give up, to say 'I'm finished', hopelessness, lack of control; too much medication	I would like to call it partial mental illness, ¾ of the time you are fine I think I am only recovering now Just take my tablets every day I can't just keep running away from it, I have to fight it	Court case (offence committed 2 years ago): panicky, anxious, afraid Bad memories from the past: abuse 'haunting you', 'paralysing' you Place/environment: would like to move area/house, lots of bad memories Medication side effects: drowsy, low concentration, low energy, - affects work and study cannot have a drink with friends/relatives – social interaction gain weight – appearance - low self esteem, social interaction Fear of social interaction: Cannot ring for jobs; afraid/shy to talk to people Panic attacks, depression, anxiety, worry, fear, insomnia Stigma associated with mental illness: jokes, sneering, hard to find jobs	Activities Learning Listening Talking Family Friends Deep breathing Exercise Poetry Prayer Art Day centre: Company and independence Feel happier and safe there Nurses: listen Doctor: suggesting I try new things	Piece of mind – get rid of panic attacks Not worrying – develop better coping skills To work, socialise Try to get out to the garden [of life?] out of this blackness [fear?] Not to take tablets for life To get rid of/reduce/panic attacks Not to be in fear of the past To feel happy and safe	To be able to have a drink and socialise To lose weight (side effects of tablets) To get a qualification, learn new skills To move to a different place To get new experiences, meet new people To get concentration back	Bad memory for work, study Old age: fewer skills and opportunities Cost of property: lack of affordable accommodation Loneliness: being on one's own in the house

Appendix I: Tentative dimensions of the code ‘fighting to get better’



Appendix K: Memo 25

Realizing one is able to make a difference, give something positive back to somebody: being worthy of life

12-30 November 2008

Fighting, or making an effort to get better can be fostered by learning or realising one is able to make a difference, to give back something good to another person or people, and by this proving to oneself that one can make a difference by being a part of this world, by being there for somebody, by taking some positive action (working, studying, achieving, listening, talking, emphasising, understanding, sympathising, creating art) in order to be of some practical or empathic help to others, by being and doing.

Yeah they [expectations about recovery] have changed because I'm actually doing an English course at the moment, I was good at English at school but I'm learning new techniques and I'm learning new... I want to go over to somewhere like Russia where English is a foreign language like you know, that's what I'm hoping to get out of English course eventually you know. So yeah I have something to look forward to, yeah I have something to look forward to (1).

Working, just filling in my day properly instead of walking around calling for friends and complaining... It makes me feel really angry like, makes me feel lazy. Working is good, because it's helping people. It makes you feel good about yourself (28).

The opposite: not making a difference at all, or making a negative difference (being a burden, being useless, or being not good to anybody; being bad or being negative, bringing nothing but trouble or distress, bringing no change or negative change to the world of people.

It's nice to know what you're around for, that you're not a burden on anyone or anything like that... The depression hang over me all the years, yeah. Sad or suicidal, thinking I wasn't any good on the world (16).

...one of my problems is I can't relate to other people... Well I would like a different personality. And I have a rather negative personality... I think I'm inevitably one of life's drop-outs. Well because I dropped out from society and I don't have anything to do with anything at all really... It's my fault, I'm, I can be rather an unpleasant fellow. ... I can't relate to people properly in workforce. And I can't stick at anything for very long. I'm unemployable actually I would say and have been for 10 or 20 years. I just am no good as an employee. I'm just trying to eh...keep the status quo and not offend people. (24).

Negative past experience can damage one's self-esteem and a sense of purpose, the belief in one's potential to make a positive contribution to the world:

I'd like to be confident, I've no confidence. I don't know, it must have been the way I was brought up. No, they were always just, you see we lived with an alcoholic you know and he wasn't very confident in himself, obviously because he was drinking so we just, we were just brought up with no confidence, because like if someone doesn't have confidence in themselves, how can they carry it on to someone else? (28).

The concept of being able to help others as the major stride in one's growth of self-esteem/confidence and therefore, recovery, was present in the narratives of both GROW peer support interviewees and those using mental health services:

... to start off with, my self esteem was very low, I had no confidence, and I had no, I had lost all belief in myself and that was a wonderful thing about GROW, the growers

encouraged me and you know they had belief in me when I didn't have belief in myself. And it was from their constant encouragement and when you start off in GROW you might be, you know after a few months then I was asked to lead a meeting... And I was asked to become organiser of the group, and I was very new, and it was through that leadership that I began to feel better about myself (10).

I was a bit nervous the very first day but then when I started talking to the crowd that's here, I kind of got a bit... More relaxed and as the weeks went on, you know even if you're away a week they miss you, they need you. Just like I need them...(18).

Through empathy and support of others one can start believing in being worthy of life (self-worth), and start working on oneself to be able to make albeit small, but still some difference (self-competence). Feeling human, feeling accepted as a human being as opposed to being treated as 'inhuman' or being treated as a mental illness not capable of contributing, not capable of making a positive change. Being accepted unconditionally as a worthy human being irrespective of current state of mood or distress brings out trust and connectedness:

Whom do you trust? Somebody who has faith in you, believes in you. Somebody who knows it's the illness, not the person. (20)

During the initial contact/treatment – underline self worth, shared humanity; acceptance

Later – gradual build up of self-competence through trial and error

2-dimensional self-esteem: acceptance of oneself through others as a worthy human being who can contribute something to the outside world. Being and doing; connected; being human.