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Dorthe Kirkegaard Thomsen, Torben Østergaard Christensen, Marie Tranberg Hansen et Mike Slade

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Résumé de l'article

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Mental health staff play an important role in facilitating personal recovery. We examined how mental health staff perceived personal recovery and the professional and personal benefits of their experience with supporting the personal recovery of service users.

Research Design and Methods

Forty-eight mental health staff wrote a narrative about a service user with severe mental illness that they believed to be in the process of personal recovery and elaborated on the impact of this professional experience. Interpretive phenomenological analysis was used to illuminate 1) staff conceptualizations of personal recovery, 2) professional contribution to recovery, and 3) positive impactof recovery-oriented care on staff.

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Staff conceptualizations of recovery focused on social connections and positive subjective states, as well assymptom remission and illness management. Professional contributions were narrated as encompassing treatment, relationships, and conversations as well as time and team collaboration. Impact on the staff included strong positive emotions, professional gains with respect to learning and self-esteem, motivation for and meaning in work, as well as belief in recovery.

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Dorthe Kirkegaard Thomsen[1]
Torben Østergaard Christensen[2]
Marie Tranberg Hansen[1]
Mike Slade[3,4]

[1]Aarhus University, Denmark

[2]Psychiatric Clinic North, Denmark

[3]Institute of Mental Health, University of Nottingham, UK

[4]Health and Community Participation Division, Nord University, Norway

Keywords: personal recovery; staff views; narrative medicine; recovery-oriented care

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Corresponding author: Dorthe Kirkegaard Thomsen
Email: dorthet@psy.au.dk

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Introduction

Mental health professionals are increasingly expected to support service users in their personal recovery,[1,2] which refers to living a meaningful life in the context of mental illness. [3-5] While traditional understandings of recovery emphasized symptom remission and functional improvement (also termed clinical recovery), with a consequent strong treatment focus on these outcomes, recent decades have seen a growing emphasis on personal recovery.[6-9] While the two recovery terms reflect distinct foci, they may intertwine in the lives of service users and in how mental health staff view their efforts to support service users.

Personal recovery is multifaceted and spans a range of interrelated concepts, including hope, positive identity, social connections, meaning and purpose.[4, 7] It is defined as "a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with the limitations caused by illness"[3] (p. 15). Personal recovery is chosen, initiated, and led by service users, but socio-cultural niches, including mental health care, can hinder or facilitate recovery.[6]

As mental health care is evolving towards supporting personal recovery, insights into the characteristics of recovery-oriented care have emerged.[1, 2] Analyzing guidelines for recovery-oriented care across countries, Le Boutillier and colleagues grouped themes in these documents into four overarching practice domains: promoting citizenship, organizational commitment, supporting personally defined recovery, and working relationship.[10] It is important to understand how these perspectives fit with staff perceptions of what facilitates personal recovery in service users and how supporting this journey impacts mental health professionals.

Many studies have investigated personal recovery from the perspective of service users,[4, 7, 11-13] but studies on staff perspectives are needed. Providing good mental health care is emotionally demanding, interpersonally complex, and requires high expertise. This is no less the case as the mental health system is changing towards recovery-oriented care driven by teams with varied professional backgrounds. A benefit of asking mental health professionals for their view is that they may possess insights into factors that foster personal recovery and the professional gains of supporting this process, which could include job pleasure, sense of competence, and learning. Illuminating professional gains is especially important in light of evidence that mental health staff are at risk of burnout with negative consequences for service[14] and studies indicating that recovery-oriented care is related to lower burnout and staff turnover.[15, 16] If we can identify staff advantages of supporting personal recovery and increase the presence of such advantages in daily practice, it may foster job satisfaction and protect against burnout which could increase staff retention with positive implications for care .[15, 16]

Studies on professionals' perspectives have mostly focused on how they conceptualize recovery and recovery-oriented care.[17-20] A review of 22 qualitative studies involving a total of 1,163 participants found that staff conceptualized recovery-oriented practice in terms of clinical recovery (e.g., medication adherence, stabilizing patients), personal recovery (e.g., inspiring hope, supporting informed

choice, partnership relation) and service-defined recovery (constrained by the financial and administrative priorities of the organization).[21]

In the present study, we build on insights from the above studies as we analyze how mental health staff narrate their experience with a service user diagnosed with severe mental illness who is in the process of personal recovery. The study was conducted within the framework of narrative medicine, where narratives are assumed to be key to how professionals understand individual service users and their own role in the healing process.[22] Narratives represent events over time, synthesizing objective information about what happened with subjective views, including emotions and interpretations, thereby imbuing experience with meaning.[23, 24] While they reflect personal experience, they are shaped through conversations with others and master narratives.[23, 25] The narratives staff construct about individual service users support empathy and patient-centred care because it brings the person, rather than the illness, to the foreground. Such narratives help staff make sense of their own actions and feelings;[22] they go beyond abstract decontextualized knowledge (e.g., “professionals should support recovery”) and capture lived experience of supporting service users’ personal recovery. For these reasons, narratives are powerful tools to elucidate staff perceptions of personal recovery and professional implications of recovery-oriented care.

We analyze the staff narratives for common themes in how recovery is described and the professional contribution to the process. Moving beyond the reviewed research, our key contribution is to analyze the staff narratives for potential personal and professional benefits of supporting recovery.

Research Questions in the Present Study

In the present study we aimed to answer three research questions:

1) How do mental health professionals conceptualize personal recovery?
2) How do mental health professionals narrate their own contribution to personal recovery?
3) What personal and professional benefits do mental health professionals experience when supporting personal recovery?

To answer these questions, we asked staff to develop a written narrative about a service user with severe mental illness that they had worked with who was in the process of personal recovery. We asked them to write about the impact this experience had on them personally and professionally. We decided to ask for written narratives partly for pragmatic reasons, and partly because writing narratives supports meaning-making. Coding written narratives is a standard procedure in narrative identity research.[26]

Research Design and Method

The study was not assessed by an ethics committee as this is not a requirement in the host country but was conducted in alignment with the Declaration of Helsinki ethical principles. The study involved mental health staff sharing narratives of service users with a potential risk of revealing information of identifiable service

users without the possibility of obtaining their consent. To minimize this risk, we explicitly instructed the staff participants to anonymize information of service users in their narratives and to indicate whether the narratives could be quoted or not when sharing research results. Narratives that were marked as “not allowed to quote” were included in analyses but were not quoted as examples of themes. Analyses were undertaken by two authors not affiliated with the hospital to reduce risks of identifying service users. We further anonymized any service user information shared in the staff narratives when we included those marked “allowed to be quoted” in the Results section. Given these procedures for minimizing disclosure of information about identifiable service users, the potential risk was assessed as minor. We note that our study concerns subjective staff views, and that the narratives were not collected to reflect service user information or for clinical use. Data is not made available to protect participant and service user identity.

Participants

We recruited mental health staff from one psychiatric hospital in Denmark. The second author invited all unit managers at the hospital to distribute recruitment emails to their staff. The first email was sent 3-4 weeks before the study was opened and alerted staff to the possibility of study participation. This email contained information about the purpose of the study and asked staff to begin thinking about a potential patient in the process of personal recovery to be described as a part of study participation (we decided on the term “patient” as this was deemed most familiar for participants and hence, we use this term throughout the Method and Results sections). Following this, an invitation email with an electronic link was distributed and reminders were sent out after 4-6 weeks. Staff were allowed 30 minutes of working time to participate. The study was closed when no more participants had entered the study for several weeks and the achieved group of participants represented a range of professional backgrounds and a relevant sample size for allowing diverse perspectives to emerge.

Materials

The electronic survey contained an informed consent form including a question where we asked staff whether they would allow us to share quotes from their narratives in the paper. Those staff participants who declined have not had quotes from their narratives shown in the paper. The survey also included questions about demographic variables and professional status (see study website).

The participants were asked to write an extended narrative about a particular patient with severe mental illness they had been in contact with and who was in the process of personal recovery. Personal recovery was described using Anthony’s definition.[3] They were told that they could choose any patient and that the description could include what happened, who was involved, the various events and their own reactions, and thoughts and feelings. Further, they were invited to include the person’s background, the illness history, treatment, change toward recovering, and other relevant aspects. They were asked to write the description in the way that

made most sense to them, and to try to write a coherent story as if they were telling someone who was interested in their personal experience. Finally, they were asked to anonymize their description of the patient by replacing names and places with initials. They were provided with an unlimited text field for the narrative.

Second, participants were asked two questions that directly targeted the impact of the experience. They were asked what this recovery experience meant to them (a) professionally and personally and (b) what feelings and thoughts they experienced when thinking back upon it. For each question, they were asked to write their answers in unlimited text fields.

Finally, they were asked to rate the impact of their experiences with patients' recovery on their sense of professional competence, work pleasure, professional pride, hope for recovery in others with mental illness, meaning of their work, and learning to provide the best possible support for recovery; all rated from 1 (very little) to 10 (very large). These questions were derived from discussions between the first and second author on potential positive impact of professional experience of supporting recovery. We included these questions to supplement the qualitative analyses.

Analyses

We used interpretive phenomenological analysis, which is concerned with how individuals make sense of their experiences.[27] We analyzed the experiences of individual participants as expressed in their written narratives while aiming to classify similar experiences into themes.[28] We take an explicit narrative approach and ground the analyses in the assumptions that 1) individuals make sense of experience through narrative (staff make sense of their patients and healing tasks through narrative) and 2) similarities in narrative themes may be identified across individuals revealing commonalties in how experience (with personal recovery) is interpreted within groups (mental health staff).

The first and the third author independently read through all narratives marking experiences relevant for each of the three research questions. They then independently reviewed the relevant parts of the narratives and labelled these to capture common themes. At the same time, they kept an open mind to detect other informative themes. At a discussion meeting, the derived themes were compared and discussed. For the most part, the two coders had derived similar themes. A few themes had been identified by one coder but not the other (e.g., "Conversations" in Table 2 was initially only identified by one coder). When this was the case, the themes were discussed with reference to narratives that the coder judged as evidencing this theme. If the other coder agreed, the theme was preserved. Some differences in identified themes reflected that the two coders had made different decisions with respect to collapsing versus not collapsing related topics into one theme (e.g., "Conversations" had initially been coded as a part of "Relationship" rather than as a separate theme by the other coder). When this was the case, discussions centred around the conceptual dependence/independence of the themes, and agreement was reached in all cases. The list of themes derived from the discussion meeting was then compared by both coders to all relevant parts of

the narratives to double check whether these were appropriately represented by the themes.

Two additional and possibly related observations were made during coding: 1) Staff expressing hope that the recovering patient was still doing well and 2) The “other” negative story. We elaborate on these below.

Results

The 48 participants comprised 20 nurses, 4 psychiatrists, 1 social worker, 7 social and health care assistants, 2 physiotherapists, 10 psychologists, 2 peer support workers, and 2 activity workers. There were 43 women and 5 men with a mean age of 47.69 years (*SD* = 12.13). The staff were employed at both inpatient and outpatient services and had worked in mental health care for an average of 12.20 years (*SD* = 9.47). The patients they described had been diagnosed with a range of mental illnesses, including schizophrenia, personality disorders, depressive and anxiety disorders, autism, ADHD, substance abuse disorder, and others.

How Do Mental Health Professionals Conceptualize Personal Recovery?

The coding revealed that participants described a variety of partly co-occurring aspects of personal recovery (see Table 1).

Table 1: Themes and exemplar quotes concerning staff conceptualizations of personal recovery (note that quotes may contain several themes)

Themes	Exemplar quotes
Improved relationships	"..go to the shared area and have coffee with the other residents which she was happy about.." [pp38] "..reestablished contact to the family and established new relationships" [pp43]
Contributing to community	"…it became possible to interact with staff and residents in the protected home, and contribute to this community…" [pp48] "…is a contributing member of the local community…" [pp1]
Education and work	"…the patient has enrolled into an education and has wishes for the future…" [pp36] "…the patient managed to work in a bookstore one day a week…" [pp20]
Leisure activities	"In addition to her family, she managed to establish a network around walking, running, and going to the cinema"…" [pp17]
Good day-to-day life	"…he manages household chores and looks after the garden…" [pp40] "…ends up getting a job which gives him energy and a good everyday life since it is now more structured…" [pp26]
Reduced treatment need	"…and the patient has not been hospitalized since then…" [pp34] "…the patient slowly reduces medication and by the end tells that he feels well and knows himself again…" [pp37]
Illness management	"..the symptoms associated with the bipolar disorder he learned to live with over many years…" [pp39] "…she feels in full control over her voices…" [pp41]
Patient as agentic	"…over time one sense an increasing wish from the patient to be able to control [illness] episodes" [pp35] "…he got can-do spirit and worked hard on his treatment…" [pp9]
Patient dreams and wishes	"…he believes that life will be good in the future and accepts that life has its ups and downs for all of us" [pp41] "…starts developing plans for the future, work-related…" [pp42]

Patient changing positively	"…more trust in others…" [pp43] "…she became more gentle and able to open up to other people and it seems like her relationships improved…" [pp13]
Patient thriving	"…feels well today, is happy, thriving and well-treated…" [pp47] "…she lives a dignified and meaningful life where she experiences robustness to get back on her feet when life challenges her…" [pp6]
Healthier lifestyle	"…she is discharged to a protected home where she manages to get out of her drug abuse with support from the staff and through her own will…" [pp44] "…he has stopped smoking and is saving for another future, wants a dog…" [pp35]

Note: Participant number shown in square brackets

Many themes appear to relate to a mixture of recovering functional level within the domains of relationships, daily living, education, and vocation (functional recovery) as well as the social dimensions of personal recovery (improved relationships, education and work, leisure activities, contributing to community, and good day-to-day life). Other themes were more directly related to mental illness (reduced treatment need, illness management). A range of themes related to patients' subjective states (patient as agentic, thriving, changing positively, dreams and wishes). A final theme concerned patients adopting a healthier lifestyle.

How Do Mental Health Professionals Narrate Their Own Contribution to Personal Recovery?

The coding yielded six themes of professional contribution to supporting the process of personal recovery. The themes often co-occurred, and we consider them mutually interdependent (see Table 2).

Table 2: Themes and exemplar quotes concerning professional contribution to personal recovery (note that quotes may contain several themes)

Themes	Exemplar quotes
Treatment methods	"…it was a turning point in psychotherapy. We, he and I, realized why earlier treatment attempts has perhaps failed, changed the course and the strategies…" [pp9] "what probably made the difference with respect to recovery was that the patient was treated with a high dose of [drug A] and a lower dose of [drug B] and a high dose of antidepressant medication. It also helped that the patient was given early retirement and supported living…" [pp40]
Practical assistance	"…I supported my patient in the situation and talked a lot about advantages and disadvantages. At the ward we agreed that I could accompany the patient when looking for an apartment. That was a big joy for the patient and gave him the calm he needed to agree to move…" [pp22] "…staff from the ward accompany the patient on home visits and the structure from the ward is transferred as much as possible into the everyday life in the protected home" [pp12]
Relationship	"…meet the patient with openness and honesty, not demand a lot, but hold on to some things; pay attention to personal hygiene, express worry about dental care, the small things that perhaps contributed to strengthening the relationship" [pp30] "…as a part of these walks we develop a reciprocal confidentiality and I underscore reciprocal […] It turns out she has an eating disorder that she is very ashamed about. The conversations develop into focusing on the heavy medication and with the patient's involvement, medicine reduction is begun […] she describes how a grey veil of indifference is removed as her medicine is reduced…" [pp24]
Conversations	"…listening and the contract that I managed to make with her gave her the opportunity to walk the path of healing […] she is a patient I have felt close with due to her family background. I realized that her anger was a shield to avoid pain…" [pp15] "The patient struggles to describe what his problem is, but over several conversations we realize what may be at stake. The patient has lost his mother and is grieving. I use my own knowledge of grief and we have a good conversation about this…" [pp5]
Collaboration	"…the course was a collaboration between the treatment responsible person, the ward, the physiotherapist and the occupational therapist. Three years of treatment…" [pp43] "…the combination and culmination of many factors interacting. You rarely know exactly what made the difference

	and you have to make do with being a small piece in a larger puzzle…" [pp40]
Persistence	"…be patient and don't give up…" [pp29] "…what the patient experienced as having an effect was that she was given time to find safety and that the staff insisted on finding ways to understand her and help her […] it takes time. Time is a factor that decides what we can do, relations, and collaboration…" [pp12]

Note: Participant number shown in square brackets

One theme related to how treatment contributed to symptom reduction and personal recovery, including medicine, medicine change, psychotherapy, and physiotherapy. Relatedly, efforts to assist patients with practical issues, such as living conditions, were described as helpful. Many staff highlighted the importance of stable, trusting, and close relationships between themselves and the patient and noted that openness in approach from their side facilitated recovery. Under the theme of conversations, the professionals noted listening, understanding, sharing experiences, and achieving new insights into the patients´ problems and illness. Final themes included sustained efforts characterized by maintaining hope and patience, even in the face of steep odds, as well as collaboration between different team members.

What personal and professional benefits do mental health professionals experience when supporting personal recovery?

We identified eight themes concerning staff perceived benefits of supporting the process of personal recovery. The themes were often overlapping and appear mutually interdependent (see Table 3).

Table 3: Themes and exemplar quotes concerning the positive impact of personal recovery narratives (note that quotes may contain several themes)

Themes	**Exemplar quotes**
Positive emotions	"…I feel a quiet sense of joy and satisfaction that patients sometimes succeed with a good treatment course…" [pp40] "…when I think back to this, I feel joy. Joy for the patient. That she can now live a life where she can do many of the things, she wants to…" [pp34] "…gratefulness is the major emotion. And I know the patient feels the same way – she is very grateful…" [pp35] "I feel immensely happy and moved, I can feel the joy run through my body as I write about it…" [pp3]
Professional development	"…an increased understanding of how the methods I use in my treatment and approach to the patient work…" [pp35] "…it has massively influenced my confidence. To realize that patients cannot be sorted into boxes and that treatment must be

	individually tailored depending on resources and comorbidity…" [pp28]
Professional self-esteem	"…I am proud of having done a good job and improved the quality of life for my patient…" [pp38] "…I am professionally proud of having given treatment with such a massive influence on another person's life. That is the core of physician work" [pp18]
Making a difference	"…I know the treatment I give can contribute to making a difference for someone…" [pp45] "…the feeling of having contributed to making a difference in her recovery process…" [pp11]
Meaning in job	"Recovery, no matter the degree of recovery, contributes to a large extent to making work in the psychiatric system meaningful. Sometimes you are directly involved all through the course, sometimes you have been a part of something, for example in the initial phases. Whether it is one or the other it gives me professional and personal energy…" [pp9] "Both professionally and personally is has been incredibly meaningful" [pp30]
Belief in recovery	"…hope for the future and the belief that it can be more and better for everyone…" [pp41] "…I can always find hope for the patients who think it is hopeless. I feel secure in myself. It is never hopeless…" [pp1]
Witnessing recovery	"…humbleness to see each person and the recovery that is possible…" [pp27] "Over the years, I have been honored by following his recovery process…" [pp41]
Motivation for job	"…personally it means a lot to me since this is what drove me pursue this education and to go to work each day. The idea that our efforts mean something to the people we try to help…" [pp6] "…this case together with other positive experiences with recovery is the reason why it is worth working in the psychiatric system…" [pp10]

Note: Participant number shown in square brackets

First, the professionals narrated strong positive emotions when thinking about the patient in the process of recovery. These included emotions felt by the professionals themselves and the patients (e.g., joy, pride, gratefulness, and hope). Two themes related to the professional role, including professional development (learning what works to support recovery) and professional self-esteem (trust one's professional judgement). Several themes relate to the professionals' investment in

supporting personal recovery (making a difference, meaning in job, motivation for job, witnessing recovery, and belief in recovery).

These analyses are further supported by the high ratings participants gave the predefined positive impact questions (rated from 1 to 10 with 10 indicating larger impact): professional competence (*M* = 8.11, *SD* = 1.37), work pleasure (*M* = 8.96, *SD* = 1.40), professional pride (*M* = 8.55, *SD* = 1.40), hope for recovery in others with mental illness (*M* = 8.26, *SD* = 1.39), meaning of their work (*M* = 8.81, *SD* = 1.62), and learning to provide the best possible support for recovery (*M* = 8.28, *SD* = 1.63).

As a final observation, we note that the personal recovery narratives appeared to be constructed as alternatives to "another" negative story. Several participants made brief notes of how recovery was rare and that they needed experience with recovery to sustain them in the face of more frequent courses of little improvement and continued relapse (e.g., "many patients seem hopeless" and "being able to help someone – that doesn't happen so often"). Some participants directly storied this negative side of their professional experience: "Sometimes when you get frustrated that nothing is working and become hopeless and by that also making the patient hopeless." These statements concerning negative stories can be viewed in connection with the observations that staff sometimes explicitly expressed hope that the patients they had described were *still* doing well. One possibility is that these expressions with their focus on "still" partly reflect the negative story: Recovery was viewed as fragile in the shadow of potential relapse. However, these expressions of hope may also be seen as another reflection of the staffs' involvement in their patients' recovery.

Discussion

When staff were invited to narrate the story of a service user in the process of personal recovery, they described a diverse set of recovery indicators, including functional recovery, clinical recovery, and illness management as well as factors associated with personal recovery. This diversity in conceptualizations aligns with previous studies demonstrating that mental health staff construe recovery in different ways.[21, 29] Still, the variety of themes is surprising given that we provided participants with a definition of personal recovery and asked them to choose a service user in personal recovery.

A positive interpretation of why clinical recovery, functional recovery, and illness management emerged in staff narratives when they were invited to write about service users in the process of personal recovery is that each service user is different and see personal recovery in their own way with staff conceptualizations simply reflecting this variety. While the definition of personal recovery used in the study clearly demarcates aspects of experience,[3] recovery likely takes on more varied forms in everyday mental health care as service users and staff work together to understand what it means and takes to get better. The findings of varied staff conceptualizations of recovery may also reflect that different conceptualizations are intertwined. For example, aspects of personal recovery, e.g.,

hope, may drive changes in behaviour viewed as functional recovery, and such gains may impact illness management and clinical recovery.

A more pessimistic explanation of why staff included clinical and functional recovery when invited to write a narrative of a service user in the process of personal recovery is that staff do not fully embrace key aspects of personal recovery, including positive identity, hope, and meaning. The implication of staff not identifying personal recovery as a goal of mental health care, or not knowing what to monitor as indicators of it, is that their professional efforts may not be tailored towards facilitating personal recovery.[21] If this is the case, service users may not be optimally supported in their personal recovery journey. In the present study, we cannot assess whether the positive or negative interpretation is most likely. Follow-up studies could use interviews to probe further into reasons why staff did not focus more clearly on key aspects of personal recovery.

When staff constructed narratives about service users in the process of personal recovery, they identified several ways they had facilitated the process. Research demonstrates that staff are narrated as supportive when they see things from the service user's perspective, nurture hope, and support autonomy.[28] Our analyses extend this literature by illuminating staff perspectives on how professional efforts contribute to recovery. Participants storied several mutually interdependent factors as supporting recovery, including various treatments. The focus on treatments may reflect that staff sometimes elaborated on clinical recovery, which is traditionally the target of treatment. It could also reflect that staff viewed treatments as facilitating aspects of personal recovery through the positive impact on clinical recovery, i.e., the remission of symptoms may foster hope and open possibilities for community participation. Furthermore, participants emphasized stable and trusting relationships to service users as well as conversations focussing on listening and understanding service users and their problems. Speaking to the importance of organizational resources, participants emphasized time and persistence as well as team collaboration. These staff narratives of personal experience with supporting recovery echo themes identified in prior literature.[1, 18-20] As personal recovery is increasingly emphasized as a goal in mental health care,[2] it is important to establish practices that facilitate this valued outcome, and our findings may inspire such efforts. We suggest that staff narratives of how their decisions and actions positively influenced service users may play an important role in building lived and contextualized expertise crucial to providing effective recovery-oriented care. This suggestion is in line with findings from our analyses on the positive professional impact of the narratives as well as ideas from narrative medicine.[22] Future studies may examine whether sharing recovery narratives among staff helps build professional competence.

The professional value of recovery narratives is further emphasized in our analyses of positive impact, that included strong emotions such as joy and gratefulness, motivation and meaning in job, and belief in and hope for recovery. This indicates that constructing narratives about service users in the process of recovery carries multiple benefits and may protect from burnout. This is consistent with other research indicating advantages of recovery-oriented care.[15, 16, 18] Using narratives of recovery as a reminder that you are making a difference, that recovering is

possible, and to sustain motivation may be especially needed when considering the "other" negative story participants referred to. This story of chronicity, relapse and fragility of recovery likely reflects a stigmatizing and negative master narrative of mental illness that is reinforced by a clinician's illusion as staff mostly see service users if and when they relapse and worsen, and not when they thrive.[28, 30] Given that service users need staff to act as bearers of hope when they are in most pain,[18] practices can be developed to counter the effects of stigma, negative master narratives, and a clinician's illusion which may lead to staff feelings of hopelessness and frustration. Such practices could include regular sharing of recovery narratives by staff and service users in the process of recovering. Future research may examine the effects of such efforts on outcomes, such as job pleasure, burnout, and staff retention.

Limitations

We collected written narratives among mostly female mental health staff with a background in nursing, located at a Danish psychiatric hospital. It is likely that interviews, probing in more depth, and recruiting staff with other backgrounds would yield different themes. In addition, we focused on positive impact of professional experience with recovery, and while we did note the negative story referenced in the data, the present study is not well-suited to illuminate the professional costs and burdens of recovery-oriented care. Nevertheless, we suggest that our key findings will likely generalize to other mental health settings in the western world. This is a question for future research.

Conclusion

We found that staff narrated recovery and their professional contribution in varied ways. The staff found much positive meaning in their narratives of service users in the process of personal recovery, including professional development, motivation, meaning, and hope. To maximize the positive impact of staff on the personal recovery journey, organizations may develop opportunities to share recovery narratives, which could build professional competence and sustain motivation with positive effects on staff retention and recovery-oriented care.

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References

1. Bellack AS. Scientific and consumer models of recovery in schizophrenia: Concordance, contrasts, and implications. Schizophrenia Bulletin. 2006;32(3):432-42. Epub 2006/02/08. doi: 10.1093/schbul/sbj044. PubMed PMID: 16461575; PubMed Central PMCID: PMC2632241.
2. Roberts G, Boardman J. Becoming a recovery-oriented practitioner. Advances in Psychiatric Treatment. 2014;20(1):37-47. Epub 2018/01/02. doi: 10.1192/apt.bp.112.010652.
3. Anthony WA. Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. Psychosocial Rehabilitation Journal. 1993;16(4):11-23. doi: http://dx.doi.org/10.1037/h0095655. PubMed PMID: 618356190; 1993-46756-001.
4. Andresen R, Oades L, Caputi P. The experience of recovery from schizophrenia: Towards an empirically validated stage model. Australian and New Zealand Journal of Psychiatry. 2003;37(5):586-94. Epub 2003/09/27. doi: 10.1046/j.1440-1614.2003.01234.x. PubMed PMID: 14511087.
5. Davidson L, Roe D. Recovery from versus recovery in serious mental illness: One strategy for lessening confusion plaguing recovery. Journal of Mental Health. 2007;16(4):459-70. doi: http://dx.doi.org/10.1080/09638230701482394. PubMed PMID: 621827468; 2007-12119-003.
6. Slade M. Personal recovery and mental illness: A guide for mental health professionals. Cambridge: Cambridge University Press; 2009. xi, 275 s. p.
7. Leamy M, Bird V, Le Boutillier C, Williams J, Slade M. Conceptual framework for personal recovery in mental health: Systematic review and narrative synthesis. The British Journal of Psychiatry. 2011;199(6):445-52. doi: http://dx.doi.org/10.1192/bjp.bp.110.083733. PubMed PMID: 1041001638; 2012-24054-004.
8. Leonhardt BL, Huling K, Hamm JA, Roe D, Hasson-Ohayon I, McLeod HJ, et al. Recovery and serious mental illness: A review of current clinical and research paradigms and future directions. Expert Review of Neurotherapeutics. 2017;17(11):1117-30. Epub 2017/09/09. doi: 10.1080/14737175.2017.1378099. PubMed PMID: 28885065.
9. World Health Organization. Guidance on community mental health services: Promoting person-centred and rights-based approaches. Geneva: World Health Organization; 2021 2021.
10. Le Boutillier C, Leamy M, Bird VJ, Davidson L, Williams J, Slade M. What does recovery mean in practice? A qualitative analysis of international recovery-oriented practice guidance. Psychiatric Services. 2011;62(12):1470-6. doi: https://doi.org/10.1176/appi.ps.001312011. PubMed PMID: 1122597358; 2012-19348-011.
11. Ridgway P. ReStorying psychiatric disability: Learning from first person recovery narratives. Psychiatric Rehabilitation Journal. 2001;24(4):335-43. doi: http://dx.doi.org/10.1037/h0095071. PubMed PMID: 619584362; 2001-01024-002.
12. Ng FYY, Townsend ML, Miller CE, Jewell M, Grenyer BFS. The lived experience of recovery in borderline personality disorder: A qualitative study. Borderline Personality Disorder and Emotion Dysregulation. 2019;6:10. Epub 2019/05/31. doi: 10.1186/s40479-019-0107-2. PubMed PMID: 31143449; PubMed Central PMCID: PMC6532193.

13. Davidson L, Sells D, Songster S, O'Connell M. Qualitative studies of recovery: What can we learn from the person? In: Ralph RO, Corrigan PW, editors. Recovery in mental illness: Broadening our understanding of wellness: American Psychological Association; 2005. p. 147-70.
14. Morse G, Salyers MP, Rollins AL, Monroe-DeVita M, Pfahler C. Burnout in mental health services: A review of the problem and its remediation. Administration and Policy in Mental Health and Mental Health Services Research. 2012;39(5):341-52. doi: https://doi.org/10.1007/s10488-011-0352-1. PubMed PMID: 1285631789; 2012-21287-002.
15. Kraus SW, Stein CH. Recovery-oriented services for individuals with mental illness and case managers' experience of professional burnout. Community Mental Health Journal. 2013;49(1):7-13. doi: https://doi.org/10.1007/s10597-012-9505-2. PubMed PMID: 1338415560; 2013-01716-002.
16. Ross AM, Choy-Brown M, Hu Y, Varas O, Stanhope V. Perception of recovery orientation as a predictor of clinician turnover in community mental health clinics. Administration and Policy in Mental Health and Mental Health Services Research. 2022;49(1):79-87. Epub 20210506. doi: 10.1007/s10488-021-01142-6. PubMed PMID: 33956268.
17. Piat M, Lal S. Service providers' experiences and perspectives on recovery-oriented mental health system reform. Psychiatric Rehabilitation Journal. 2012;35(4):289-96. doi: https://doi.org/10.2975/35.4.2012.289.296. PubMed PMID: 1015243905; 2012-10377-002.
18. Dalum HS, Pedersen IK, Cunningham H, Eplov LF. From recovery programs to recovery-oriented practice? A qualitative study of mental health professionals' experiences when facilitating a recovery-oriented rehabilitation program. Archives of Psychiatric Nursing. 2015;29(6):419-25. doi: https://doi.org/10.1016/j.apnu.2015.06.013. PubMed PMID: 1824552538; 2015-52893-011.
19. Chester P, Ehrlich C, Warburton L, Baker D, Kendall E, Crompton D. "What is the work of recovery oriented practice? A systematic literature review". International Journal of Mental Health Nursing. 2016;25(4):270-85. doi: https://doi.org/10.1111/inm.12241. PubMed PMID: 1803467369; 2016-33548-001.
20. Le Boutillier C, Slade M, Lawrence V, Bird VJ, Chandler R, Farkas M, et al. Competing priorities: Staff perspectives on supporting recovery. Administration and Policy in Mental Health and Mental Health Services Research. 2015;42(4):429-38. doi: https://doi.org/10.1007/s10488-014-0585-x. PubMed PMID: 1560644309; 2014-34912-001.
21. Le Boutillier C, Chevalier A, Lawrence V, Leamy M, Bird VJ, Macpherson R, et al. Staff understanding of recovery-orientated mental health practice: a systematic review and narrative synthesis. Implementation Science. 2015;10:87. Epub 20150610. doi: 10.1186/s13012-015-0275-4. PubMed PMID: 26059397; PubMed Central PMCID: PMC4464128.
22. Charon R. Narrative medicine: Honoring the stories of illness. Oxford, New York: Oxford University Press; 2006. xvi, 266 s. p.
23. Bruner J. Acts of meaning. Cambridge, Mass.: Harvard University Press; 1990. xvii, 181 s. p.
24. Polkinghorne DE. Narrative knowing and the human sciences. New York: State University of New York Press; 1988. 232 s. p.
25. McLean KC, Pasupathi M, Pals JL. Selves creating stories creating

selves: A process model of self-development. Personality and Social Psychology Review. 2007;11(3):262-78. doi: http://dx.doi.org/10.1177/1088868307301034. PubMed PMID: 621829883; 2007-11764-003.
26. Adler JM, Dunlop WL, Fivush R, Lilgendahl JP, Lodi-Smith J, McAdams DP, et al. Research methods for studying narrative identity: A primer. Social Psychological and Personality Science. 2017;8(5):519-27. doi: http://dx.doi.org/10.1177/1948550617698202. PubMed PMID: 1952974214; 2017-38203-005.
27. Smith JA, Osborn M. Interpretative phenomenological analysis. In: Smith JA, editor. Qualitative psychology A practical guide to research methods 3rd ed: Sage Publications; 2015. p. 25-52.
28. Thomsen DK, Holm T, Lind M, Jensen RAA, Pedersen AM. Storying mental illness and personal recovery: Cambridge University Press; 2023.
29. Dean R, Siddiqui S, Beesley F, Fox J, Berry K. Staff perceptions of borderline personality disorder and recovery: A Q-sort method approach. British Journal of Clinical Psychology. 2018;57(4):473-90. doi: https://doi.org/10.1111/bjc.12180. PubMed PMID: 2027384143; 2018-17129-001.
30. Cohen P, Cohen J. The clinician's illusion. Archives of General Psychiatry. 1984;41(12):1178-82. doi: http://dx.doi.org/10.1001/archpsyc.1984.01790230064010. PubMed PMID: 616993111; 1985-09585-01