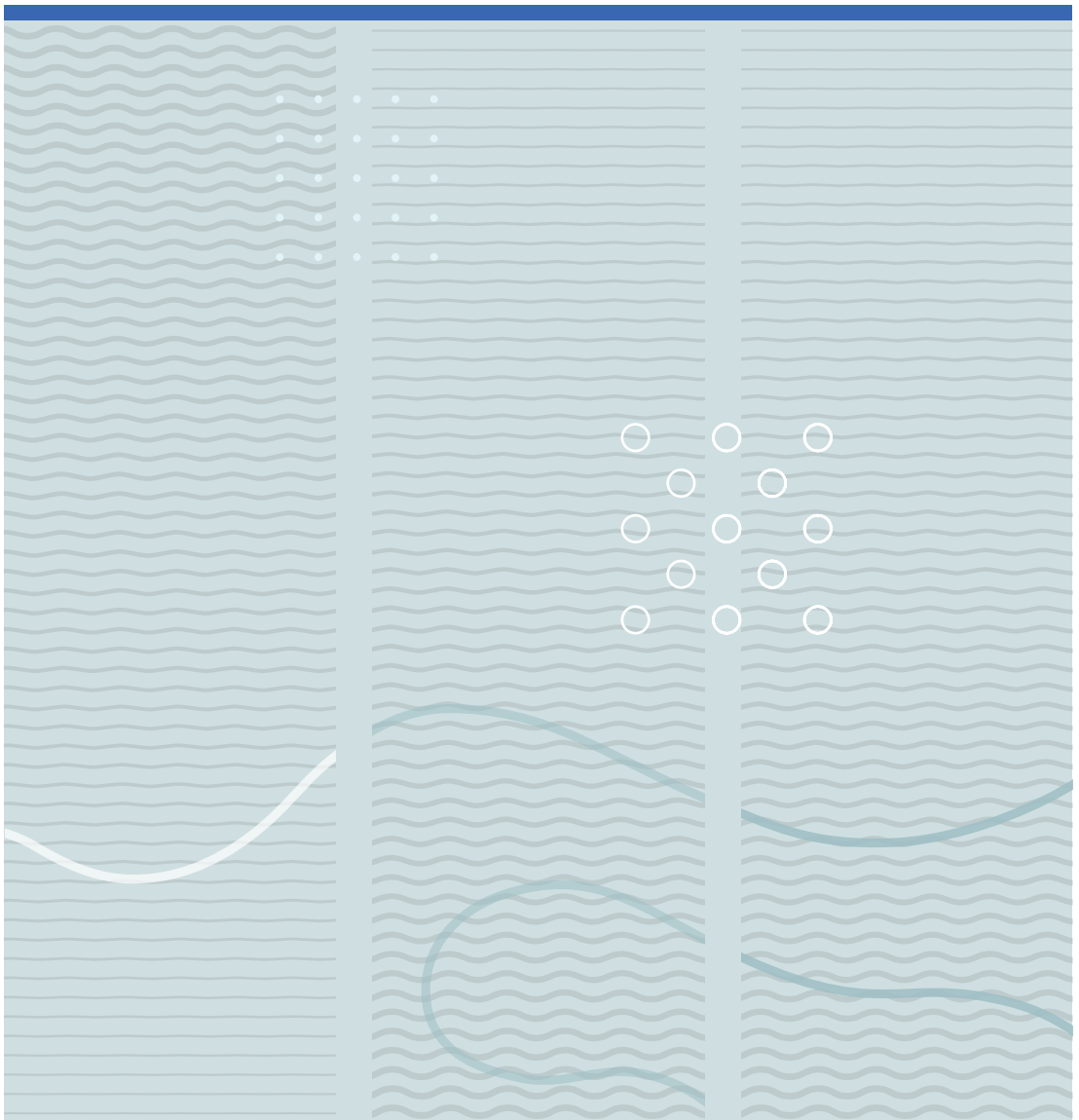HSN

Trude Klevan

The importance of helpful help in mental health crises
Experiences, stories, and contexts – A qualitative exploration

HSN

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A PhD dissertation in
Person-centred Health Care

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John Donne once wrote, "No man is an island entire of itself." This also speaks truth for a PhD student. This study could not have been conducted without the valuable time, effort, collaboration, and support of a number of people.

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Abstract

The main aim of this thesis was to explore experiences of helpful help in mental health crises within the context of crisis resolution teams (CRTs). Helpful help has been explored from three different perspectives: 1) service users, 2) carers, and 3) CRT clinicians. These perspectives are represented through three different sub-studies in this thesis. The study included a strategic sample of participants recruited from eight different health trusts, geographically covering large parts of Norway. Individual interviews with 14 service users and 12 carers as well as eight focus group interviews with a total of 50 clinicians were conducted. All interviews were conducted locally.

The thesis has an explorative and troubling approach to truth and how knowledge can be created. My initial assumptions and understandings of truth and knowledge and how these are entwined with contexts, participants, and the researcher have been subject to continuous questioning, troubling, and development. These processes are understood as important parts of the knowledge that emanates from this project and are made transparent and reflected upon throughout the thesis as significant parts of its overall framework. A competence group consisting of people with diverse experiences as service-users, carers, and/or clinicians has contributed to the processes of exploring, troubling, and creating knowledge.

The first article of this thesis explores service users' experiences of helpful help in a mental health crisis. A hermeneutic phenomenological approach was used to analyze data into common themes across the dataset. The article suggests that experiences of mental health crises and helpful help are closely entwined. Mental health crises are experienced as devastating and multilayered events affecting the practical sides of life, sense of having worth, and sense of safety. Important issues relating to help that were emphasized by the participants were practical support and help with daily structure, establishing a foundation of safety, and strengthening the sense of self. The article discusses how these different issues of help are connected, suggesting that practical help plays an important role in supporting self-worth and the sense of safety. However,

practical and structural issues were rarely addressed by CRTs. The article suggests the need for a broadened and social contextual-oriented perspective on mental health crises as important in developing practices that are perceived as more helpful.

The second article explores carers' experiences of helpful help. Data were analyzed using a narrative approach, focusing on emplotment. The configuration of data elements into coherent stories, using a personal plot as an organizing structure, revealed that seemingly thematically similar experiences have a highly personal imprint. Though experiences of burden and loss were common, these experiences were embedded within the personal history and context of the carer. The article discusses how understanding a carer's individual experiences and needs in a contextual, storied manner can reveal information that is crucial to the collaboration of help that is perceived as helpful within a home-based approach to mental health crises.

The third article explores discourses through which CRT clinicians understand and talk about helpful help. Data were analyzed using a discursive psychological approach. Two broad discourses were identified: helpful help as something "made," with CRT workers as creators of collaborative and innovative practices, and helpful help as something "given," with the CRT workers as representatives of a predefined specialist mental health service culture. The article discusses how the contradictions between these discourses reflect the diverse rationale for the development of CRTs and the possible tensions and pressures under which CRT work is conducted. In this overall context, the article also critically examines the tensions between the discourse of constructing new practices and existing practices constituted by the more traditional discourse in the specialist mental health services.

Based on an overall discussion and reflection combining the three sub-studies, this thesis speaks to the necessity of introducing more person-in-context-oriented approaches in the understandings and practices of helpful help in mental health crises. There appears to be a gap between service users' and carers' desire for more contextually and practically oriented help and how help is talked about and acted out

from the professional side. This thesis calls for further research on possible causes for this divide.

Keywords:

Helpful help – mental health crisis – crisis resolution team – context – lived experiences

List of papers

Note that papers are omitted from the online version due to publisher's restrictions

Article 1

Klevan, T., Karlsson, B., & Ruud, T. (in press, accepted 25.02.16). "At the extremities of life"—Service user experiences of helpful help in mental health crises. *American Journal of Psychiatric Rehabilitation*.

Article 2

Klevan, T., Davidson, L., Ruud, T., & Karlsson, B. (2016). "We are different people"— A narrative analysis of carers' experiences with mental health crisis and support from crisis resolution teams. *Social Work in Mental Health*. http://www.tandfonline.com/doi/full/10.1080/15332985.2015.1133471

Article 3

Klevan, T., Karlsson, B., Ness, O., Grant, A., & Ruud, T. (2016).Between a rock and a softer place—A discourse analysis of helping cultures in crisis resolution teams. *Qualitative Social Work*. doi: 10.1177/1473325016668962

Contents

I just hate to be in one corner. I hate to be put as only a guitar player, or either only as a songwriter, or only as a tap dancer. I like to move around.

Jimi Hendrix

1. Introduction

"You have never been too good at planning." This statement came from my father many years ago. The occasion for his statement is not important in this context. The main point is that he was right. And he was wrong. I do make plans. Only sometimes things happen that were not part of the original plan, which means the plan has to be altered. Being able to stick to a plan can be understood as holding the characteristics of structure and determinedness. But you also run the risk of missing out on what is outside the framework of the plan. This is a thesis created by *not* sticking to the plan. I did not actually plan that. But it happened.

The aim of my PhD project was to explore experiences of helpful help in a mental health crisis from the perspectives of service users, carers, and clinicians. The experiences were explored within the context of crisis resolution teams (CRTs) in Norway.

CRTs represent a mode of delivering acute mental health care in the community. The principal objectives of CRTs are (1) to prevent unnecessary hospitalization and offer support locally and (2) to develop more humane mental health services by focusing on collaboration and voluntariness (Borg & Karlsson, 2010).

Former research conducted on CRTs has mostly focused on structural issues pertaining to the development of CRT services and on macro-level outcomes such as cost-effectiveness and admission rates. A more limited amount of research describes and explores the content of the services offered by CRTs, how and why the clinicians conduct their chores, and how service users and carers experience and value the various aspects of help given (Hubbeling & Bertram, 2012; Lyons, Hopley, Burton, & Horrocks, 2009; Sjølie, Karlsson, & Kim, 2010). In order to provide help that is perceived as helpful to someone experiencing a mental health crisis, it is crucial to expand the knowledge of experiences of the actual content of helpful and/or unhelpful help.

This PhD thesis explores the following research questions from three perspectives: 1) service users, 2) carers, and 3) CRT clinicians.

1.   How is mental health crisis described and experienced?

2.   How is helpful help in mental health crisis described and experienced?

3.   How do current descriptions and experiences of practices in CRT concur with experiences of helpful and/or unhelpful help?

The study has a descriptive, explorative, and interpretive design and rests on onto-epistemological assumptions of the world and knowledge as being "made" through interpretations and dialogue at both intra- and interpersonal levels. Thus, my assumptions have been developed and adjusted during the course of this project. As such, the knowledge that emanates from this research project and the ways of creating and understanding this knowledge must also be regarded as "made." It is unfinalized and ever developing—every time I think about it or talk about it to someone else and whenever someone else listens to it or reads it, the knowledge develops slightly.

The PhD study consists of three sub-studies. A total of three articles have been written, one based on each sub-study. The article "'At the extremities of life'—Service user experiences of helpful help in mental health crises" explores service users' experiences. The second article "'We are different people'—A narrative analysis of carers' experiences with mental health crisis and support from crisis resolution teams" explores the experiences of family carers. The third article is entitled "Between a rock and a softer place—A discourse analysis of helping cultures in crisis resolution teams" and identifies and explores how clinicians in CRTs construct discourses of helpful help.

Writing three articles was part of the original plan. How data were analyzed, interpreted, and written up was not. The aim of this thesis is to explore experiences of helpful help. However, in carrying out this PhD study, it has also become increasingly apparent to me that *how* experiences are explored influences the findings and how meaning can be created. As such, the methodology and findings of the study are closely entwined. Moreover, conducting a PhD study is not solely about learning to do research but also about questioning and finding one's role as a researcher. Thus, this thesis also explores how the process of becoming a researcher is entwined with the methodology and findings of the study. My process of becoming a researcher will be reflected on throughout the thesis. I did not really plan that either. But we have lived together for three years now, this study and I. We have influenced and co-created each other on the way. A separation at this point would not seem right. As such, the writing up of this thesis is our joint story.

1.1. Structure of the thesis

This thesis is based on three accepted papers, which are included in their entirety in the appendix section. In chapter 2, background for the development of CRTs and a short description of current research in the CRT field are presented. Some core concepts relevant to the focus of this thesis are also presented in chapter 2. In chapter 3, the theoretical context of the study is presented. Chapter 4 describes the study, its aims, and its procedures. Chapter 5 presents the methodology of the thesis and places it within an ontological and epistemological understanding. It also explores how this is entwined with my own development as a becoming researcher. The main findings of the three sub-studies are presented in chapter 6. In chapter 7, some overarching issues based on the three sub-studies are discussed in relation to onto-epistemological assumptions, theoretical framework, and relevant research. Chapter 8 suggests some possible implications for clinical practice and further research based on the study.

As the introduction of the thesis suggests, the performance and writing of this thesis has not been a linear process, and this will also be visible in that the content of each chapter is not necessarily clearly delimited from that of the other chapters.

2. Background

The understandings of health and how to provide helpful help in situations of health difficulties and distress have been altered over the past decades. In "The People-Centred Health Care—A Policy Framework" (World Health Organization [WHO], 2007), the WHO describes how people now expect health systems and providers that have a more holistic and humanistic approach to health care, where the individual in need for care is respected as a whole person with multidimensional needs (WHO, 2007). To meet these multidimensional needs, the WHO advocates a need to put people in the center of the

care, regarding people not only as patients with biomedical needs but as placed within a broader cultural and psychosocial context. Health is regarded as existing beyond the individual in a clinical setting; it involves families and communities. The WHO urges health systems to move beyond the traditional medical models of providing health care and of measuring health system performances. With a more holistic and contextual understanding of health, the need to focus on the experiential sides of health care is emphasized (WHO, 2007).

Mental health is commonly understood as an integral part of the overall experience of health and well-being. Though the idea of juxtaposing mental distress with physical diseases can be discussed, there is firm evidence that mental distress affects physical health and life expectancy (Johnstone, 2014; WHO, 2013).

Risk factors related to psychosocial issues such as housing difficulties, low income, and scarcity of network affect mental and physical health (WHO, 2013). However, despite several studies focusing on the need to extend the understanding and treatment of mental illness to also include contextual factors, mental distress is still commonly understood and treated as "inner" psychiatric conditions occurring in individuals in a decontextualized sense, thus requiring individually focused solutions (Ljungqvist, Topor, Forssel, Svensson, & Davidson, 2015; Priebe, Burns, & Craig, 2013; Proctor, 2006). Despite outspoken intentions of placing the person and his or her individual needs at the center of holistic care, limited attention appears to be offered to the fact that people are part of a social, cultural, and historical context.

In Norway, political guidelines and recommendations like "The National Action Program for Mental Health" (1999), "The Coordination Reform" (2009), and "Mastering

Together" (2014) have prepared the ground for recovery and person-oriented understandings and practices, focusing on values like service user involvement, independence, autonomy, and the ability to live and cope within the community. People struggling with mental distress and/or substance abuse should be given help and support locally and maintain a connection to their daily lives and local communities. This counts for people with both severe and more short-term and transient mental distress (Norwegian Ministry of Health and Social Affairs, 2009).

2.1. The local context and crisis resolution teams

In line with a more holistic and community-based understanding and approach to health distress, in many Western countries, services for adults with mental health problems have gone through major changes over the past three to four decades. There has been a transition from institutional to community-based care. Different models of community care have been established that aim to minimize the use of hospital admissions. CRTs represent a mode of delivering acute mental health care in the community. The main objectives of CRTs are to offer comprehensive treatment and support in people's home environments in an acute mental health crisis, thereby trying to prevent unnecessary hospital admissions, and to contribute to the development of more humane and collaborative mental health services (Biong, Ness, Karlsson, Borg, & Kim, 2012; Johnson, Needle, Bindman, & Thornicroft, 2008).

In 2005, the Norwegian Parliament, inspired by the international focus on home-based services, mandated that, by the end of 2008, all of the country's community mental health centers (CMHCs) should have established a CRT as part of their services (Karlsson, Borg, & Emaus, 2012; Norwegian Directorate of Health and Social Welfare, 2006). International guidelines and recommendations describe a model for CRTs in which the key features are 1) 24/7 availability, 2) rapid response, 3) gate-keeping function, and 4)

work with users with severe mental illness who might otherwise be admitted to hospital. In Norway, it appears that CRTs have been implemented without these features (Hasselberg, Gråwe, Johnson, & Ruud, 2011). Recommendations for CRTs in Norway can be argued to be vague and, thus, open to a variety of practices (Norwegian Directorate of Health, 2014a; Norwegian Directorate of Health and Social Welfare, 2006). Norwegian CRTs show diversity in organization, treatment philosophy, and practices (Karlsson, Borg, Eklund, & Kim, 2011; Ruud, Karlsson, Klevan, & Hasselberg, 2015). Diversity regarding opening hours, treatment philosophy, practices, and organization is also found in the UK (Lloyd-Evans & Johnson, 2014; Wheeler et al., 2015). The UK is the country, other than Norway, that has introduced CRTs most systematically as part of its national mental health services. Norwegian teams are inspired by the CRT model as it has been suggested in the UK with the four key features described above but also by treatment philosophies and practices based on, for instance, the open dialogue societies in Northern Finland (Norwegian Directorate of Health, 2014a; Sjølie, 2014).

International research shows diversity concerning the effects of CRTs. However, one of the sturdiest findings is that a slight reduction in hospital admissions seems to be achieved. There also appears to be a better level of user satisfaction (Hubbeling & Bertram, 2012; Lloyd-Evans & Johnson, 2014). In a recent, systematic review on CRTs aiming to establish available evidence regarding the characteristics of effective and acceptable CRTs, Wheeler et al. (2015) conclude that it is not possible to draw conclusions regarding critical components of CRTs. The authors suggest that a clearer definition of the CRT model is required. They call for future studies that examine the relationship of an overall CRT model fidelity to outcomes or that evaluate the impact of key aspects of the CRT model.

A significant part of research on CRTs has focused on structural issues pertaining to the development of CRT services and on macro-level outcomes such as cost-effectiveness and admission rates. The actual content of the services that CRTs offer is less well explored, as is the experiential side concerning how different groups experience the practices and services offered (Hubbeling & Bertram, 2012; Lyons et al., 2009: Sjølie et al., 2010). In collaboration with the research group of the CRT Optimisation and Relapse Prevention (CORE) study in the UK led by Professor Sonia Johnson, in 2012–2013, practices and experiences in Norwegian CRTs were explored using both qualitative and quantitative methods (Ruud et al., 2015). The qualitative part of the study explored experiences of mental health crisis and support from CRTs from the perspectives of service users, carers, CRT clinicians and collaborative professionals. The study showed diversity in how carers and service users experienced the services given and what kinds of services they wished for, compared to CRT clinicians. In general, service users and carers called for extended opening hours and more broad-range services, including more focus on practical support.

2.2.   Mental health crisis

"Who is to tether a bird moves?" The question is posed by the Norwegian poet Hans Børli in his poem by the same name (Børli, 1984). The question often pops up in my mind as I frequently get the feeling that, in mental health practices and research, for instance, this is exactly what we are trying to do: to tether and frame what cannot be captured. For instance, why do we actually believe that we can measure and predict the likelihood of someone committing suicide? We live in a world where we cannot even predict which flavors of chips will sell and which will not.

"Mental health crisis" is a diverse expression. From the clinician point of view, it is often agreed that vital signs of a mental health crisis are 1) a risk of harm to self or others, 2) functional disruption, and 3) a need for additional support (Tobbit & Kamboj, 2011).

However, research focusing on the experiences of service users, carers, and clinicians shows that the term can be complicated. The views from these mentioned groups on what they consider a mental health crisis and how and when help is needed can sometimes contradict that of clinicians (Lyons et al., 2009). The term is often connected to the outburst or deterioration of mental illness. Mental health crises that are not necessarily part of what is recognized or categorized as a serious mental illness, but that nonetheless can be experienced as devastating, are generally less well explored (Lakeman & Fitzgerald, 2008). The latter type of mental health crises also may not trigger support from mental health services that service users and carers may wish for (Burns-Lynch, Murphy, Gill, & Brice, 2014). Crisis services often assume a pathology-oriented perspective, guiding admissions, treatment philosophies, and funding of services. Thus, services that are available to people experiencing undefined mental distress are often scarce (Lakeman & Fitzgerald, 2008; Rhodes & Giles, 2015).

CRTs are aimed at targeting people experiencing "severe mental health crises." It has not been clearly defined what actually counts as a mental health crisis. Although CRTs are intended to humanize mental health services, the teams are also criticized for working with crises that are too "light." A Norwegian survey that has mapped out practices in CRTs shows that, although Norwegian CRTs seem to have few users with a diagnosed or suspected severe mental illness, a great majority of service users score very high on experienced degree of mental suffering (Ruud, Hasselberg, Holgersen, Uverud, Foss, & Neuhaus, 2016).

A PhD thesis by Gullslett (2016) that explores service users' experiences of mental health crisis shows that crises are not linear experiences. They are complex experiences entangled with people's everyday lives. However, Gullslett argues that there is a limited amount of knowledge that specifically brings the service user's voice to the fore. Thus,

there appears to be support in previous research for the need to further explore mental health crises from a subjective, first-person perspective.

2.3.   What is help?

It can be argued that the main aim of CRTs and other mental health services is to help someone in need of help. The word "help" is both a verb and a noun. The etymologic meaning of the Old English verb *helpan* is to "help, support, succor, benefit, do good to; cure, amend," whereas the noun *help* means "assistance, succor" ("help", n.d). Thus, help is both something we *do* to or with someone and a result of these actions. How help in a mental health crisis is understood and acted out is closely related to how crises are understood. Crises understood as caused by an inner, biomedical cause may require a different kind of help than crises understood as a psychosocial matter.

According to Priebe et al. (2013), which paradigms we use when explaining mental disorders and what is regarded as helpful interventions need to be questioned. Although mental disorders can be normatively understood as having neurobiological, psychological, and social dimensions, Priebe et al. (2013) argue that the dominant paradigm in mental health research and practices is that there is a hierarchy between these dimensions, assuming that it is primarily within the neurobiological dimension that explanations and solutions to mental distress are to be found. However, despite a lot of effort and resources having been put into research and development of practices within the neurobiological paradigm, Priebe et al. (2013) argue that there is an evident lack of progress within the field of mental health. As such, alternative paradigms need to be considered, and the authors highlight a need to focus on the social paradigm. Within the social paradigm, mental distress is best explored and amended within peoples' social context (Johnstone, 2014; Ljungkvist et al., 2015; Priebe et al., 2013; Tew et al., 2011).

The social paradigm shares commonalities with a recovery or a person-in-context-oriented understanding of help in crisis. Help is here understood as supporting people in the social context they are part of, which often indicates that home-based and network-oriented approaches are most useful in both understanding and resolving the crisis (Borg & Karlsson, 2017; Johnson et al., 2008).

By understanding help as contextual and collaborative practices in which the solutions are not defined as repairing an inner fault but as constructing understandings and solutions appropriate to individuals in their respective contexts, helpful practices are not fixed. Instead, helpful practices are understood as being in progress. Thus, helpful practices can be regarded as being co-created in each unique case and context rather than being about the helper doing something to someone based on predefined understandings of help as something that "is." As such, introducing a social perspective on helpful practices in crisis also entails the possibility of more dynamic helper, service user, and carer roles (Smith & Grant, 2016).

3. Theoretical perspectives

In planning this explorative project, I aimed to let data guide the choice of theory. Despite these good intentions, my pre-understandings and my new understandings that developed in the course of the study affected how data were analyzed and understood. As such, the idea of research as a linear process can be argued to be an illusion. How can we put aside what we know and how we think (Lock & Strong, 2014)? According to Frank (2010), we are constantly interpreting each other. Interpretation is crucial for understanding. Perhaps we can only make attempts to meet the other as unconditionally as possible and try to describe what guides our reasoning and choices. Although this PhD project has definitely not been a linear process, it has been my sincere attempt to bring the experiences of the participants to the fore before placing them in a theoretical framework.

The purpose of the study was to explore experiences of helpful help in a mental health crisis from the perspectives of service users, carers, and clinicians in the context of CRTs in Norway. The study did not use a diagnostic-oriented approach to mental health crisis but included participants the local CRT viewed to be within its scope. The study aimed to explore subjective, lived experiences through attempting to bring forward how the participants described and experienced helpful help in mental health crisis.

Through the interviews, some theoretical perspectives stood out as important in analyzing data and finding ways of interpreting and creating meaning. These perspectives do not explain the experiences but may hopefully contribute to ways of understanding. The importance of understanding crises and help as subjective and person-oriented matters became very apparent during the course of the interviews and in the process of analysis. However, how these experiences are inextricably entwined with the context people are part of—and, thus, need to be explored and interpreted as part of this context—stood out even more clearly along the way.

3.1. The context

What is actually context? Is context "found," or is it "made"? Social sciences commonly recognize that individuals live within a complex set of environmental systems that influence their experiences and wellbeing. Moreover, human beings also shape their context. Issues like whom we are surrounded by in our daily life, how we live, and what our economic situations are can, at a first glance, appear to be contextual factors that "are." However, even measurable issues like these can be argued to be a matter of how people experience and understand them. Having an income of 300 000 NKR a year does not necessarily say anything about someone's economic situation. Living with a family does not say anything about experiences of support and companionship or of loneliness

and struggle. Research in social sciences can thus be argued to be highly context-dependent.

According to Flyvbjerg (2001; 2006), this close relation with context is what distinguishes social sciences from natural sciences. Flyvbjerg (2001) argues that, at least so far, this has also made it impossible to make rule-based and predicative theories of human actions. Context not only provides thick descriptions and enable understanding rather than just explanation; context also determines what counts as knowledge through how human beings understand and interpret their interaction with their surroundings and how they value or disvalue their actions as either important or immaterial.

To enable the grasping of subjective context and contextual experiences, the necessity of a narrative understanding that enables the "long" and individual stories as opposed to the often-described "meta narratives" that people can be considered part of, became apparent in this PhD study (Frank, 2016a; Grant, 2014; Topor, 2014). A contextual, narrative approach acknowledges how people constitute and are constituted by their context and how this can be expressed through the stories people tell about themselves.

However, through the understanding of the impact of contextual, storied experiences and understandings, some troubling thoughts also occurred to me during the course of this PhD study. To what degree are counter-stories allowed to come to the fore? Which understandings and knowledge are recognized as valid? And how free are we to define our own context? The need to expand the understanding of context to also include larger discourses that constitute our contexts and stories occurred to me (Grant, 2016). Moreover, these discourses are also related to what counts as knowledge and what knowledge is often discarded (Denzin & Giardina, 2008).

Decontextualizing knowledge and understanding is often argued to be in line with the important rules of research and theory generation. However, as for instance Flyvbjerg (2001) argues, in social sciences, context cannot be excluded as it defines the type of phenomenon that the theory encompasses. Context does more than add meaning to experiences. Context also determines what counts as important data. Discarding context entails the risk of important knowledge and understandings being neglected. Without context, the phenomenon of interest runs the risk of being deprived of content and meaning, or it can be misinterpreted (Flyvbjerg, 2001; Topor, 2014). As contextual knowledge is intrinsically contradictive to establishing general theories, contextual knowledge can also be argued to challenge what is commonly regarded as research.

3.2. Subjective experiences and a person-centered understanding

The development of CRTs and other community-based services can be viewed as part of the humanizing and deinstitutionalizing that has been going on within the field of mental health services over the past decades (Borg & Karlsson, 2010; Johnson et al., 2008; Mezzina & Vidoni, 1995). The downsizing of mental health institutions can be regarded as an attempt to acknowledge people suffering from mental distress as whole persons with civil rights. This includes the right to live in a community and to be supported in living a "normal" life (Davidson, 1996). CRTs aim to focus on collaboration and voluntariness by offering crisis intervention within the community. This collaborative and community-based focus can be argued to imply a person-centered approach, important aspects of the intervention being about treating people as individuals, respecting their rights, and building trust and understanding in order to enter a collaborative relationship (Borg et al., 2011; McCormack & McCance, 2010). Co-creation of care between the patients, their family and carers, and health professionals is the core component of person-centered care, a concept that is becoming increasingly

influential (Ekman, Hedman, Swedberg, & Wallengren, 2015; McCormack & McCance, 2010).

The concept of person-centeredness is described as having multi-faceted roots. Person-centered approaches and practices are often associated with humanism and Carl Rogers' work from the early 1940s. In Rogers' terms, the end-goal for a person-centered intervention is "becoming a person" (Borg & Karlsson, 2017; O'Hara, 2006). Rogers focuses on the potential for growth and transcendence that lies in human beings and understands help as connected to liberating people to be who they want to be. Paulo Freire is another inspiration in the understanding and development of person-centeredness. Like Rogers, Freire understands authenticity as a crucial aspect of humanness. However, Freire has a more socio-political understanding of authenticity. Though Freire sees authenticity as a goal for people to become "beings for themselves" in terms of being subjects of their own experiencing, self to Freire is also closely related to social, cultural, and historical contexts (Freire, 1972). Thus, a person-centered intervention following Freire would be connected to educating people so that they can reveal how contexts affect them and use this knowledge in a liberating sense (O'Hara, 2006). Following the line of Rogers and Freire, important parts of person-centered approaches involve empowering and emancipating people in both an individualistic sense and a contextual and socio-political sense (O'Hara, 2006).

A person-centered understanding places the person in the center of the understanding and approaches to mental distress. Important issues in person- centered understandings are treating people as individuals and respecting their rights as persons. Thus, it is the individual experiences of the situation that should guide the approach. A person-centered understanding has consequences for what is regarded as competence and who withholds the expertise. The unique individual is regarded as an expert on his or herself

and his or her life and on what helpful help is in the concrete situation (McCormack, Karlsson, Lerdal, & Dew, 2010; McCormack & McCance, 2010).

3.2.1. Person-centeredness in research

The concept of person-centeredness not only suggests an understanding and framework in clinical work but can also pose a useful framework for research. Within research, person-centered values and understandings are understood as influencing the whole research process. In this PhD project, a person-centered understanding is regarded as an important theoretical perspective at three different levels. First, person-centered understanding, with its focus on subjective experiences as an important source for developing knowledge, is understood as also recognizing *the researcher* as a person. Second, person-centeredness applies to how *the participants* of the study are understood as subjects who interact with the researcher rather than as passive objects and suppliers of an objective reality. Third, person-centeredness in this project is understood as being *contextually* situated. Thus, the researcher and the participants are understood as situated in a social, cultural, and historical context that simultaneously and continuously shapes and is shaped by these persons.

3.3. Person-in-context and context-in-person

Parts of the literature and research within person-centered understandings and approaches can be criticized for not paying enough attention to the significance of context. This applies for the importance of context not only when the person is in contact with mental health services but also considering that service users are also living in a context before and after being a service user. Health problems need to be considered as both personal and social (Borg & Karlsson, 2017). Social factors—like, for instance, housing and economic problems—must be understood not only as personal problems in assuming that mental health problems lead to poverty and housing difficulties. On the contrary, research also shows that it may very well be the other way around in that such problems may often both cause and intensify mental distress

(Davidson et al., 2004; Ljungqvist et al., 2015; Topor, Ljungqvist, & Strandberg, 2016a). As such, there appears to be a need for having a person-in-context-centered approach, taking into account how both the close and the more remote contextual factors influence and are influenced by the person.

A person-centered or a person-in-context-centered approach can give the impression that a person is something stable, coherent, and finalized. However, if assuming that people both shape and are shaped by their contexts, one can also argue that people are ever developing and multifaceted. We are different persons in different contexts, and this also changes over time. From this perspective, we are continuously storying and re-storying ourselves and our lives. Thus, who people are and the stories they are embedded in are unfinalized (Frank, 2005; Grant, 2016; Short, 2010).

As such, this study can be argued to be based on a *persons-in-context* understanding, acknowledging that a human being is not one coherent person but several persons that are in constant dialogue with both the different, inner parts of themselves and the outer context they interact with. Thus, as the person is understood as unfinalized and ever developing, context can also be understood as unstable and in progress. In this PhD study, context is not solely understood as structures that are "out there" but also as shaped and interwoven with the person. Rather than merely representing a structural framework, context shapes and is shaped through people's stories.

3.4. Peoples' stories and storied people

"Thank you for listening to me. I've never told this to anyone before. You know, no one has ever asked me." Utterings like this were more the rule than exceptions when I conducted the interviews for my PhD study. It puzzled me a bit. A lot of these people had been in contact with mental health services for years; could it really be that no one had

asked them or listened to them before? I spoke with some qualitative research colleagues, and it turned out that they had had similar experiences. I kept thinking about this. As clinicians, do we ask questions that don't coincide with what people need to tell? Or do we listen without hearing? "The universe is made of stories, not of atoms" is a quote from a poem by the American poet Muriel Rukeyser (1968). Are clinicians more concerned about people's atoms than their stories?

The reflections above were written during my process of conducting interviews for this PhD project. The participants' urge to have and thankfulness for having an occasion to tell their stories was striking. The relief and gratefulness many expressed corresponds to what Bourdieu (1999) describes as "a joy in expression," in the sense that people often want and take the opportunity to be heard and to construct meaning about themselves and the world. According to Frank (2010), stories accompany us through life. They not only tell us who we are but also show us who we want to be or who we can be. In that sense, rather than being viewed as true accounts of who people are or what has happened, stories are part of "making" people in the present. They also point forward, and, thus, they can have a transformative power (Frank, 2010; Mattingly, 2010).

Stories are not merely accounts of the truth through representing "windows" to research participants' "true," lived experiences. They are also shaped by and experienced in a cultural context. Stories represent cultural reflections, but through their transformative power, they can also be understood as a means of affecting and shaping culture. This possibility becomes especially evident through focusing on stories that challenge the grand stories or metanarratives that are commonly told within their respective fields (Frank, 2016a; Grant & Zeeman, 2012; Short, Turner, & Grant, 2013). Within the field of mental health, some voices and stories are given more attention than others. The dominant stories about understanding mental distress and how people can

best be helped have primarily been told by health professionals. Grant and Zeeman (2012) argue that, through placing metanarratives at center-stage, counter-stories are suppressed. The authors stress the need to focus on the counter-stories of mental health experiences. Through bringing a diversity of stories to the fore, new understandings can develop at both personal and interpersonal levels. This focus on counter-stories also challenges views on what is generally recognized as valid knowledge within the field of mental health.

Back in my school days, German grammar used to thrill me. The way the words fell into place and how they followed a logical order gave me a feeling of inner peace and satisfaction. But I also loved poetry. Reading and taking in the works of modernistic poets like Sigbjørn Obstfelder, who followed few rules of rhythm and rhyme, was mind blowing and made my heart sing.

Research interviews withhold the possibility of supporting the metanarratives of lived experiences of, for instance, mental health crisis. As researchers, there is always the possibility of hearing and finding the stories that confirm what we already think we know and categorizing them accordingly (Davies, 2016). At times, confirming approaches can be important within research. However, such approaches appear to be contradictory to the nature of *explorative* research. Perhaps it is important to be attuned to context and listen for unexpected stories in exploratory qualitative research. This means setting aside the normative research ideals of rationality, categorization, and rigor, leaving the safe ground and embracing uncertainty.

3.5.   What counts as knowledge and knowledge that counts

I had been working in the CRT for nearly ten years and was considered one of the "seniors" in terms of both age and experience. Together with the other "seniors," I was

commonly asked for advice from less experienced colleagues. I knew that, in this job, it was not possible to know everything. Knowing that I did not always have to know and that sometimes you just have to go with the flow represented a way of managing to keep calm in crisis and chaos. With the opening of a new ward intended for short-term crisis hospitalization, the management decided that the clinicians in the CRT should provide training in crisis assessments for the ward staff. This was due to the CRT clinicians being recognized as the most competent within the CMHC in doing crisis and risk assessments. I saw no need to disagree with that as this was something we did every day. However, I, along with several other colleagues, was not included in this project of training and supervising the staff at the ward. The sole reason for this was simple: We had the "wrong" professions. I am a social worker, and other excluded colleagues were nurses. A 25-year-old woman who had just finished medical school and who was working at the CRT for the summer while waiting for an internship placement was not excluded. Despite never having worked in mental health services before, she was regarded as competent.

Flyvbjerg (2001), following Aristotle, describes three types of knowledge. These are referred to as *epistheme, techne,* and *phronesis. Epistheme* is often translated as "scientific knowledge" and represents the rational and theoretical knowledge that is absolute and proven. It concerns universals and knowledge that is invariant within time and space. In research in the social sciences, such knowledge can be argued to be equivalent to evidence-based research and practice and, thus, corresponds to the modern scientific ideal.

Techne represents the practical side of knowledge and is often translated as "art" in the sense of "craft." The objective of this kind of knowledge is the rational application of technical knowledge according to a conscious goal. In contrast to *techne,* although also a practical kind of knowledge, *phronesis* is closely connected to value judgment.

Phronesis is often translated as "practical common sense" and emphasizes practical ethics. It is based on a practical value-rationality and is variable and context-dependent. As such, *phronesis* prioritizes particularity rather than universal rules. Phronesis is commonly associated with practical wisdom and is a kind of knowledge that is based on experiences. Flyvbjerg (2001) argues that phronetic knowledge needs to be put to the fore within the social sciences. However, within health sciences, the commonly acknowledged hierarchy of what is considered best research places Randomized Controlled Trials on top and qualitative research at the lowest level (Kvale & Brinkmann, 2009). Thus, phronetic knowledge often appears to be overshadowed by episthemic knowledge.

However, as argued by, for instance, Priebe et al. (2013), advances within the field of mental health can be argued to be limited, despite extensive research. This does not mean that episthemic knowledge and research is wrong or without value, but it indicates that it needs to be supplemented by other forms of knowledge and research that are more attentive to context.

"[I]n their role as *phronesis,* the social sciences are strongest where the natural sciences are weakest: just as the social sciences have not contributed much to explanatory and predicative theory, neither have the natural sciences contributed to the reflexive analysis and discussion of values and interests, which is the prerequisite for an enlightened political, economic, and cultural development in any society, and which is at the core of *phronesis"* (Flyvbjerg, 2001, p.3).

This explorative PhD project with its focus on subjective experiences can be understood as coinciding with phronetic understandings of knowledge. This includes both an understanding of what counts as knowledge and how knowledge can be developed. The contextual and flexible understanding of persons and lived experiences described above

are considered to be entwined with how knowledge is developed and will be elaborated on further in the methodology section.

4. The study

This PhD project has been developed from a research project at Akershus University Hospital in collaboration with The University College of Southeast Norway. This study explored practices and experiences in CRTs in Norway and used both qualitative and quantitative methods. The Norwegian study collaborated with a larger-scale research project in the UK, the CORE study. Data for the Norwegian study were collected in 2012–2013. The qualitative part of the study involved interviews with service users, carers, CRT clinicians, and collaborative professionals from other welfare and health services. Semi-structured interview guides for the qualitative study were translated from English into Norwegian and slightly adapted. A total of 42 qualitative interviews were conducted.

I was employed at that point as a project worker and conducted all the qualitative interviews. A report based on the findings of the study was written by the project group in 2013. The report revealed some interesting views and experiences of mental health crisis and the services given by the CRT. However, it was apparent that the qualitative study contained rich and valuable descriptions that were not covered by the report. Further exploration of the data also appeared to be in line with the uttered wishes from several participants about wanting their experiences to be shared and known. Based on this, an application for funding of a PhD study using the already-collected data on the perspectives of service users, carers, and CRT clinicians, but with a different approach and new research questions, was submitted. The PhD project was granted full financing by the Norwegian ExtraFoundation.

4.1.   Aim of the study

The aim of this PhD study is to explore experiences of helpful help in a mental health crisis from three perspectives: 1) service users, 2) carers, and 3) CRT clinicians.

The aim of the study is expressed through the following research questions:

1.   How is mental health crisis described and experienced?

2.   How is helpful help in mental health crisis described and experienced?

3.   How do current descriptions and experiences of practices in CRT concur with experiences of helpful and/or unhelpful help?

4.2.   The participants

All 58 Norwegian CRTs were invited to participate in the original study. Of the 24 teams wanting to participate, a strategic sample of eight teams was made. These teams comprised two teams from each national health region. We attempted to include teams from both rural and more urban areas and both experienced and more newly started teams. The eight participating teams were given the responsibility for recruiting service users and carers to participate in the study. Each team sent out an invitation to participate, information about the study, and a letter of informed consent to between 5 and 8 participants among both service users and carers. Those who wanted to participate replied directly to the research group and were then contacted by me to arrange a time and place for an interview. Inclusion criteria were that potential participants should have received services from their local CRT due to a mental health crisis within the last three months, but they should no longer be in contact with the team. The type of crisis was not specified in the inclusion criteria other than that the team should view it to be within the target group and scope of CRT services. The

recruiting teams were encouraged to invite service users and carers who had experienced crises due to a variety of reasons.

Fourteen service users and 12 carers agreed to participate. The 14 service users consisted of eight men and six women with an age span between 25 and 70 years. The 12 carers consisted of eight women and four men with an age span between 25 and 80 years. Their relationship to the person they cared for varied: husband, wife, father, mother, daughter, and family friend. Individual, qualitative interviews were conducted with 14 service users and 12 carers. Interviews lasted between 60 and 120 minutes. All interviews were conducted locally at a location chosen by the participant. The vast majority of interviews with service users and carers were conducted in the participants' homes.

Employees of the eight participating teams were interviewed through eight focus group interviews. All CRT workers participating were involved in clinical CRT work. Altogether, 50 clinicians were interviewed through eight focus groups with an average of six participants in each group. Focus group interviews with CRT clinicians were conducted at the location of the respective CRT.

4.3. Interview procedures and contexts

Me: *"But what is it like here in bad weather? How is it to reach the mainland?"*

Local participant: *"Oh, if the weather is bad, we can't. Then we just have to wait. It could take a couple of days, though."*

I conducted all the interviews, spending several months travelling Norway from south to north, east to west. During my journeys, it soon became very apparent that CRT work

and experiences are also definitely part of a local context. Some teams were very small and had limited opening hours. Several of the service users and carers who participated in the study could only be reached by long car drives through rather desolate landscapes. Some places, I had to use ferryboat to get there. For other places, it took me most of the day to get there and back. Approximately half of the interviews were conducted in the winter. That meant long drives on snowy roads and having to dig my car out of the snow after the interview. This is also part of the context.

Interviews with service users and carers were conducted using a semi-structured guide that focused on experiences of being in mental health crisis and receiving support from a CRT as well as what the participants had experienced as helpful and/or unhelpful in the help they had received. The participants were given the opportunity to elaborate on subjects that they considered important. They were also given the opportunity to discuss subjects that the interview guide did not particularly focus on. Focus group interviews with CRT clinicians were also conducted using a semi-structured interview guide covering many of the same subjects as in the interviews with service users and carers but also focusing how the organizing of the team and its duties within the CHMT organization could promote and/or hinder helpful practices. All interviews were audio recorded and transcribed verbatim.

4.4.   The competence group

A competence group, which initially comprised five people with experiences as service users, carers, and CRT clinicians, was set up specifically for this PhD project. One of the participants chose to withdraw from the group after the first two meetings. Although the participants were invited to join the group due to their respective experiences as service users, carers, or clinicians, it soon became apparent that people have experiences from different roles. The fact that we understood and discussed subjects in the meetings based on our multiple roles and experiences was frequently discussed and

acknowledged by the participants as entailing a sense of safety, mastery, and equality. No one was "just" a carer; no one was merely a clinician.

The group was involved in analysis and interpretation of data and in discussing how data could be written up. None of the participants had prior experience with research. During the first meeting with the group, all members signed an agreement of confidentiality. The group then discussed how to collaborate and work with the data. Preceding the following meetings, the group members were given access to parts of the anonymous written data material and the ongoing analysis, which were subsequently discussed in the meetings. Meetings lasted for approximately two hours, and the group met two times every semester in the course of the PhD project. The members of the group were compensated for their participation. The involvement of the competence group and co-creation of knowledge will be elaborated on in more detail in section 5.9.

5. Methodology: Onto-epistemological assumptions, scientific procedures, and the becoming of a researcher

This chapter describes and explores the methodology of the study and the connections with the ontological and epistemological assumptions it rests upon. However, these assumptions do not begin here. What has previously been presented in this thesis as background and theoretical perspectives must be understood as connected to the ontology, epistemology, and methodology of the study. The emphasis on the significance of context and subjectivity and the visibility of myself as a researcher indicates an understanding of "truth" as context-dependent, subjective, and created. The involvement of the competence group also suggests that "truth" is multiple and co-created through relations and contexts. This chapter aims to explore these assumptions

further. I will also reflect upon how conducting a PhD study involves "the becoming of a researcher" through reflecting, questioning, troubling, and making choices on the way.

What characterizes an explorative study? Explorative studies commonly aim to expand the knowledge within fields that are limitedly explored. In general, explorative studies aim to stay close to the participants' lived experiences in an attempt to reveal a "hidden world." It is often assumed that the true meaning of these lived experiences can be grasped through interviews characterized by a trusting and safe atmosphere (Alvesson, 2003; Grant, 2014). By creating such an atmosphere, the participant will be able to share his or her "true" experiences. This was also my point of departure when starting this project. However, through the process of conducting and analyzing the interviews, it became more and more apparent that "the truth" is more complicated than merely existing as something "out there" that can be approached in the setting of an interview (Zeeman, Aranda, & Grant, 2014).

Research is commonly regarded as having functions like, for instance, testing hypotheses or filling knowledge gaps. According to Grant (2014; 2016), an equally important aim with regard to qualitative research is "to trouble the world." In doing research, being—or, perhaps more so, becoming—a qualitative researcher can also be argued to be about troubling oneself and one's ways of reasoning. As such, my initial assumptions about reality, what can be known, and how to proceed in order to explore the truth have been subject to constant troubling and succeeding reorientations in the course of this project, and, thus, they have developed. My assumptions have moved from searching for rule-based modes of analyzing a truth that was, at least partly, understood as being "out there" to understanding "truth" as context-dependent, interpreted, and created. In this process, reflexivity has been an ongoing process. This includes not only an awareness of how I, as a researcher, affect and contribute to the

research process but also how the participants have their different conscious and unconscious motivations for participating in the project (Alvesson, 2003). It has also involved an evolving understanding of how the researcher, the participants, and what counts as knowledge are situated in historical, social, and cultural contexts. Moreover, it has involved an exploration of how the ways through which we proceed to find or create knowledge are inevitably entwined with what we "find." As such, this section of the thesis is one of troubling exploration.

5.1. Onto-epistemological assumptions

> There are two kinds of truth: The first believes in "is." It finds comfort in the equation. The second, as any poet knows, lets "is" stand in until a better verb can be found. It finds joy in fracturing the infinitive "to be." The first is useful for building bridges; the second for building people. (Pelias, 2004, p.8)

As Pelias suggests, truth can be understood as either something that "is" or something that is "in the making." What we regard as truth and how to get knowledge about truth is at the core of ontological and epistemological questions. Ontological issues commonly relate to the nature of reality and its characteristics whereas epistemological issues relate to how knowledge is known (Creswell, 2013). In this thesis, I use the term "onto-epistemological," suggesting that how we view reality and how we can obtain knowledge of reality are closely entwined and difficult to separate (Kaiser & Thiele, 2014). Understanding reality as "made," becoming, and multiple is also connected to understanding the acquiring of knowledge as becoming and multiple. This requires research approaches and a researcher that are evolving together in terms of questioning and troubling how knowledge is generated, the knowledge itself, and how both these issues are contextually situated. As such, the understanding of "reality" as becoming is entangled with a way of being in or, more so, becoming in the world. In this sense, ontological and epistemological issues are related and both contribute to the becoming of each other (Barad, 2007; Davies, 2016; Kaiser & Thiele, 2014).

The distinction between onto-epistemological assumptions that regard the world as "found" on the one side and assumptions that regard the world as "made" and interpreted on the other is common in qualitative research (Grant, 2014; Laverty, 2003). Kvale and Brinkmann (2009) refer to this diversity as viewing the researcher as either a "miner" or a "traveler." If the world is understood as something that "is" out there, it can be assumed that the mission of the researcher is to take the miner's position and reveal this hidden world. Within qualitative approaches that examine the content of talk, interviews can be understood as windows to "true" lived experiences (Alvesson & Karreman, 2000; Grant, 2015; Sullivan, 2012). According to Sullivan (2012), varieties of grounded theory, phenomenology, and some forms of narrative analysis will commonly be based on such onto-epistemological assumptions.

In opposition to this understanding, there are qualitative approaches that regard talk as reflections of power relations and negotiations of identity. These approaches recognize truth as multiple and made through interactions, and the researcher is considered a contributing part to this truth-creating journey. Within this understanding, one can find varieties of discourse analysis and some forms of narrative analysis (Sullivan, 2012).

There are not necessarily always clear distinctions between approaches that regard reality as made and those that regard reality as found. However, researchers will have to make choices, and these choices guide how data are generated, analyzed, and understood (Colahan, Tunariu, & Dell, 2012; Langdridge, 2003). These choices are commonly reflected upon initially in the research process as part of mapping out the design of the project. This can be understood as an important prerequisite for carrying out research projects with a congruent and coherent design, visible in all parts of the process (Creswell, 2013). But what do you do when your initial assumptions do not seem

to do justice to the data and to your ways of reasoning and understanding? Where do you place notions of yourself changing and developing new ways of thinking along the way?

This project was planned using a descriptive, explorative and interpretive design with a hermeneutic phenomenological approach. This approach combines elements from both phenomenology and hermeneutics and is considered useful for obtaining a deeper understanding of the meaning of life–world experiences (Ajjawi & Higgs, 2007; Lavarty, 2003). As the aim of the study was to explore experiences of helpful help, this interpretative understanding and approach seemed appropriate. What planning and describing the PhD study did not take into account is that a PhD study is not only about researching the world; it is also about the PhD student becoming a researcher. What does "becoming" a researcher involve? Although there appears to be no straightforward answer to that, being in a process and striving towards greater understanding involves reflecting, troubling, questioning, reconsidering, and making choices. Thus, if I were to choose one word to describe what has driven this PhD project and my process as a becoming researcher, it would perhaps be "troubling."

Although the interpretive approach of the study has not been set aside, it has been troubled. This has led to altered ways of understanding the participants, the truth, the significance of context, and my own role. As such, interpretation has turned out to be not simply interpretation. How we understand interpretation is also connected to our onto-epistemological assumptions. Understanding this led me on to the concepts of hermeneutics of faith and hermeneutics of suspicion as a valuable source of inspiration. This will be elaborated on in section 5.3. Another important choice of onto-epistemological character in this PhD project was to include my own process as a becoming researcher in the understanding of how knowledge and truth can be troubled

and made. This also involved being transparent about my evolving questions, reflections, and feelings of discomfort. The idea of making the researcher as a person transparent can be questioned. However, there are approaches within qualitative research that value the transparency of the researcher. Thus, autoethnography as onto-epistemology and methodology became another important inspiration.

5.2. Autoethnographic inspirations

Being a researcher is obviously about searching. When your dialogue with yourselves and the ways you have been thinking no longer seem right, a feeling of discomfort can occur. You need to search outside yourself for a new dialogue partner. The moments when you find that, and when you can almost physically feel how engaging in new dialogues expands and changes your framework, are golden. Coming across the autoethnographic works of Grant and colleagues was such a moment.

Email to my supervisor, February of 2015:

I just came across a researcher from Brighton, Alec Grant. He is committed to moving away from the "big stories" about being a service user, being in recovery, being a survivor, etc., and the way I read him, he's committed to look at differences and nuances rather than patterns. He also takes a kind of issue with "lived experience" as "true knowledge" and writes about how the so-called self constantly needs to be understood within time and context as something that is constructed through language and relations.… I think he has some great points and reflections. I actually suspect him to be a bit of an old rebel.

Autoethnography is a form of inquiry that focuses on how subjective experiences in the researcher can also be understood as reflecting larger cultural, social, and historical issues. As such, these issues are understood as flowing though the person (Olson, 2015;

Short et al., 2013). This PhD project is not autoethnographic, but it has been inspired by autoethnographic understandings and reflections of how reality is shaped through the person experiencing it and how culture is perceived and interpreted though the lenses of personal history and context.

Autoethnography can be understood as dialogic as it brings the personal experiences in dialogue with the culture. It acknowledges that, in some way or other, we are all inevitably culturally located and contingent. As such, to produce qualitative research that is not affected by the researcher is an illusion. Rather than struggling to bracket our pre-understandings, culture, and context, these are all understood as inseparable parts of how truth and knowledge are constructed. By setting these issues in dialogue with oneself as a researcher, it is possible to produce thicker and richer descriptions and understandings of how truth can be perceived (Olson, 2015). Through these thick and subjective accounts, autoethnographic writing seeks not only to connect with people in a cognitive manner but also to connect with people emotionally, indicating that the world can be influenced and changed through different kinds of knowledge and perceptions of it.

By producing evocative and subjective accounts, autoethnography often aims to challenge metanarratives of how the world is experienced. The idea of capturing the voice and, through that, the lived experiences of a group of people is challenged, as is the idea of abstracting and generalizing lived experiences into common themes (Grant, 2014). Lived experiences are part of a context when experienced, shared in an interview, and received by a researcher. If they are decontextualized, important prerequisites for trying to understand people and their experiences are lost (Topor, 2014).

Autoethnographic research often has troubling the world and what counts as "truth" as part of its agenda. Even more so, it is also about troubling how truth is found, produced, or, perhaps, created. For me, my encounter with autoethnography has led to a constant troubling of myself. Perhaps one needs to be ready for something in order for it to find you. Perhaps I did not "find" autoethnography and the ways of reasoning within it. It seems to me we rather found each other. Sometimes, you just have to stop doing what you are doing and do something else.

New understandings may not necessarily be "better" understandings. However, the process of stopping doing something and starting to do something else involves reflexive and dialogic processes going on between the different "mes." Knowledge is developed through participation with others and their ideas but also with oneself and one's ideas as they develop. Frank (2005) states that "dialogue begins with recognition of the other's unfinalizability" (p. 967). This implies that one cannot define or say the last word about the other as people are always becoming through dialogic processes. In the context of this PhD project, I would suggest that dialogue is also about recognizing one's own unfinalizability. As such, it could be argued that the onto-epistemological assumptions in this project are driven forward through troubling dialogues with both the outer and my inner world.

5.2.1.   Autoethnography and person-centeredness

Autoethnography regards the person experiencing and reflecting on cultural, social, and historical issues as a prerequisite for and creator of knowledge. As such, the person, in terms of the participant, is not to be understood only as the object of research. Rather, research can be understood as knowledge that is shared and created by the participant-in-context in a dialogue with the researcher-in-context. Thus, it is possible to understand an autoethnographic inspiration as contributing to an expansion of a person-centered understanding in research. Though focusing and celebrating first-person experiences as important sources of knowledge within research, autoethnography can also be argued

to bring in a clearly contextual dimension. The person, in terms of both the participant and the researcher, is not understood as a defined, autonomous person or subject but as someone in constant dialogue and interchange with the context. This acknowledges how people need to be understood within both a close and remote context and how people are social and relational beings that are unfinalized (Short et al., 2013).

5.3. Hermeneutics of faith and suspicion—Inspirations

This PhD project was initially placed within a hermeneutic phenomenological framework. The plan was to explore first-person, lived experiences with helpful help in mental health crises, recognizing that conveying and grasping these experiences would also involve some level of interpretation from researcher and participants. However, as the project developed, it became more and more apparent to me that the idea of developing knowledge based on decontextualized and common themes of experiences of helpful help could definitely be questioned. Though an interpretive approach acknowledges that experiences are interpreted through interaction with oneself and the other, there is still commonly an understanding that interpretations are related to some kind of truth "out there."

However, onto-epistemological assumptions of truth as made or found can be argued to follow different modes and understandings of interpretation. In my troubling and becoming understandings of these issues, the distinction made between hermeneutics of faith and hermeneutics of suspicion turned out to be a useful inspiration. Hermeneutics can be defined as "a style of interpretation" (Sullivan, 2012, p. 9). Sullivan (2012) works on Paul Ricoeur and his distinguishing between hermeneutics of faith and hermeneutics of suspicion. A hermeneutics of faith aims to examine a text in a manner that "gives voice" to the participants. The text of the interview is regarded as a window to the intended meaning of the participant. Hermeneutics of suspicion, on the contrary,

aim to decode and problematize the participant's voice and strives for interpretations that go beyond the text (Colahan et al., 2012; Josselson, 2004; Sullivan, 2012).

Although there are no rigid distinctions, through assuming truth as either found or made, different methodologies will assume different levels of faith or suspicion in the interpretation of data. For instance, phenomenological research that regards interviews as a window to the voice and true experiences of the participants will commonly assume an interpretive attitude of faith. Text is regarded as revealing the unknown world of the participant. On the other hand, narrative analysis will often work on a combination of faith and suspicion, both regarding the text as opening up the world of the other and assuming the possibility of the narrator having an agenda for bringing his or her story to the fore (Langdridge, 2003; Sullivan, 2012). A hermeneutics of suspicion stance is also often used in different varieties of discourse analysis, in terms of attempting to go beyond the talk and look into what purposes talk serves at a local level but also the possible power dynamics, both conscious and unconscious, that can be hidden in talk (Sullivan, 2012).

Through the process of analyzing data from the three sub-studies in this PhD project, an emerging sense of how interpretation is not just interpretation occurred. Following Sullivan's (2012) interpretation of Ricoeur, qualitative analysis is not only about revealing the participants' intended meaning. Once the spoken word has left the participant, it starts living a new life as a text that can be interpreted in different manners. It has left its original time and space and, thus, is no longer a part of its original context. In a way, it can be argued to be decontextualized. As such, rather than being concerned solely about the intended meaning, which we may not ever be able to reveal, qualitative researchers should also focus on the reader of the text (Sullivan, 2012). Thus, which interpretations of the text contribute to enriching and troubling the world?

It can be argued that an increasing level of suspicion in my processes of troubling the truth, the world, and myself characterizes this PhD project. This evolving notion of suspicion will be described and explored through three different acts. This does not mean that the process from acts one through three has been linear. Processes rarely are. A spiral is perhaps a more appropriate description. There is always something of the past in the present and vice versa.

5.4.   Act 1—A hermeneutic phenomenological approach

A hermeneutic phenomenological approach combines elements from phenomenology and hermeneutics. It differs from a descriptive phenomenology, where the aim is to capture essences of lived experiences. A hermeneutic phenomenological approach seeks to obtain a deeper understanding of identified lived experiences and recognizes that experiences involve interpretation by both participants and researcher (Ajjawi & Higgs, 2007; Laverty, 2003). Represented by philosophers like Martin Heidegger and Hans-Georg Gadamer, this branch of phenomenology regards lived experiences as rooted in our practices and actions. The self is part of the world, and, as such, pre-understandings are structures of being in the world. The individual is part of the world and cultures without necessarily being aware of it, and, thus, pre-understandings cannot be set aside; they are part of being in the world. Interpretation is crucial to understanding. Our pre-understandings are part of interpretation, but interpretations are also affected by our current contexts (Laverty, 2003). Thus, meanings are constructed by human beings in unique ways depending on their contexts and personal frames of reference as they engage with the world (Ajjawi & Higgs, 2007).

In sub-study 1, which explored the experiences of service users, the plan was to use a hermeneutic phenomenological approach in the process of data analysis. My aim was

to stay close to the lived experiences as expressed by the participants and to represent, explore, and understand them.

The vast majority of these interviews were conducted in people's homes by the choice of the participants. I was invited into all kinds of homes—city homes and countryside homes, small homes and large homes, family homes and single homes. But I was always received as a welcome guest. Not because it was me, but maybe because I represented an opportunity to be heard. Although I used a semi-structured interview guide, participants also had the chance to elaborate on what they found important. They had agreed to participate in the interviews, and they had invited me to their homes. As such, it seemed like common courtesy to also allow for their agenda for participating come to the fore.

I listened to the audio-recorded interviews shortly after having conducted them and made reflective notes. Conducting and listening to the interviews was an evocative experience. What I had was not just data; I had people's stories (Frank, 2000). On the tiny recorder machine, I had some of their stories connected to helpful help in crisis. I also had their laughter and tears. The sound of tripping dog paws. The pouring of a cup of coffee. The entrance of a curious husband who had been "banished" to the basement. Though attempting to stay true to the content of the recordings, incidents like the above were somehow lost through transcription. However, they constituted part of my pre-understanding in the analysis and interpretation of the text.

 In the analysis of the text, I worked based on my initial beliefs about the data representing a possibility to reach the true meaning of the participants and that it was possible to find some common themes that could capture the lived experiences of

"helpful help." The software program Nvivo was used to decontextualize, code, and organize data. Coded items were abstracted into subthemes and themes across the dataset. Following a hermeneutic phenomenological reasoning, an iterative process between the evolving themes and data set as a whole and between pre-understandings and new understandings was used to generate the final themes of the sub-study. Thus, it can be argued that onto-epistemological assumptions and methodological approaches in sub-study 1 shared commonalities with "hermeneutics of faith."

5.5.   Troubling the hermeneutic phenomenological approach

Through the analysis of data in sub-study 1, an emerging feeling of discomfort occurred. By searching for common themes across the dataset, the individuals and their stories of how they experienced and dealt with the complexity of their everyday life in crisis, which appeared to come though very strongly in the interviews, were decontextualized and lost.

In conducting interviews and in the process of transcribing, it occurred to me that participants appeared to be telling stories that ran through the semi-structured interviews. These stories framed the interviews in idiographic and personal ways. Though, as a researcher, I had an agenda for conducting the interviews, so did the participants! Rather than viewing the participants as simply being suppliers of information, it seemed to me that they participated in interviews for their own reasons. In the interviews, participants stood out as competent subjects who had their own agendas and motives for participating in the study (Alvesson, 2003). Often, they would state something like, "and this is the actual reason I wanted to participate in this study." Thus, although they had been informed in advance about the aims of the study, they had also defined their own aims. It occurred to me that they had stories they wanted to share, representing their own, personal ways of making meaning in their experiences. According to McAdams, "[h]uman beings are storytellers.... Storytelling appears to be a

fundamental way of expressing ourselves and our world to others" (1993, p.27). It was not that the participants did not answer the questions of the interview. They did. But they had found a way of doing so that provided richer responses than I could ever have dreamed of in my carefully developed semi-structured interview guide.

The interviews appeared to not so much represent a truth "out there," gathered by the researcher. The truth seemed to be co-created through the interviews. For instance, participants could express during the interview how they realized what they *actually* thought about their experiences with help from the CRT. Thus, their understanding of themselves and their experiences was not necessarily stable and coherent truth but was created and developed through the dialogic situation of the interview (Denzin, 2014; Grant, 2015). As such, the experiences were made "true" in the current context of the interview.

My intention in analyzing the interviews through abstracting their content into decontextualized themes needed to be reconsidered. It may be regarded as unscientific to state that "the data spoke to me," but, in a way, they did. In sub-study 2, through my dialogue with the participants in the interviews, with myself, and with the transcripts, what had been an evolving notion in working with data in sub-study 1 became even more apparent. I needed to find another way of analyzing data, a way more applicable for safeguarding the contextual stories shared. It was time to "move closer" and explore my notion that participants were telling stories.

5.6.   Act 2—A narrative approach

 "This book ought to be read twice. It has a message as well" (Mykle, 1956).

The decision to do a narrative analysis of the interviews with carers in sub-study 2 forced its way through. My notion about people telling stories despite—or, perhaps, caused by—my questions in the interviews was also apparent when analyzing interviews with service users. However, at that point, I chose to carry through with doing a hermeneutic phenomenological analysis as originally planned. I actually did try to do a narrative analysis because it seemed to be appropriate. But I just couldn't figure out a way to do it.

However, in engaging in the data from sub-study 2, there seemed to be no way out of it; I had to give it a try. Through the processes of my dialogues with the participants, the written texts, and my own evolving thoughts regarding how "truth" could be understood, a narrative understanding of the data was created. Though many carers shared experiences of the burden of being a carer, this burden was also embedded in a unique story, including their backgrounds, networks, and relationships with their near ones. Striking in sub-study 2 was that carers shared their experiences of rarely or never being asked for their side of the story and what they considered helpful help, both for the person they cared for and for themselves. Thus, it appeared important to bring these stories center-stage to elucidate how carers are persons and not just part of a large group (Grant & Zeeman, 2012).

The analysis of data in sub-study 2 did not follow a standard "recipe" for narrative analysis. In fact, I did not find such a "recipe." Most of what I found on narrative analysis resembled what Polkinghorne (1995) refers to as following a paradigmatic kind of cognition. The primary operation of paradigmatic cognition is to classify objects or experiences as belonging to a specific category or concept. When following a paradigmatic manner of cognition, narratives are collected as sources of data. The narratives are then analyzed through a process in which the researcher seeks themes

and patterns across the dataset, and, as such, their storied form is broken down into smaller units and categories across the dataset. Polkinghorne (1995) distinguishes this approach, which he calls "analysis of narratives," from "narrative analysis." In performing "narrative analysis," the researcher follows a narrative manner of cognition. Narrative cognition is directed towards understanding human action and how action is an outcome of the interaction of previous and present experiences, knowledge, and contexts. As a result of this interaction, human actions are regarded as unique. Thus, in contrast to paradigmatic knowledge, which focuses on what is common among actions, narrative knowledge focuses on the uniqueness of each action (Polkinghorne, 1995).

The framework of "narrative analysis" seemed to be applicable to sub-study 2. Inspired by Polkinghorne's work, McCormack's work on storying stories (2004), and Ricoeur's writings on emplotment (1991), sub-study 2 suggests an approach for narrative analysis aiming for configuration of stories using a personal plot as an organizing structure. Although the interviews were condensed, the words of the participants were kept as they were expressed in the interviews. The process of constructing individual stories meant thinking the other way around compared to the analysis in sub-study 1. It implied a step away from searching for decontextualized and common categories towards searching the unique and contextual actions and stories.

A narrative analysis focusing on emplotment can be argued to be inspired by both hermeneutics of suspicion and hermeneutics of faith (Ricoeur, 1991; Sullivan, 2012). Thus, although narratives can be understood as revealing the inner world of the participants, it is also possible to understand narratives as reflecting the agenda of the politics of the participants' own point of view.

The writing up of stories was regarded as an attempt to capture the possibly intended message that each participant was trying to convey. That does not mean that the narratives represent the truth. However, they represent an attempt to capture a contextual truth that could be argued to be true at a certain time and in a certain relation. The approach also elucidates how lived experiences represent truths that are contextual, personal, and time and space-dependent.

5.7.   Troubling the narrative approach

Sub-study 3 involved focus group interviews with CRT clinicians. Focus group interviews were considered useful as they enabled exploration of how clinicians who normally work together as a team discuss and make meaning concerning helpful help (Onwuegbuzie, Dickinson, Leech, & Zoran, 2009). Through the interviews, the groups of clinicians, representing different CRTs, discussed and constructed their stories of how helpful help was understood and practiced within their respective teams. Often, there appeared to be a great degree of coherence within the team, almost as though they were speaking with one voice. This was somehow surprising to me at first. But, as part of an organization and mental health professions, how free are people to actually shape their own truth and stories?

Reflection note, November of 2015:

"I've been going through the interviews with the clinicians several times, and there seems to be something that just 'doesn't add up.' People are consistently talking about CRTs being something 'more and different' than the regular mental health services. Simultaneously, despite the good intentions and values they express, there is something about how they express this, in terms of the language they use. They still use a rather medically oriented language. So I am thinking, is it possible to actually change mental health services if the language is not changed? Can this be the cause to what seems to be a lack of real change? And moreover, is it possible to perform radical changes within

the framework of the specialist mental health services? This is something I believe the data say something about. But how to explore this?"

Data analysis can be argued to start long before the actual process of analysis begins. Thus, my pre-understandings and initial reflections and troubling can be understood as important parts of the analysis. My reflections regarding data for sub-study 3, comprising interviews with CRT clinicians, troubled me for, although it was definitely possible to look at the *content* of what people were saying, there also appeared to be something more to it. As such, it can be argued that the stories we choose to tell about ourselves and what we do have a function. They are also part of constructing our identities and justifying our actions (Hitzler, 2011).

As a former CRT clinician, CRT work is a known field to me. To bracket my pre-understandings would seem impossible. However, in conducting focus group interviews with the CRT clinicians, I aimed to take a somehow reclining role, trying to be careful not to let my own opinions and attitudes regarding CRT practices shine through. There are, of course, numerous reasons why they are still prone to have done so such as possible aspects of my body language and facial expressions and the very fact that the participants knew that I was "one of them." Although I could be regarded as one of them, at the same time, I was not, as I was currently not engaged in clinical work. Not fully being "part of them" also opened up the possibility to see things from the outside (Grant, 2016). Thus, it appeared to be useful to try to go beyond the content of *what* the clinicians talked about in interviews and to question *how* CRT clinicians construct their understandings and stories of helpful help. What purpose does clinicians' use of talk serve, both at an individual level and at a group level? And how to elaborate what possibly lies beyond the text and what people say?

5.8.   Act 3—A discursive psychological approach

The data from sub-study 3 certainly had interesting content—in other words, *what* the participants said. However, it occurred to me that there was not always coherence between the actual content of what was spoken of and how it was expressed. For instance, though seemingly talking about representing new understandings and approaches to mental distress, a more traditional psychiatric language often appeared to be used. With an understanding of truth as interpreted and created, the focus group interviews stood out as a great opportunity to investigate not only what clinicians understand as helpful help but also how they talk about and construct these understandings.

With my pre-understanding and concern about the apparent lack of mental health services changing in a recovery-oriented direction, despite outspoken health political intentions and research suggesting that service users often prefer such approaches as a backdrop, I decided to try to go beyond the content of what was said (Barker & Buchanan-Barker, 2011; Grant, 2010; Tickle, Brown, & Hayward, 2014).

A discursive psychological approach was chosen. This approach acknowledges that people and their actions are shaped by not only external structures and power relations but also how people talk about and understand their world (Winther Jørgensen & Phillips, 1999). As such, how people communicate and interact in a team is a matter of interest, including how language is used in specific contexts to constitute and construct meaning and actions and how different versions of elements like society, community, institutions, and experiences emerge through discourses (Onwuegbuzie et al., 2009). Thus, the CRT clinicians in this study were understood as not speaking solely on their own behalves but also as representatives of professions, the team, and the specialist mental health system.

It can be argued that most kinds of discourse analysis tend to be suspicious of the purposes served by people's talk. Talk is never just talk. It is assumed that talk has a function, both at a local level and at more macro-oriented level. In the focus groups, for instance, talk was understood as possibly reflecting personal agendas and positioning within the group and as reflecting issues of power and knowledge, both at a conscious and unconscious level (Sullivan, 2012).

The discursive psychological turn in sub-study 3 can be understood as introducing a more suspicious approach to the understanding of data but also an increased suspicion or questioning about my role as a researcher. Like the narrative turn in sub-study 2, the discursive approach troubles the idea of lived experiences as "out there," made available through interviews. The discursive turn also recognizes that participants may have an agenda with participating in interviews. This was very evident in the current study as the interviews were conducted shortly before the submission of new recommendations for CRT work in Norway. Many participants referred to this process, expressing concern that they might have to work in other ways than those they found useful. As such, they were eager to justify their current practices. What these justifications for "best practice" are based on is questioned through a discursive approach, as it is oriented towards how people make meaning through what is said and questions what can and cannot be said within a group and culture.

The analysis of data in sub-study 3 does not attempt to be un-biased by me as a researcher. The findings generated through the analysis are a result of my interaction with the participants during interviews and my interaction with the text succeeding interviews. It is also a result of my interaction with my own evolving suspicion that the

truths we present are part of larger discourses about what counts as knowledge or not within the field of mental health.

5.9.   Co-creation of knowledge

The three "acts" **above** explore the development of the onto-epistemological assumptions and methodology of this project and how my altered understandings of truth and knowledge are entwined with my becoming as a researcher. However, the creation of truth and knowledge are also relational processes and is, in this project, best understood as co-creative. Thus, truth and ways of exploring truth have been developed and created through interaction and collaboration with supervisors, colleagues, fellow PhD students, and the competence group. Through presentations, reflections, and discussions, ways of approaching knowledge and the knowledge itself changed, as did I. As such, the knowledge and ways of knowing in this project can be understood as an ongoing movement. Movement in this sense is related both to movements within the persons involved, between these persons, and between the persons and the "realities" that the project explores (Davies, 2016).

A significant contribution to this movement was the collaboration with the competence group. The group was involved through all three onto-epistemological "acts." The different methodological "turns" were discussed in the group in terms of whether it could be feasible to understand and interpret data in the different ways described above.

The process of involving and collaborating with the competence group was, in many ways, guided by me as a researcher. Thus, the collaboration was not one between two parts collaborating on equal terms. The process of making a selection of which texts the group should have access to involved a dialogue between the texts and me when doing

an early reading of the texts in terms of deciding what I thought could be suitable parts of it to share with the group. Although I attempted to make a selection of texts that could represent a variety of experiences and that I believed could be read and understood in several ways, this did, of course, involve a predefinition and interpretation from my side. These texts were then sent to the participants, who read them before the meetings, and, thus, they can be argued to have engaged in their own dialogues with the texts. The dialogue in the meetings was conducted in an open manner to allow the emergence of different views and interpretations of the data. The group discussed how data could be interpreted and what seemed to be important. Collaboration with the group resulted in multiple views and understandings of the data through adding new layers of dialogue and movement to the study.

In the meetings, our dialogues and understandings of the texts met, and new understandings were created. The reading of the texts and our discussions truly engaged the participants. Statements in the texts that I understood as rather neutral could sometimes be perceived as provoking by the group. For instance, in discussing possible discourses in the data from sub-study 3, the group members found certain statements from the clinicians to be very condescending. These were statements that I had found rather neutral, and, thus, this served as a reminder to me of how, as a former CRT worker, I perhaps tended to identify with the clinicians. It was also a reminder of how we tend to see what confirms what we already know (Davies, 2016). Thus, collaboration with the competence group in particular represented a way of troubling my assumptions and understandings.

The group members shared how they were touched and provoked by the texts. This also appeared to trigger and articulate experiences from their own lives. They appeared to work on these experiences in the interpretations of the texts but also vice versa,

meaning that their own experiences were understood and given new meaning in light of the data from the study. As such, the involvement in and of the competence group enabled the participants, including myself, to both reinterpret and re-story our own experiences, ourselves, and the data.

Reflection note, November of 2014:

Initially, in today's meeting, I was really wondering if we were completely astray, but on the way, I started thinking that, perhaps, this is some kind of hermeneutic spiral? The participants express that this is exiting and useful; it gives them experiences that they can take with them. I am thinking that it seems impossible to draw a line between research and "life." Everything is connected, kind of.

5.10. An onto-epistemology and methodology of troubling

"No is, generally speaking, a better answer than yes" (O'Brian, 1967).

How can the onto-epistemological and methodological turns described in this study be connected? As described in section 5.1, the onto-epistemological basis of this project is that reality and knowledge are made. However, through the onto-epistemological turns in this project, truth and knowledge are perhaps better understood as connected to ways of actively becoming in the world rather than passively being situated in it (Davies, 2016; Mattingly, 2010). These ways of becoming in the world can be understood as connected to emerging truth, to how truth is explored, and to myself, as a researcher. Moreover, my exploration of how the onto-epistemological assumptions and methodology and my becoming as a researcher are connected in this thesis can be understood as driven forward by *troubling* as the source of propulsion. Troubling can be argued to be a force that drives practices that aim for better understanding through change and movement but also through uniting and contextualizing. Troubling needs to be understood as entwined with me as a researcher, my dialogue with the participants,

their stories, the competence group and other dialogue partners, and the socio-historical contexts we are part of. Troubling requires the acknowledgement of a culturally embedded and experiencing researcher and is closely connected to onto-epistemological assumptions of autoethnography (Grant, 2014). That does not mean that, as in much autoethnography, the researcher is the person of main interest in this study. It does mean, however, that the researcher-in-context is a prerequisite for co-creating and troubling truths and knowledge (Short et al., 2013). As such, troubling is related to reflexivity.

5.11. Reflections on reflexivity

Within qualitative research, it is commonly acknowledged that interpretation and writing are positioned and that the researcher contributes to the shaping of the different parts of the research process. Making one's position explicit is often considered an important characteristic of good qualitative research. The researchers' consciousness of values, biases, and experiences that influence and shape this position is commonly referred to as reflexivity (Creswell, 2013). As such, reflexivity is not added to a study in the concluding part of the process but is to be understood as a part of the entire research process. Although there is consensus regarding the importance of reflexivity in qualitative research, there appears to be little consensus about *what* it is, *how* to do reflexive research, and *why* it is important (Pillow, 2003). Although most qualitative researchers claim they are being reflexive, they often do not define how they understand reflexivity and how they use it. Reflexivity is most commonly preoccupied with the researcher's self and its significance in various parts of the research process. However, several qualitative researchers have also criticized this extensive use of "me reflexivity," suggesting that reflexivity needs to go beyond the confessions and catharsis of the researcher (Alvesson, 2003; Pillow, 2003).

Pillow (2003) refers to four reflexivity strategies—"reflexivity as recognition of self," "reflexivity as recognition of other," "reflexivity as truth," and "reflexivity as transcendence"—which are all commonly used in qualitative research. All these strategies of reflexivity have been reflected upon in this PhD project.

Throughout the project, I have attempted to work with an extended understanding of reflexivity and to make my reflections on reflexivity explicit throughout the writing up of the thesis. My reflections concerning what reflexivity is, how to do reflexive research, and why it is important have all been part of my development as a researcher. "Reflexivity as recognition of self" is connected to consciousness of what I brought into the project as a former CRT employee, social worker, and private person. My own experiences from CRT work and what I have experienced as being helpful and unhelpful practices are likely to have influenced what I have focused on in interview situations and analysis of data. The fact that I am a former CRT worker might also have influenced the participants in interview situations in different ways. Nearly all participants expressed that they found it reassuring that I had CRT experience in that they believed it would make it easier for me to understand what they were trying to express. However, there is also the possibility that participants held things back or moderated their statements as they were asked to explore experiences with a service that I could be regarded as representing.

Though this might be the case, it is also reasonable to state that any trait or characteristic of any interviewer would have influenced the participants in the interview situation. It is not a matter of indifference that I am a woman; that I am in my forties; or, for that matter, when travelling around and meeting informants in their homes in rural or, even more so, desolate parts of Norway, that I am an "urban girl." There is no such thing as a neutral interaction between people.

In the interpersonal meetings shaped by the interview, the participant also brings in his or her story, traits, and agenda. Reflexivity as "recognition of the other" recognizes research participants as much more than objects (Pillow, 2003). In this project, it appeared evident that both participants and members of the competence group had their own motivation for participating. As such, a prerequisite for reflexivity in this project has been the understanding of both the researcher and participants as active, contributing, and unfinalized persons.

Moreover, in addition to understanding reflexivity as consciousness about what I, as a researcher, bring in and also how the agenda and personal context of the participants might affect how the empirical material of the study is shared and perceived, reflexivity can also be argued to be about constantly questioning what counts as "truth" and how "truth" can be found. This is what Pillow (2003) refers to as "reflexivity as truth." Initially, in this PhD project, I regarded truth more or less as a phenomenon with certain common features that could be shared and perceived in interview situations. Questioning my own perceptions and emerging feelings of discomfort and discussing this with fellow researchers and the competence group led to changes, both onto-epistemologically and methodologically, as described in chapter 5.1.

Through knowing oneself, the other, and the truth, the fourth strategy of reflexivity suggests that the researcher can transcend these issues (Pillow, 2003). However, if we transcend these issues in a self-satisfied feeling of comfort, having "done reflexivity," are we still being reflexive?

5.11.1. Troubling reflexivity

A possible problem with the concept of reflexivity is that, despite attempting to use different strategies, all these strategies have the researcher as the point of departure. It is how I understand and interpret myself in relation to the other and the research project and how I understand the other and the truth that shape the reflexivity of the study. This is the case even in the collaboration with the competence group. Though discussions with the group brought in new perspectives and interpretations, these were filtered through me. There appears to be no escaping this. Thus, there is always the risk that the use of reflexive strategies serves to confirm the presumptions and understandings of the researcher rather than troubling and expanding them. However, these common strategies of reflexivity can be argued to depend on subjects, both the researcher and the participants, which are singular, fixed, and knowable (Grant, 2010; Pillow, 2003). The reflexive strategies described above can be understood as paying little attention to the assumptions that this thesis discusses, implying that oneself, the other, and the "truth" are also culturally embedded and are thus dialogic and unfinalized (Alvesson & Sköldberg, 1994; Grant, 2010; Short, 2010). As such, in the course of this project, the narrative turn in sub-study 2 and the discursive turn in sub-study 3 can be argued to reflect my evolving notion of the significance of context and that what can be said and what cannot be said are restrained or supported by the different cultures we are part of.

Throughout this study, my attempts to trouble myself and my assumptions and to engage in dialogue with these can also be argued to be an attempt to promote reflexivity and transparency. To reflect upon reflexivity and to trouble my understandings and practices of it are also part of my "becoming as a researcher." Through my assumption that, as a person and researcher, I am not finalized but prone to develop and change in dialogue with myself and the research process, understandings of reflexivity are set into

play. At its best, this can be a reflexive strategy. However, sometimes an important part of a strategy can also include recognizing when to let it go.

5.11.2. Reflexivity—From strategy to "letting go"

Having worked as a CRT clinician for nearly ten years before I was engaged in this research project, I had an idea of what I thought people would talk about when asked about their experiences with receiving help from a CRT due to a crisis. According to Bourdieu (1999), we "apprehend these (stories) through perceptual categories which, by reducing the personal to the impersonal and the unique drama to a human interest story, allow us in a way to economize on thought, on emotion, in short on understanding" (s. 614).

Searching for the familiar and categorizing is natural to humans. We need order to not be overwhelmed by chaos. Thus, we often listen to hear what we already know. However, if understanding an important mission with research is to explore the world and extend knowledge, this also implies the necessity of setting our tendency to assimilate and categorize aside. It implies listening in order to challenge our normative assumptions and work against ourselves (Davies, 2016). Bourdieu (1999) argues for the necessity of *intellectual love* in the sense of, as a researcher in an interview setting, aiming to forget oneself and to truly engage in the story of the participant and to make the problems of the participant one's own. As a novice researcher, I found that, during the early interviews of the study, I was concerned about how I was perceived as a researcher and about acting "professional." I wanted to do things "right" and struggled hard to find my role as a researcher as opposed to being a clinician. However, in the process of finding my way and role as a researcher, something changed.

It's late in the evening. I'm somewhere in rural Norway. It's snowing heavily outside. I can't seem to let go of the participant I interviewed earlier today. I picture her, alone in an empty house. Her family, job, and who she once was gone. And still, she had served me food and offered to give me a lift back to my hotel after the interview. She even thanked me for listening. The small hotel room seems to creep in on me. I want to call someone, but I know that some things are impossible to share. I feel very lonesome and vulnerable.

In the course of this project, part of being reflexive about myself and my role as a researcher can also be argued to be about letting go and not being constantly occupied with whether or not I was doing things "right" and being reflexive at all times. As such, it included listening to and connecting with people and shifting focus away from me and my "research mission" to the other. Perhaps it did not matter that much if I was asking the "right" questions or if I had the "right" researcher attitude. What became more and more evident to me was the importance of letting people express themselves, to actually listen and to recognize that they were participating in the study for their own, unique reasons.

Questioning and changing my views and understandings of myself, the other, research, and the "truth," all embedded in culture, can thus be regarded as elements in an unfinalized reflexive process. As such, the movement between reflexive strategies, letting go, and back again shape a flexible reflexivity taking into account that the researcher, the other, and the truth are not fixed. Being reflexive is about being relational in terms of attempting to relate to unfinalized versions of oneself, the other, and the truth (Short, 2010). It is a relational project of becoming in the world. Through engaging in these dialogues of relations, new understandings can be constructed. It's not about, once and for all, finding what to be reflexive about and setting it aside.

Thus, reflexive practices call for constant efforts of troubling, both the subjects of reflexivity and the concept of reflexivity in itself. To capture reflexivity as a troubling and unfinalized concept, Barad's (2007) concept of diffraction appears as useful to me. Barad uses 'diffraction' as a posthumanist replacement concept for reflexivity. Reflexivity pre-supposes known, predictable people who are changing in predictable ways, within pre-established reality-knowledge parameters. Diffraction, as opposed to reflexivity, does not reproduce an image of what we assume is already there. It is focused on the ongoing production of ourselves, the other, and reality through intra-action. Thus, it concerns subjects and truths in the making.

5.12. Ethical considerations

"You know, you can use the interview for whatever purpose you like. I don't care if you use my name either. You do whatever you find most useful. I just want my story to be known." Utterings similar to this were quite common when I did the research interviews. Whereas I was very careful to reassure the participants that they would be protected by confidentiality, many of them were not concerned about this at all. On the contrary, many were more than willing to come forward with their experiences. Why do we regard certain groups of people as vulnerable? Who are we most eager to protect by bestowing such an identity on others?

The Regional Committee for Medical Research Ethics in Norway, Region southeast, assessed an application for carrying out the study in 2012 (2012/1458a). The committee decided that the study did not need their approval in order to be carried out as they regarded this to be a study exploring experiences with health services.

It can be argued that this rather schematic assessment of the application left out the experience many qualitative researchers have; people often tend to talk about what

they want in interview situations. For instance, the participants in this study all responded to the same topics from the interview guides, but they emphasized and elaborated on what they found important. An answer to an interview question went beyond a simple answer in being embedded in a personal story. As such, this simple assessment from the committee about what the study asked for and what would be the obvious response to these questions undermined the fact that participants are not only objects being researched; they are just as much subjects, using the occasion of the interview to actively construct and tell their story. This is also supported by Morse, Niehaus, Varnhagen, Austin, and McIntosh (2008), who suggest that "the control of the research interview is largely in the hands of the participant" (p. 205). This lies in the inductive and explorative nature of studies like this PhD project; you cannot control what you will get.

As previously mentioned, stories shared in qualitative interviews are not merely windows to peoples' minds; they are also a crucial form of human activity (Frank, 2010). If we regard interviews and people's tendency to tell stories as a human activity and meaning making, this also opens up the possibility of viewing research ethics in a slightly different manner. As such, research ethics do not only have a procedural and general side with an intention of safeguarding the participants at a group level. Ethics also have a subjective side and a relational side, implying the need to consider the unique participant as a meaning-making subject. This PhD project raises some evident ethical considerations, but it is also possible to reflect upon some perhaps not-so-evident considerations.

5.12.1. Ethics as procedural

According to Kvale and Brinkmann (2009), qualitative research on human beings places a demand on the researcher to pay specific attention to four issues: informed consent, confidentiality, responsibility for the consequences of the research, and the role of the researcher. In this project, written, informed consent was gathered from all participants

prior to interviews. In addition, oral information was given connected to the interview situation. Participants had the opportunity to contact the researcher to ask questions before, during, and after interviews. Confidentiality was maintained throughout the study. No personal details have been collected and kept. Information that could identify the participants was omitted in the transcription of data. All oral and written data have been stored on an approved research server at Akershus University Hospital. Responsibilities for the consequences of the research have been attended to by giving participants the ability to contact either the researcher or their local CRT should they have any reactions succeeding interviews. In addition to omitting personal information that could possibly identify the participants, information that could relate the participants to a specific CRT has also been omitted. This was done to ensure that information shared by the participants could not affect possible future contact and relations with their local CRT. The fourth ethical issue, related to the role of the researcher, will be elaborated on below.

5.12.2. Ethics as person-centered

Understanding research ethics within a person-centered paradigm places the participant at the center of ethical reflections and considerations. However, as described in section 3.2.1, this thesis understands person-centeredness in research at three levels: the researcher as person, the participant as person, and person as contextually situated. These different levels are connected and are also important in reflections on ethics.

According to Kvale and Brinkmann (2009), the role of the researcher must be given attention in the attempt to safeguard ethical issues. The authors claim that who the researcher is as a person will influence the research process and how ethical considerations are made along the way. Preceding interviews, the participants were informed that I had former experience as a CRT clinician. This was received positively in the sense that participants expressed that they believed my background would make it

easier for me to understand what they were saying. This did, of course, seem reasonable. However, I also thought there might be a risk that participants would "polish" their experiences of CRTs as I could be regarded as part of "them."

Before commencing the project, the research group had discussed and planned the study in order to adhere to the ethical issues as suggested by Kvale and Brinkmann (2009). We were particularly concerned about participants among service users and carers belonging to possible vulnerable groups in the sense that they had been going through a severe mental health crisis within the last three months. The Icelandic author Einar Mar Gudmundsson wrote that "[r]eality is always catching realism by surprise" (2007). This reflection also seems to apply to the current study. I was prepared for people's reactions and that going through the interviews could be tough for some. Together with the other members of the research group, I also considered the possibility that participants might want to withdraw from the study either during or after the interview. What I was not fully prepared for was how important it was for many of the participants to participate in the study and to have a chance to tell their story. It meant something to people. As such, people did not just provide "data"; they shared something that was part of their lives, and that was important to them. What also struck me was the fact that I have worked as a clinician for more than ten years. How could I not have anticipated this?

As such, an important part of research ethics can also be about giving people a chance to be heard. Denying someone a voice because of assumed fragility can be unethical. The autoethnographic researcher Turner (2013) argues that, while researchers are always concerned about the people they write about and how the research might affect them, there are also reasons to question what happens to all those people who are, for diverse reasons, *not* included and heard. In the course of doing the interviews for this

study, it became apparent to me that perhaps one of the most important ethical issues in this study was not to protect vulnerable people against themselves and their stories. It was much more about figuring out how I could manage this precious gift and trust the participants had bestowed on me. How do you write up research of peoples' stories and lives in an ethical manner? How do you avoid trapping people's experiences in static themes or typologies (Frank, 2005; Frank, 2016b)?

Though qualitative research commonly aims to expand understanding rather than providing explanations within a field, there is always a risk of participants becoming static objects. As such, participants and their experiences can be "othered"; they become objects about whom the researchers tell the "truth. "Othering" works by depriving or denying people's contexts in stripped down and reductionist stories (Grant, 2016). Through this process, participants also run the risk of being finalized and deprived of the possible transferable power that lies in the interview (Mattingly, 2010).

The ethical issues concerning what researchers do to people by decontextualizing and reducing their stories into themes are rarely discussed. As such, it can be argued that an important dimension in qualitative research, in addition to the four suggested by Kvale and Brinkmann (2009), is about reporting findings in ways that are attentive to the significance of viewing people as contextual and unfinalized beings (Frank, 2016b). Throughout the work with this thesis, an ongoing reflexivity and dialogue with the data, competence group, and co-researchers and the attempt to question, trouble, and adjust the methodology and research process along the way can be argued to be part of ethical considerations. The ethical issues, though having been considered before commencing the study, have also been a developing part of the whole research process. As such, ethical considerations are also constantly "in the making."

5.12.3. Ethical considerations in the competence group

Procedural and person-centered ethics were also issues in the competence group. This included signing an agreement of confidentiality regarding data that were discussed in the group but also reflecting on and considering personal experiences that were shared in the group. As such, the cooperation with the competence group was a clear reminder of how doing research is entwined with life and how it may be neither possible nor desirable to separate the two (Short et al., 2013). The risk of finalizing people in research is apparent in the involvement of competence groups. Being included as a "service user" or "carer" can involve the risk of entrapping people in these roles. As such, it can be argued that researchers have an ethical responsibility not to finalize people in roles that we impose on them (Frank, 2010).

The fact that people commonly tend to fill diverse roles and that these roles also change during a lifespan was discussed in the group. Whether we were researcher, carer, service user, or clinician turned out to be less and less important during the course of the study, and this was something the group commonly reflected on. As such, reflection and dialogue on roles served as an evolving, ethical practice in an attempt to avoid finalizing people in predefined roles.

6. Findings

The term "findings" suggests that there is a reality to be found out there. In this thesis, the term "findings" is better understood as something that is not found once and for all but as practices in terms of being something we *do*. Through different levels of dialogue, the lived experiences that comprise the data in this thesis are constantly in the making and in the finding.

This thesis contains three sub-studies that explore helpful help in mental health crises from three different perspectives: the service user perspective, the carer perspective, and the clinician perspective. A paper based on each sub-study has been written. The paper on sub-study 1 has been accepted and is in press in the "American Journal of Psychiatric Rehabilitation." The paper on sub-study 2 has been published in "Social Work in Mental Health," and the paper on sub-study 3 has been published in "Qualitative Social Work." All three papers are included in the appendix section of this thesis. In this chapter, I present an overview of the aims, methodology, findings, and conclusions of each paper.

The findings from the three separate sub-studies and their possible implications for clinical practice and further research will be discussed through some suggested overarching concepts in chapter 6.

6.1.   Sub-study 1

The article based on sub-study 1 is entitled "'At the Extremities of Life'—Service User Experiences of Helpful Help in Mental Health Crises." The aim of this sub-study was to explore experiences with helpful help in a mental health crisis from a service user perspective. Qualitative interviews were conducted with 14 service users who had first-person experiences with receiving support from a CRT due to a mental health crisis. Data were analyzed following a hermeneutic phenomenological approach.

The study showed that experiences of mental health crises and helpful help are closely entwined and difficult to separate. However, in the data analysis, we chose to make a thematic distinction between these by organizing the findings under two broad main themes: 1) experiences of crisis and 2) experiences of helpful help. Each of these two broad themes was explored through three subthemes. Experiences with mental health

crises were explored through the following three subthemes: 1) "Losing foothold": the loss of outer structures and daily life structure, 2) "Becoming smaller and smaller": the loss of self-worth, and 3) "On the edge": crisis as a matter of life and death. Experiences with helpful help were explored through a further three subthemes: 1) "One cup at a time": help as structure and practical support, 2) "Not having to be afraid": help as safety, and 3) "Someone valuable": help as supporting self-worth.

The findings in this sub-study highlight that mental health crises are complex and call for compound services. Crises were commonly experienced as being connected to feelings of loss across several dimensions that related to social structures like employment, personal economics, and housing and to practical and organizational challenges in everyday life. Existentially related notions of loss connected to struggling with keeping connected to oneself, others, and life were also prominent. The agonizing effects of crises both at a practical and an existential level seemed to occur regardless of whether or not the crisis was related to a serious mental illness.

The important aspects of help accentuated in this study mirrored these diverse experiences of crises and were connected to remediating different feelings of loss. This included both social and practical support and help with daily structure and existentially related forms of help, like contributing to the sense of safety and self-worth. The CRTs were commonly experienced as being supportive, accessible, and contributing to the sense of being worthy and safe within their opening hours. However, limited opening hours posed a major deficit concerning the sense of safety. Even though social and practical consequences were commonly emphasized as dominant and devastating consequences of crises, the support that was offered by the CRTs rarely seemed to address these issues. Participants described a clear notion that such issues were not within the scope of the CRTs.

The study implies the need for CRTs to take subjective experiences of mental health crises seriously and to recognize them as subjective human experiences rather than parts of a disease. The study also suggests that, if CRTs are to be a realistic alternative to hospitalization in a mental health crisis context, they need to address a broader range of crisis reactions and need for support, including both existential and practical issues.

6.2.   Sub-study 2

The findings of sub-study 2 were published in the article "'We are Different People'—A Narrative Analysis of Carers' Experiences With Mental Health Crisis and Support From Crisis Resolution Teams." The aim of sub-study 2 was to explore what carers of someone in a mental health crisis experience as helpful help from CRTs. Qualitative interviews were conducted with 12 carers. The interviews were analyzed using a narrative approach. This approach involved analyzing and writing up the experiences and incidents shared in each interview into a unified story structured around a thematic plot—one story for each participant.

The narrative analysis revealed that, although carers share some common experiences, their experiences are also embedded within their personal history and context. These personal contexts affect how the crises are experienced and what is considered helpful help in each unique case. The participants' notions of having various aspects of life burdened by the crisis were overarching. The carer role was experienced as lonesome, both in the sense of feeling alone in the relationship and being isolated from the outside social world. Caregiving in crisis impacted several areas of the carer's life, including the practical organizing of daily life, the possibility of living one's own life, and, perhaps most of all, the tremendous emotional burden of fearing for the life and well-being of one's loved one, both in the present and in an unpredictable future. Though support from

CRTs was valued, it appeared that the support did not considerably relieve the burden as experienced by the carers.

By analyzing and presenting the experiences of the carers in an ideographic, "long," narrative manner, this study reveals how experiences of crisis and help, which may thematically share commonalities, also have a distinct, personal imprint. As such, the methodology developed and used in the study can also be argued to be part of the findings.

The study suggests the necessity of understanding carers' situation and need for support in light of their personal history and context and how this contextual approach is crucial in the collaboration on and providing of help that is perceived as helpful.

6.3. Sub-study 3

The findings of sub-study 3 are presented in the article "Between a Rock and a Softer Place—A Discourse Analysis of Helping Cultures in Crisis Resolution Teams." The aim of sub-study 3 was to explore the discourses through which CRT clinicians understand and talk about helpful help. Fifty CRT clinicians from eight different CRTs were interviewed in eight focus groups. The study used a discursive psychological approach.

Two broad discourses were identified through the analysis: ''The creators of

something new and different''—help as made and (b) ''The representatives of the

expert system''—help as given.

Within the discourse of help as "made," helpful help was talked about and understood as promoting and creating "new" values and practices within mental health services, as opposed to the "old" and more traditional medical culture. Help was understood as being co-constructed in dialogue with the service user and his or her network rather than as a predetermined practice. Thus, helpful help was talked about as something "in the making." This understanding of helpful help enabled the construction of a different professional identity within the team and a different service user role.

Within the discourse of help as "given," helpful help was talked about and understood as defined by an existing framework comprising predefined understandings of help in a CRT context and of rules and structures within the CMHC organization. The CRTs were understood as being the holders and suppliers of expertise competence and help, acting on the behalf of the CMHC organization. Though partially experienced as restraining, this discourse was also talked about as entailing predictability and quality for both service users and clinicians.

These two seemingly contradictive discourses reflect the diverse rationale for the development of CRTs and the possible tensions and pressures under which CRT work is conducted. The study critically examines the tensions between the discourse of constructing new practices and existing practices constituted by the specialist mental health services' traditional discourse. However, though being contradictive, the study suggests that both discourses can restrain creativity and the development of humanizing practices. Thus, the study suggests that how clinicians in CRTs talk about and understand help needs to be constantly reflected upon and questioned in collaboration with service users, carers, and other services.

7. Discussion

In this chapter, all three sub-studies are combined for overall reflection and discussion through three overarching issues related to helpful help: 1) Helpful help—Who defines what it is? 2) Helpful help—inner or outer matter? 3) Helpful help or helpful control? The findings of the three sub-studies are discussed in relation to the theoretical perspectives of this thesis and to other research. At the end of this chapter, methodological considerations and suggested implications of the study for clinical practice and further research will be reflected upon.

The intention of this PhD project has not been to definitely and finally state what helpful help in a mental health crisis is and how it should be done. The aim has been to hopefully contribute to a development of new understandings and knowledge within a field that interests me and that has been part of my life for many years. It is also a field I thought I knew something about. However, through the process of working with this PhD project, it has become more and more apparent how little I knew before and how few answers I have now. It is not that what I thought I knew then or what this study shows is not true or does not mean anything. It does—under certain circumstances, at certain times, or in certain places. But perhaps most of all, this project has contributed to new questions. This is, come to think of it, quite all right.

7.1.   Helpful help—Who defines and decides what it is?

I don't really get the title of your project. I mean, it's a really interesting project and all, but why do you call it "helpful help"? Isn't it obvious that help is helpful?

When I have discussed and presented this project in various forums, reflections like the one above have been common. Nearly all who have found the term "helpful help" to be somehow odd and stating the obvious have been on the clinician or professional side.

Why do we automatically tend to assume that what is commonly regarded as "help" from a professional perspective is actually optimally helpful? Help in a clinical setting within the field of mental health has, throughout history, often proven to be anything but helpful. Although the intentions of the providers might have been the very best, there are numerous examples in mental health of help that has been violating, dehumanizing, and, in many cases, directly harmful (Karlsson & Borg, 2013). The empiricism of this study elucidates how help is a multifaceted issue. But even more so, it elucidates how help is not an established phenomenon but varies distinctly according to the position of the definer and with context, time, and place.

Over recent years, there has been an increasing emphasis on service user involvement and collaborative practices in mental health services. The shift towards more community-based services can be argued to demand a more user-oriented approach as the services are provided in a home-based and everyday-oriented context (Borg, Karlsson, & Kim, 2009; Voronka, Wise Harris, Grant, & Komaroff, 2014). However, as, for instance, Borg et al. (2009) and Pilgrim (2008) argue, a common problem appears to be that, in the defining of the problem and the need for help, the professional definition still appears to be superior. Being trained and educated and working within a medically oriented system that has assessing, sorting of problems, and labeling as part of its concept, the mental health worker will often understand the problem and the solution to it in a causal manner from a professional contextual position. This may not concur with how the service user or carers perceive it, as they often experience and understand the problem and its solutions within a framework of everyday life. As such, service users and carers can experience a disconnection between what they desire and experience as helpful help and what is currently being offered (Frank, 2016a; Voronka et al., 2014).

This thesis suggests that service users and carers have far more practical experiences of how mental health crises affect their lives and of what they would have wished for concerning help than do the clinicians. Both service users and carers tend to talk about

how their lives during crises are affected at several levels. Though being experienced as emotionally challenging and burdening, crises also have very practical sides to them. However, though CRT clinicians were commonly experienced as friendly and attentive, it appeared that their understanding of and approach to crisis was overly existentially and emotionally oriented.

This could occur as somehow surprising as one of the important aims of CRTs is to understand users' and cares' problems and their solutions within an everyday context. The possibility of understanding and approaching the crisis in a daily-life context is cherished by the clinicians in sub-study 3 of this thesis, and the very experience of being able to work in this way is experienced as useful and rewarding. Sjølie (2014) refers to some of the same findings in her thesis on the experiences of CRT members, where the clinicians focus on the nature of the work in itself as rewarding. However, though service users, carers, and clinicians alike find the possibility of meeting and working together in a crisis in people's homes to be a desired and useful practice, it might be timely to ask the question of whether the potential that lay in this change of practice is being fulfilled.

Borg and Karlsson (2010) find that working in people's homes entails a new professional role, a more empowered service user role, and the possibility for more collaborative practices with the home as an arena. The findings from this PhD project seem to support the findings of Borg and Karlsson (2010) in terms of how the roles of the professionals and the service-users are talked about and experienced as being more equal and collaborative. However, it appears that the collaboration on defining practices of help and what helpful help should actually contain still appears to be overly defined on the basis of mental health professional clinical and therapeutic understandings of mental distress and help. As such, it can be argued that, although help is talked about in a more humane and collaborative manner, there appears to be a pre-understanding among the

different groups of participants that help in a CRT context still remains defined by the structures and traditions of the specialist mental health services. This pre-understanding seems to set limitations on what can be talked about and what kinds of help can be asked for or provided.

It appears that the practical and social sides of help are defined to be beyond the scope of the CRTs, first and foremost by the clinicians but also by service users and carers in terms of their expressed notion that this is "something the CRTs don't do." Thus, the arena for providing help has changed, but this thesis suggests that the content of the help can be argued to still be defined within a clinical paradigm.

7.2.   Helpful help—Inner or outer matter?

What is defined as helpful needs to be related to what it is intended to address. Helpful help can be defined as an "inner" matter, focusing on the cause and solution to mental distress in the individual, or it can be understood as an "outer" matter, focusing on the cause and solution in social, material, and economic conditions. It can, of course, also be understood as a combination of the two (Sanders, 2006). Based on the sub-studies of this project, it could seem that CRTs aim to draw on both these understandings with an outspoken intention of challenging and expanding the traditional focus on inner cause and approach to crisis and help through a holistic and contextual approach.

This thesis suggests that service users and carers appear to define helpful help in the context of their current lives and history. This does not mean that they do not define help as also being about tending to inner issues. As crises are often described and experienced as feelings of mental suffering, despair, and chaotic thoughts, helpful help is commonly associated with having someone to talk to in terms of being met and

listened to and having someone to sort and nuance one's thoughts with (Gudde et al., 2013; Winness, Borg & Kim, 2010). However, although experienced as inner issues, these issues also need to be understood as part of people's lives and history (Gullslett, Kim, Andersen, & Borg, 2016; Gwinner, Knox, & Brough, 2013). When inner understandings are placed and understood within the context of peoples' lives, the subjectivity and complexity of helpful help is revealed (Klevan, Davidson, Ruud, & Karlsson, 2016). As such, inner understandings without outer context lack color and nuance. This state of affairs also camouflages the fact that people are more than one thing; they develop, change, and vary in interplay with their surroundings. Within a person-centered understanding, it would appear to be crucial to contextualize inner causes and understandings of helpful help.

In this thesis, the help offered by the CRTs appeared to mainly concern "talking cure." The tendency that Norwegian teams mostly offer talk as help is also found in a new study by Ruud et al. (2016) that maps out practices in Norwegian CRTs. This extensive focus on talking as help partly seems to differ from CRT interventions in the UK that appear to also have a more practical side (Ruud et al., 2015). However, research exploring user satisfaction with CRTs in the UK also shows that service users often find that the help offered fails to meet their needs on several aspects of life and that some users experience the support given as too medically oriented (Mind, 2011).

As shown in several studies exploring service users and carers' needs in crisis, people's needs are diverse and multifaceted and commonly connected to their daily lives (Burns-Lynch et al., 2014; Gullslett, 2016). Desired help is often described as connected to family issues, social life, education, employment, and financial issues (Biringer, Davidson, Sundfør, Ruud, & Borg, 2016). However, service users often continue to be offered help that regards mental distress as more or less solely caused by inner matters

(Sanders, 2006). Hence, the task of the clinician will overly be understood as helping to mend these inner issues in order for people to be able to deal with outer issues in their lives in more useful ways.

A pressing question to ask would be why clinicians mainly continue to offer support aimed at the "inner causes" to mental distress when research also shows that outer issues can cause or worsen mental distress. As such, it is not automatically so that the inner distress causes outer difficulties and that working with the inner causes will repair the outer difficulties. Research by, for instance, Topor et al. (2016a) and Davidson et al. (2004) also indicates that it might be the other way around.

When clinicians still tend to focus principally on inside work, the answer to this might need to be sought other places than within research on "what works." Clinicians in mental health work within a discourse that mainly views mental distress as an inner matter. As such, assuming a more outside-oriented and social approach would represent a breach with the dominant discourse in education institutions and mental health organizations.

It can be argued that a persistent focus on inner causes of mental distress and, therefore, understanding help as attending to these inner causes maintains a risk of preserving social inequalities (Cooper, 2006; Proctor, 2006). The case that somebody is in charge of fixing what is broken inside of somebody else is also a part of this picture. When, as emphasized in this thesis, the outer causes are rarely addressed by CRTs as triggering, contributing to, or maintaining mental distress, service users are indirectly held accountable for their own distress. Proctor (2006) discusses whether therapeutic approaches often contribute to maintaining inequality through their excessive focus on

inner causes: "When therapists ignore the links between social inequalities and psychological distress, they serve the interests of privileged social groups rather than those of their clients" (p. 71).

It is a fact that people struggling with serious or recurrent mental distress often also struggle with social issues (Balmforth, 2006; Borg & Karlsson, 2013; Pilgrim, 2008). This affects their overall health and life expectancy and possibilities to engage in different social arenas and form relations with others (Topor, 2016a). When this is known and mental health services are reorganized to become more holistic, why do approaches from services like CRTs appear to remain mainly inner-focused?

7.2.1. Constructing or preserving identities

How people identify themselves and others as filling certain roles can also be understood as part of the picture (Hitzler, 2011). Being a CRT clinician implies being part of the specialist mental health services. In general, engaging in practical and contextual issues of people's lives in a mental health crisis will represent a breach of what clinicians regard their job as being about. It could include an experience of having to do the work that "someone else should do" as elaborated on in sub-study 3 of this thesis. Thus, constructing a professional identity is also about drawing boundaries between own areas of work and that of others (Klevan, Karlsson, Ness, Grant, & Ruud, 2016).

I sometimes have this feeling that, in clinical work, we are often more concerned about defining what is not our job (and, thus, is someone else's job) rather than defining what is our job. What is the worst thing that could happen if we did something that is not defined as our job? Would it necessarily make us less professional?

The content of the CRT work appears to be deficiently described and explored (Hubbeling & Bertram, 2012; Sjølie et al., 2010; Wheeler et al., 2015). Although it has been described as being about new and more collaborative and humane understandings and practices in mental health, it has not been clearly described what this actually implies. As such, in order to preserve an identity as a mental health worker, it might be natural for CRT workers to look to the mental health role that is already there and has been for decades—the role of the repairer of distress as inner-caused. Constructing a new mental health worker role appears to be challenging, and, thus, CRT workers run the risk of being pulled into the identities that align with the dominant institutional narrative. In this sense, professional identities can be understood as not first and foremost being something the clinicians choose, following an inner set of values and personal convictions. Rather, the developing professional identities within CRTs need to be understood as subsets of the institutional identities that are available in the context in which they are acted out (Hitzler, 2011; Juhila & Abrams, 2011).

The professional identities that are available to CRT workers can be understood as limited, and, thus, the kind of help offered may also be acted out within this limited framework. This is also likely to affect what service users and carers feel they can ask for. If mental distress is met with an overly "inside approach," this could cause service users to adapt this understanding of their problem and wish for support in order to coincide with the image the CRTs present. Thus, "What do you need from us," a question that CRT clinicians in this study claimed to ask service users and carers, might not evoke the variety of answers implied by the question. Rather, it could trigger answers that are intended to meet the possibilities that are perceived as available through how clinicians, service users, and carers identify the professional role and job and not what is desired in an ideal world. It could also be about how service users want to identify themselves or how they want to be perceived by others.

7.2.2. Available service user identities—A choice between two evils?

Though the practical and structural consequences and sides to mental health crises appear to be considerable in this PhD study, the shamefulness associated with not being able to cope, not having a job, or having to borrow money from relatives is also apparent (Klevan, Karlsson, & Ruud, in press). Being poor or unemployed can be associated with shamefulness and feelings of not belonging in a country like Norway where the general standard of living is relatively high (Fløtten, Hansen, Grødem, Grønningsæter, & Nilsen, 2011). Thus, it might be possible that focusing on the inner causes and help as attending to these can, in some cases, be easier than displaying that one's life is falling apart in several areas. Going into therapy can be argued to be associated with middle-class values; struggling with housing, work, and daily chores is not (Balmforth, 2006). Though several studies have explored the stigma of mental illness, the stigma of not living up to the middle-class standards of living may be less well explored (Gullslett, Kim, & Borg, 2014). This includes not only living standards but also ways of living and what is considered "quality of life." As such, the tendency to define "normality" as coinciding with white middle-class values does not only count for what is regarded as mentally healthy. Ways of living that deviate from the middle-class norm, be that willingly or unwillingly, may also be defined as "abnormal" and, thus, can be experienced as connected to shame and stigma (Proctor, 2006).

Focusing on and bringing the subjective stories of the marginalized to the fore can be argued to be an important social justice mission in research. If these stories of lived experiences are left more or less uninterpreted and unedited by researchers, they may be able to tell their own stories and not the stories that describe the normative or main tendencies (Frank, 2010; Grant, Biley, & Walker, 2011; Klevan, Davidson et al., 2016).

7.2.3.　Changing the person or changing the world?

Person-centered research and approaches have been criticized for leaving the context out (Borg & Karlsson, 2017; Cooper, 2006; Sanders, 2006). This PhD project elucidates the urgent need not only to focus on the person as the center of help to be provided but also to understand person-centered help as person-in-context-centered help. Sanders (2006) poses the question of the extent to which mental health workers are actually set up to focus on the outer world. It can also be questioned whether mental health workers view this to be within the scope of their job.

This thesis addresses the fact that it is timely to discuss why contextual approaches and understandings are so limited in mental health work. However, a contextual approach in a person-centered context, placing the individual in the center of the context, might also disguise the fact that mental health difficulties and how they are understood also need to be viewed in a larger, cultural context. Person-oriented and user-involving practices have also been criticized for obscuring social structure determinants of mental health problems with their excessive focus on the individual (Cooper, 2006; Pilgrim, 2008). Topor et al. (2016a) cite Wilkinson and Picket's statement (2009, p. 33) that the solution to poverty does not lie in "*mass psychotherapy aimed at making everyone less vulnerable*" but, rather, in reducing inequality among citizens. As such, addressing issues like inequality, unemployment, and poverty at a society level can be argued to be crucial in mental health work (Topor, Ljungqvist, & Strandberg, 2016a, 2016b).

There appears to be an increasing tendency in mental health work to focus on the individual as both the cause of mental distress and the target of helpful help. Mental health workers have moved away from the barricades and into the therapy room. It could be argued that, in order to alleviate mental distress at not only a person-centered level but also a people-centered level, people need to be recognized as part of society

and humanity (WHO, 2007). This implies the need to recognize civil rights and social justice as crucial parts of mental health work (Borg & Karlsson, 2013; Copper, 2006; Davidson, 2006).

Rather than placing the responsibility of recovering and becoming more in line with the norm for how citizens should behave at the individual level, mental health is also about troubling and exposing how the ways of the world contribute to distress at a personal level. A part of an uncomfortable truth is also that not only the individual can be blamed for mental distress, and, as such, changing the person might not be enough. Mental health work is also about changing the world.

7.3.   Helpful help or helpful control?

Through my career as a mental health worker, I have always aimed to focus on how parenting and family life are affected by a mental health crisis. Quite often, I have experienced having good and open dialogues with people on this subject. I have often found conversations on these subjects to entail an atmosphere of closeness and shared humanity. And now, as a researcher, people I've only met once commonly share very personal details about this subject with me, disclosing themselves in a manner I have rarely experienced before, saying "I haven't actually told anyone before" to the researcher, who is kind of nobody to them—and who is basically nothing but an ear. Maybe that is part of the clue?

As the title of this thesis indicates, help is not an unequivocal issue. It can be helpful or unhelpful; its helpfulness may vary depending on the eyes of the beholder, and it can be guided by diverse interests. Help within institutional frames is by no means politically neutral. The help is offered within a system that serves certain interests (Denzin & Giardina, 2008; Mearns, 2006). As such, help is also about economics and efficiency.

Help can be understood as about offering not what is experienced as best from a service user or professional perspective but what is presumably best, given the cost and time available. Thus, when clinicians in sub-study 3 of this PhD project discuss what they regard as helpful help, it is guided and constrained by the frames they work within and perhaps also by how they construct their own identities as helpers (Klevan, Karlsson et al., 2016).

Flyvbjerg (2001) argues that, by definition, phronetic research focuses on values and poses questions about power. Following Flyvbjerg, the following could be important questions to ask regarding helpful help: Who gains and who loses from current practices of help? Through what power relations are practices acted out? What possibilities are available to change these power relations? A challenge with help provided by mental health services is that help is commonly offered by the same instances that also prosecute control (Mearns, 2006). As such, there is a power imbalance that is prone to cause a barrier between the helper and the helped. The help is not only provided as an act of humanity; it is also enacted on behalf of a control instance. The understanding of help as social control is not new. According to Foucault (2005/1972), the introduction of apparent humanism in the care of the "mad" at the end of the 18th century also brought social control through guilt and morality into the asylum. Though "the mad" were freed from their physical chains, a subtler form of enchainment occurred through sanctioning of behaviors and actions that were considered to deviate from the common morality and norms for behavior. As such, the asylums served as effective means for excluding those who did not conform to the current ideas of rationality and normality.

It could seem that the understanding of mental distress and practices of help have changed vastly and that the great exclusion described by Foucault is history. Through the de-institutionalizing and democratizing of mental health that has been going on over

the past three to four decades, practices and language of help in the field of mental health have changed. We now often talk about mental health rather than psychiatry, implying that mental health is something more than biomedical issues. The term "mental health" can also be argued to give an impression of something that is more universal, applying to all human beings as "everybody has mental health." The normalizing of mental health and the arising concept of recovery as an important target of helpful help can be argued to have taken some of the edge off the discussion of mental health services offering support in a borderland between help and control (Grant, 2014; Landheim, Wiig, Brendbekken, Brodahl, & Biong, 2016; Mearns, 2006).

However, the understanding and content of recovery can be discussed. Originally rooted in service user movements, the term and its contents have been increasingly adopted by professionals (Lavallee & Poole, 2010; Thornton & Lucas, 2011). Mental health services today often claim to have a recovery-oriented approach (Borg, Karlsson, & Stenhammer, 2013; Tickle et al., 2014). Service users and carers commonly express that they value recovery-oriented approaches, referring to important aspects of the help being focusing on goals and opportunities rather than deficits and disabilities and taking social and contextual issues into account (Burns-Lynch et al., 2014; Edgley, Stickley, Wright, & Repper, 2012; Grant & Westhues, 2012).

However, there are also voices that are critical to the concept of recovery, suggesting that it appears to have been adopted by professionals, and, thus, its content runs the risk of being standardized and assimilated (Edgley et al., 2012; Pilgrim, 2008). There is an expressed concern that the concept of recovery runs the risk of being colonized (Lavallee & Poole, 2010). According to Thornton and Lucas (2011), recovery can be argued to be a value-based concept as the goal of it is commonly connected to well-being and quality of life. Within a recovery and person-oriented understanding of

distress and help, it might seem apparent that the person experiencing the distress is to define which values should decide well-being and quality of life in his or her unique case. Although understandings of help related to recovery during recent years have increasingly emphasized the need to regard recovery as a personal and social process and not an outcome, recovery is still related to ideas of obtaining a good life (Davidson, Tondora, & Ridgway, 2010; Landheim et al., 2016). As such, it is timely to question what can happen to the understanding and content of the concept of recovery if its ownership and definition are moved away from the service user to professionals. If the definition power is in the hands of the "normal" and well adapted, will there be room for "the mad" within the concept of recovery? Or will understandings of well-being and quality of life be related to norms stated by professionals and "the normal"?

A possible colonization of the understanding and content of recovery might be difficult to reveal. The language used within recovery-oriented mental health services commonly works on humanistic and person-oriented values, as, for instance, elucidated in this thesis' sub-study 3. In all its humanity and good intentions, this language and these values may be hard to criticize. Nonetheless, it may conceal that services are still heavily influenced by more biomedical and neo-liberalistic understandings and practices (Grant, 2015; Karlsson, 2015; Pilgrim, 2008; Tickle et al., 2014). Although mental health workers in CRTs may both express and intend to work in line with humanistic and recovery-oriented values, there appears to be a tendency for distress, help, and recovery to still correspond with the assumptions of the dominant institution culture (Klevan, Karlsson et al., 2016; Smith & Grant, 2016).

Even though mental health services have arguably gone a long way in providing more collaborative services, based in the needs of service users and their near ones, there appears to be little reason to rest assured that "everything is now fine." There appears

to be a constant need to critically examine and reflect upon the possible risks that the underlying intentions of help are masked by a sugar glazing of humanity.

7.4.   Methodological considerations

"You need to use a proper method," someone told me in the earlier days of this project, suggesting that I should use a method that was well described and carried out by others before me. This would increase the validity of the study.

Qualitative research methodology can be argued to be pulled between at least two main and somehow contradictory traditions. While, on the one side, many qualitative researchers argue for the need to follow rigorous, step-by-step approaches when conducting analysis, there is also an emerging tendency to criticize such approaches, arguing that they tend to quantify qualitative research. Rather than striving towards validity measures developed for quantitative research, qualitative research should be conducted and valued for its explicit qualitative value, such as subjectivity, richness, and context-sensitivity (Denzin, 2014; Denzin & Giardina, 2008; Flyvbjerg, 2001; Grant, 2016; Polkinghorne, 2006).

This thesis adheres to the latter tradition. In a project that rests on onto-epistemological assumptions of the world as made and interpreted, the troubling and expanding of a normative methodology became natural. Although the project may be criticized for not following a "proper methodology" with clear and consistent rules and steps, it has been my aim throughout the project to make my actions, choices, reflections, and collaboration with others as transparent as possible. Part of these procedures has included making me as a researcher and person visible throughout the project. Though the subjectivity of the researcher is commonly regarded as bias, it is only so if we regard the self as an autonomous phenomenon. However, if the self of the researcher is regarded as relational and inscribed within a culture, the subjectivity of the researcher becomes a necessary means for showing how culture flows through the self and vice

versa. As such, this project assumes that it is not possible to research on a reality separated from the self, and, thus, making the process transparent is a way of incorporating the reader in the reasoning and understanding of the researcher (Grant, 2010; Short et al., 2013). These attempts toward transparency can be argued to enhance the validity of the project.

Perhaps more appropriate terms than validity in this project are credibility and connectedness. The bottom line is that it could be argued that all research is a matter of communicating a message to others that is perceived as credible. In several branches of qualitative research, it is acknowledged that we connect with people not only through rationally acquired information but also through evocative accounts that connect with people's feelings (Grant, 2016; Short et al., 2013). As such, an aim of this project has not been to *tell* people about the truth but to provide rich descriptions and suggest possible interpretations of "the truth" that also enable people to make their own interpretations and decisions about credibility and possible transferability (Creswell, 2013).

7.5.   Implications for practice and further research

The intention of this project has not been to present findings that can be generalized. On the contrary, it has been an important aim to develop subjective and contextual knowledge that, in itself, speaks against the possibility of generalizing knowledge of human experiences. However, the knowledge that has been developed though this project makes it possible to point to some suggested implications for clinical practice and research.

7.5.1.   Implications for clinical practice

The need for holistic, person- and recovery-oriented, and contextual understandings and approaches to mental distress have been advocated by mental health decision makers, clinicians, service users, and carers over the past three decades (Hummelvoll,

Karlsson, & Borg, 2015; Norwegian Directorate of Health, 2014b). The introduction and development of CRTs in Norway can be understood as part of this attempt to introduce a more humanistic paradigm within mental health, concerning both understanding and practices.

This thesis elucidates that the help that is perceived as helpful by service users and carers is closely connected to the contexts people are part of. Though it is possible to find common themes that encapsulate essential features of helpful help, it appears that it is when we also consider the personal context that these features are given meaning. This speaks to the necessity of introducing a far more context-oriented approach in the further development of CRT practices and the understanding of helpful help. This includes not only the actual practices of help but also exploring how mental health crises are experienced.

Following a checklist for, for instance, assessing suicide risk and determining the need for support runs the risk of being inadequate if the subjective context of both service user and carers is not taken into consideration. In attempting to understand what helpful help is and to develop help that is perceived as helpful, CRTs need to shift focus away from individual and internal understandings of crisis and help to more contextual understandings. This involves not only having a family and network approach but also being oriented towards how, for instance, economics, housing, and employment affect people's lives and mental health. Rather than having an overly "talking cure" approach to mental distress, practical and contextual issues also need to be emphasized. If such a contextual approach were actually to be carried out, it would imply questioning whether it is altogether possible to work in a context-sensitive manner in a CRT and specialist mental health service context. This might also imply looking behind and troubling how clinicians talk about and understand helpful help in mental health crises. The language

and discourse that seem to be used to describe how CRT clinicians understand helpful help partly appear to betray a traditional technological understanding of mental distress and help that still seems to constitute a large part of actual practices.

7.5.2. Implications for further research

This section often describes how more research is needed on the subject. In this thesis, this can be assumed as a statement with modifications. This does not mean that the thesis describes the final truth concerning helpful help. However, this study partly confirms already existing knowledge that helpful help also includes focusing on the context that people are part of (Borg & Davidsson, 2008; Borg & Karlsson, 2013; Borg & Topor, 2003; Topor, 2014; Topor et al., 2016b). As such, this thesis does not necessarily suggest that more research is needed on this subject to confirm that it is so. However, the thesis indicates that more research is needed to explore the divide between the outspoken intentions of help as expressed by clinicians, what service users and carers desire, and what they experience that they are currently being offered.

A recent mapping on Norwegian CRTs shows that the teams work home based to a limited extent, they do not offer intensive treatment, and practical support is rarely offered (Ruud et al., 2016). This diverges from the intentions behind the development of CRTs. There is a need for research on how intentions of developing more collaborative, humanistic, and recovery-oriented services that are commonly described in guidelines actually affect and change the experiences of service users, carers, clinicians, and decision makers and what contributes to the promoting or hindering of the development of these desired practices. Furthermore, there is a need to develop knowledge on what promotes and hinders the development of services that coincide more with how service users and carers define and understand helpful help.

The thesis also elucidates the necessity of researching people's subjective experiences in context-sensitive ways. As such, the thesis suggests some possible limitations in strictly following methodological and representational normativity in conducting and presenting qualitative research. Implications for further research include not only what needs to be researched but also how this can be done. It is not only the findings presented in this thesis that have "been found"; the ways these findings have been generated are also to be considered a finding. Thus, how findings are entwined with how the research is conducted is a field that calls for further exploration in order to challenge the idea that we are able to find the one and only truth.

8. Concluding comments

The title of this section is perhaps misleading. This is not a conclusion per se. As the methodology and findings of this study suggest, what we find and how we find it are better understood as processes. As commonly assumed in qualitative research, truth is a multiple issue, and qualitative research can only aim to elucidate certain parts of reality. What is found through qualitative research should not be regarded as hard facts about a stable and finalized reality. Rather, it suggests how certain parts of the world may be understood.

The aim of this PhD project was to explore helpful help in mental health crises from the perspectives of service users, carers, and CRT clinicians. As the project evolved, not only the experiences but also ways of exploring and the role of the researcher in that process have been explored. This thesis has hopefully contributed in shedding light on how truth, methodology, and the researcher are intrinsically entwined and, as such, contribute to the becoming and making of each other.

Through this multi-perspectival, multi-methodological, and partly autoethnographic-inspired thesis, some of the complexity of exploring and understanding helpful help have been pointed out. Though several aspects of help, the helped, and the helper are

explored, what stands out as an overarching finding is how helpful help appears to be inexorably contextual. When deprived of both the close and personal or more remote contexts, helpful help is drained of content and meaning. Moreover, this exploring and understanding of help as evidently contextual reveals that a tendency towards the opposite is often the case within CRTs. Despite good intentions, the dominant understanding and definition of help still appears to mainly concur with a biomedical and individualized one. Though services like CRTs are organized in manners that appear to be suitable for a contextual approach, there appears to be a gap between how service users and carers on the one side and clinicians on the other understand helpful help. This thesis suggests the need for a flexible, unfinalized, and person-in-context-oriented understanding of helpful help.

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Appendix 1-3
Papers omitted due to
publisher's restrictions

Appendix 4:

Interview guide, service users

(in Norwegian)

Ambulante akutteam i Norge 2012: Praksis og erfaringer

Fase 1 – Guide for intervju med brukere

Deltaker ID-nummer:

Hvilket AAT:

Dato for intervjuet:

Kjønn
- ☐ 1 Mann
- ☐ 2 Kvinne

Aldersgruppe
- ☐ 16-24
- ☐ 25-34
- ☐ 35-44
- ☐ 45-54
- ☐ 55-64
- ☐ 65+

Etnisk bakgrunn

☐ 1 Hvit norsk
☐ 2 Hvit skandinavisk
☐ 3 Hvit andre

Farget/Farget norsk
☐ 4 Karibisk
☐ 5 Afrikansk
☐ 6 Farget andre

Asiatisk/Asiatisk norsk
☐ 7 Indisk
☐ 8 Pakistansk
☐ 9 Bangladesh
☐ 10 Asiatisk andre

Blandet
☐ 11 Hvit/Farget karibisk
☐ 12 Hvit/Farget afrikansk
☐ 13 Hvit/Asiatisk
☐ 14 Andre blandet

Kinesisk eller andre
☐ 15 Kinesisk
☐ 16 Annen etnisk gruppe

Antall ganger den intervjuede har benyttet seg av AAT:

Hvor lenge er det siden siste kontakt ble avsluttet?

Erfaringer med innleggelser, hovedsakelig i psykiatrisk sykehus (J/N):

Hvor lenge er det siden siste innleggelse ble avsluttet?

Har intervjupersonen for øyeblikket en individuell koordinator?

Aktuell diagnose
- ☐ Ikke kjent
- ☐ Psykose
- ☐ Bi-polar lidelse
- ☐ Depresjon eller angst
- ☐ Personlighetsforstyrrelser
- ☐ Andre (vennligst beskriv nærmere)

Intervjuguide – brukere

*I dette intervjuet er det fint om du først og hovedsaklig forteller om dine erfaringer fra din **siste** kontakt med AAT. Til sist i intervjuet vil vi spørre deg om dine andre og tidligere erfaringer med bruk av AAT.*

1a. Hvordan kom du i kontakt med teamet når du trengte hjelp?
1b. Kunne noe gjort det enklere for deg å komme i kontakt med teamet?
Underpunkter:
- Hvor enkelt var det å finne informasjon om hvordan du kunne få hjelp?
- Hvordan ble din første kontakt med teamet organisert? Var andre tjenestetilbud involvert? (f.eks. fastlege, kommunale psykisk helsetjenester, andre?)
- Hvor raskt fikk du respons fra teamet?
- Fikk du tilbud om alternativer til AAT? (I så fall hvilke? Var de til hjelp?)

2. Hva var de viktigste delene i hjelpen du fikk fra teamet?

3. Hva synes du om den hjelpen du fikk fra teamet?
Underpunkter: Hva synes du om:
- Å være hjemme i stedet for å dra til sykehuset?
- At det hovedsakelig var de samme fagpersonene du fikk besøk av ved ulike anledninger?
- At fagpersonene virket å ha den korrekte informasjonen om deg og dine behov og ønsker?
- At avtalene med deg fant sted når du forventet dem, og til riktig tid?
- Tidspunktene og stedene for avtalene med AAT?
- Hvem som besøkte deg? (Fagpersonenes profesjoner, kjønn og etnisitet)?
- Tiden fagpersonene tilbrakte sammen med deg og lengden av besøkene?
- Lengden på kontakten du hadde med teamet?
- Måten fagpersonene fremsto når de møtte deg (f.eks. høflighet, respekt, forståelse, behandlet de deg med likeverdighet, vennlighet, virket de stresset på tid)?
- Hvordan involverte teamet din familie og dine venner?
- Om den hjelpen du fikk (hva gjorde teamet når de var sammen med deg og hvilke former for hjelp fikk du; medikasjon, ikke-medikamentelle tilbud, praktiske hjelp etc)?
- Muligheter for videre hjelp eller behandling fra teamet?

4. Hva synes du var mest nyttig i hjelpen fra AAT?

5. Hva synes du var minst nyttig i hjelpen fra AAT?
Underpunkter:
- Var det noen former for hjelp du helst ikke ville ha blitt tilbudt?

6. Hvilke, hvis noen, former for hjelp ville du helst ha hatt?

7a. Hvilke kontakter, hvis noen, hadde teamet med andre former for tjenestetilbud (f. eks. fastlege, kommunale psykiske helsetjenester)?
7b. Til hvor mye hjelp var teamets kontakter med andre tjenestetilbud?
Underpunkter:
- Var det felles besøk med fagpersoner fra andre tjenestetilbud sammen med teamet? I så fall, hvor nyttig var dette for deg?
- Hvilke andre tjenestetilbud burde teamet ha samarbeidet med?
- Ble det klargjort hvilke andre tjenestetilbud teamet ville dele sin informasjon med?
- Ble du spurt om hvilke andre tjenestetilbud du ville at teamet skulle kontakte?

8a. Hva syntes du om måten teamet avsluttet kontakten med deg?
8b. Kunne noe vært gjort annerledes og bedre i måten teamet avsluttet samarbeidet med deg?
Underpunkter:

- Avsluttet teamet kontakten med deg etter en forhåndsbestemt tidsperiode?
- Hvilke avtaler ble gjort etter at kontakten var avsluttet? (Var det muligheter for hjelp fra teamet også etter at kontakten var avsluttet? Var det avklart hva som skulle skje videre etter avsluttet kontakt?)
- Hadde du noen valg og innflytelse på når kontakten med teamet skulle avsluttes?

9 Totalt sett, hva betydde mest for den hjelpen du fikk i den aktuelle krisen?

10 Er det noe annet du vil si om hvordan hjelpen fra teamet kan forbedres?

(For informanter som har erfart mer enn en kontakt med et AAT)

11a) Vennligst fortell om andre og viktige erfaringer du har hatt med samarbeid og hjelp fra et AAT.

11b) Hva gjorde den viktigste og største forskjellen i hvor nyttig hjelpen fra teamet var?

(For alle informanter)

12a) Ville du har vært interessert i andre former for hjelp i den tiden du var i kontakt med teamet som kunne ha hjulpet deg i din bedringsprosess og forhindret fremtidige kriser?

12b) I så fall, hvordan ville det ha vært for deg å møte en utdannet person som også hadde egne erfaringer med bruk av psykisk helsetjenester?
Underpunkt:

- **Kan du beskrive hvilke forskjeller det kunne ha gjort om hjelpen du får blir tilbudt av personer med egen erfaring eller fagpersoner?**

12c) Hvordan skulle denne formen for hjelp bli tilbudt deg på en best mulig måte?
Underpunkter:

- Når skulle hjelpen tilbys? Ved slutten av kriseperioden, like etter at kontakten med teamet var avsluttet, eller noen uker eller måneder senere?)
- Hvor skulle denne finne sted? (Hos teamet, at noen kommer hjem til deg, andre steder?)
- Hvilke personer skulle tilby slik hjelp? (Er det best at det er personer med egen erfaring som tilbyr denne hjelpen? Hvem kan gjøre det best – personer som selv har benyttet AAT? Personer som har opplevd samme form for krise som deg?)
- Hva skulle hjelpen inneholde? (Skulle den være veldig strukturert eller mer uformell? Hva skulle den inneholde: hovedsaklig en person som lytter og deler erfaringer med deg? Hjelper deg å sette mål, identifisere tegn på en krise som kan komme, strategier som kan hjelpe deg til å unngå en krise? Hjelp med praktiske problemer?)
- Hvordan kan denne hjelpen best organiseres? (I gruppe, en til en eller en blanding av begge former? Bruk av nettbaserte tilbud: "spør en ekspert", en chattelinje, en nettbasert plan for å forhindre en krise? Andre forslag?)

Intervjuguide – brukere

Appendix 5:

Interview guide, carers

(in Norwegian)

Ambulante akutteam i Norge 2012: Praksis og erfaringer

Fase 1 – Intervjuguide for pårørende

Deltaker ID-nummer.:

Hvilket AAT:

Intervjudato:

Kjønn
☐ 1 Mann
☐ 2 Kvinne

Informantens aldersgruppe
☐ 16-24
☐ 25-34
☐ 35-44
☐ 45-54
☐ 55-64
☐ 65+

Etnisk bakgrunn

☐ 1 Hvit norsk
☐ 2 Hvit skandinavisk
☐ 3 Hvit andre

Farget/Farget norsk
☐ 4 Karibisk
☐ 5 Afrikansk
☐ 6 Farget andre

Asiatisk/Asiatisk norsk
☐ 7 Indisk
☐ 8 Pakistansk
☐ 9 Bangladesh
☐ 10 Asiatisk andre

Blandet
☐ 11 Hvit/Farget karibisk
☐ 12 Hvit/Farget afrikansk
☐ 13 Hvit/Asiatisk
☐ 14 Andre blandet

Kinesisk eller andre
☐ 15 Kinesisk
☐ 16 Annen etnisk gruppe

Intervjuer: Vennligst forsøk ved starten av intervjuet å bruke en fast betegnelse for den personen som informanten har en omsorgsrelasjon til (f.eks. din sønn/datter, din venn, din kone/mann) og bruke betegnelsen gjennom hele intervjuet.

Relasjon til den personen du har omsorg for:

Bor du sammen med denne personen (J/N):

Hvor mange ganger har personen du har omsorg for benyttet AAT:

Hvor lenge siden er det den siste kontakten med AAT ble avsluttet?

Har personen du har omsorg for noen gang(er) vært innlagt i et psykiatrisk sykehus (J/N):

Hvor lenge siden er det den siste innleggelsen i psykiatrisk sykehus ble avsluttet?

Har personen du har omsorg for en individuell koordinator for øyeblikket?

Intervjuguide – pårørende

Hva er den aktuelle diagnosen til personen du har omsorg for?
☐ Vet ikke
☐ Psykose
☐ Bi-polar lidelse
☐ Depresjon eller angst
☐ Personlighetsforstyrrelse
☐ Andre (vennligst beskriv)

I dette intervjuet ønsker vi at du først forteller om den <u>siste</u> perioden hvor personen du har omsorg for har hatt kontakt med et AAT. Avslutningsvis i intervjuet vil vi spørre deg om andre og tidligere erfaringer med teamet.

1a. Hvordan kom du, eller personen du har omsorg for, i kontakt med teamet når dere trengte hjelp?
1b. Kunne noe ha gjort det enklere å komme i kontakt med teamet?
Underpunkter:
- Hvor lett var det å finne informasjon om hvordan få hjelp?
- Hvordan ble den første kontakten med teamet organisert? Var andre tjenester involvert ? (f.eks. fastlege, kommunale psykiske helsetjenester?)
- Hvor rask var responsen fra teamet?
- Ble det tilbudt alternativer til AAT? (Hvilke? Hvor nyttige var de?)

2. Hva var de viktigste formene for hjelp som teamet tilbød personen du har omsorg for?

3. Hva synes du om den hjelpen personen du har omsorg for fikk fra teamet?
Underpunkter: Hva synes du om:
- Å være hjemme i stedet for å dra til sykehuset?
- At det hovedsakelig var de samme fagpersonene som kom på besøk av ved ulike anledninger?
- At fagpersonene virket å ha den korrekte informasjonen om personen du har omsorg for og dennes behov og ønsker?
- At avtalene fant sted når dere forventet dem, og til riktig tid?
- Tidspunktene og stedene for avtalene med AAT?
- Hvem som besøkte dere? (Fagpersonenes profesjoner, kjønn og etnisitet)?
- Tiden fagpersonene tilbrakte sammen med dere og lengden av besøkene?
- Lengden på kontakten personen du har omsorg for hadde med teamet?
- Måten fagpersonene fremsto når de møtte dere (f.eks. høflighet, respekt, forståelse, behandlet de dere med likeverdighet, vennlighet, virket de stresset på tid)?
- Om den hjelpen dere fikk (hva gjorde teamet når de var sammen med dere og hvilke former for hjelp fikk dere; medikasjon, ikke-medikamentelle tilbud, praktiske hjelp etc.)?
- Muligheter og råd for videre hjelp eller behandling fra teamet?

4. Hvilken hjelp fikk dere fra teamet?
Underpunkter:
- Møter med fagpersoner som var involvert i samarbeidet med personen du har omsorg for (for deg selv eller sammen med person du har omsorg for?
- Fikk du informasjon (om tilstanden eller behandlingsplan for personen)?
- Ble du spurt om dine synspunkter (f. eks. om hvordan personen var eller dennes behov)
- Ble du involvert i avgjørelser som ble tatt (f.eks. om behandlingsplan eller fremtidige planer)?
- Praktisk hjelp eller støtte til deg som omsorgsperson?
- Følelsesmessig støtte til deg som omsorgsperson?
- Familiesamarbeid/familieterapi? (Møter eller terapeutiske møter som kunne bidra til å arbeide med relasjoner og samhandling mellom dere som familie)

Intervjuguide – pårørende

5. Hva synes du var mest nyttig i hjelpen fra teamet?

6. Hva synes du var minst nyttig i hjelpen fra teamet?
Underpunkt:
- Var det noen former for hjelp, du eller personen du har omsorg for ønsket, som teamet ikke kunne tilby?

7. Hvilke former for hjelp, om noen, kunne ha forbedret tilbudet dere mottok fra teamet?
Underpunkt:
- Hvilke, om noen, former for hjelp kunne du ha ønsket fra teamet? Enten til deg selv eller personen du har omsorgen for?

8a. Hvilke(n), hvis noen, kontakt og samarbeid hadde teamet med andre tjenestetilbud i relasjon til personen du har omsorg for (f.eks. fastlege, kommunale psykiske helsetjenester)?
8b. Hvor nyttig var kontakten teamet hadde med andre tjenestetilbud?
Underpunkter:
- Var det felles besøk med fagpersoner fra andre tjenestetilbud sammen med teamet? I så fall, hvor nyttig syntes du dette var?
- Hvilke andre tjenestetilbud kunne teamet ha hatt et samarbeid med?
- Ble det klargjort hvilke andre tjenestetilbud teamet ville dele sin informasjon med?
- Ble du spurt om hvilke andre tjenestetilbud du ville at teamet skulle kontakte?
- Ble personen du har omsorg for spurt om hvilke tjenestetilbud denne ville at teamet skulle kontakte?

9a. Hvordan vurderer du måten teamet avsluttet kontakten med personen du har omsorg for?
9b. Kunne noe har vært gjort annerledes og bedre i måten kontakten med personen du har omsorg for ble avsluttet på?
Underpunkter:
- Avsluttet teamet kontakten med dere etter en forhåndsbestemt tidsperiode?
- Hvilke avtaler ble gjort etter at kontakten var avsluttet? (Fantes det muligheter for hjelp fra teamet også etter at kontakten var avsluttet? Var det avklart hva som skulle skje videre etter avsluttet kontakt?)
- Hadde personen du har omsorg for noen valg og innflytelse på når kontakten med teamet skulle avsluttes?
- Ble du spurt om når teamet skulle avslutte sine tilbud om hjelp?

10. Totalt sett, hva er viktigst i den hjelpen som tilbys i en akutt psykisk krise?

11. Er det noe annet du vil si om hvordan hjelpen fra et AAT kan gjøres bedre?
- I henhold til den hjelpen person du har omsorg for, får?
- Hvordan teamet involverer og støtter personens familie og/eller venner?

(For pårørende som har erfaringer med mer enn en kontakt med et AAT)

12a) Vennligst fortell om noen andre og viktige erfaringer du har med hjelp fra et AAT.
12b) Hva gjorde den viktigste og største forskjellen i hvor nyttig hjelpen fra teamet var?

Intervjuguide – pårørende

Appendix 6:

Interview guide, clinicians

(in Norwegian)

Ambulante akutteam i Norge 2012: Praksis og erfaringer

Fase 1 – Fokusgruppeintervju med fagpersoner og fageksperter

Dato:

Deltaker ID-nummer:

Jobbtitler:

Team:

Helseforetak:

Kjønn
- [ ] 1 Mann
- [ ] 2 Kvinne

Aldersgruppe
- [ ] 16-24
- [ ] 25-34
- [ ] 35-44
- [ ] 45-54
- [ ] 55-64
- [ ] 65+

Etnisk bagrunn
- [ ] 1 Hvit norsk
- [ ] 2 Hvit skandinavisk
- [ ] 3 Hvit andre

Farget/Farget norsk
- [ ] 4 Karibisk
- [ ] 5 Afrikansk
- [ ] 6 Farget andre

Asiatisk/Asiatisk norsk
- [ ] 7 Indisk
- [ ] 8 Pakistansk
- [ ] 9 Bangladesh
- [ ] 10 Asiatisk andre

Blandet
- [ ] 11 Hvit/Farget karibisk
- [ ] 12 Hvit/Farget afrikansk
- [ ] 13 Hvit/Asiatisk
- [ ] 14 Andre blandet

Kinesisk eller andre
- [ ] 15 Kinesisk
- [ ] 16 Annen etnisk gruppe

Profesjonell bakgrunn:
- [ ] Sykepleier
- [ ] Sosialt arbeid (Sosionom/barnevernspedagog/vernepleier)
- [ ] Ergoterapeut
- [ ] Psykolog/Klinisk psykolog
- [ ] Medisiner
- [ ] Andre (vennligst beskriv nærmere):

For fagpersoner i helseforetaket:

Hvor mange år har du arbeidet i helseforetaket?

Hvor mange år har du arbeidet i teamet?

Hvor mange år har du arbeidet i det tjenestetilbudet du i dag arbeider i?

Intervjuguide – fagpersoner og fageksperter

1. Hva er de viktigste karakteristika på et godt AAT og deres tjenestetilbud?

2. Hva er de viktigste effektene av et AAT?
Underpunkter:
- *Økonomien i helseforetaket/DPS'et?*
- *Innleggelser i psykiatriske sykehus (Antall innleggelser, antall sengedøgn)?*
- *Selvmord? Reduksjon i antallet selvmord?*
- *Kliniske forbedringer?*
- *Pasientenes erfaringer? Pårørendes erfaringer?*

3. Hvilke faktorer fremmer og hemmer implementering av gode praksiser i AAT?
Underpunkter:
- *Ressurser og teamets kompetanse?*
- *Fagpersonenes ferdigheter og utdanning?*
- *Eksterne forventninger om å ta imot henvisninger?*
- *Kontinuitet i tilbudet om hjelp? (Innen teamet og mellom tjenestetilbud).*

4. Hvordan kan AAT optimalisere brukernes og pårørendes erfaringer med tilbudet?
Underpunkter:
- *Hvilke områder av tjenestetilbudet er best evaluert av brukere og pårørende?*
- *Hvordan kan synspunktene fra brukere og pårørende bidra til teamets tjenester og utviklingen tilbudet?*

5. Hvem skal teamet ta i mot som brukere?
Underpunkter:
- *Hvem bestemmer at teamet skal ta i mot en person som pasient?*
- *Hvilke eksklusjonskriterier brukes? (Personlighetsforstyrrelse, aldersgrupper)*
- *Farlighets- og/eller symptomvurdering som avgjørende for innleggelse eller hjelp fra teamet?*
- *Er personens problemer er så omfattende at de bør innlegges i sykehus eller snart vil antas å være i et slikt behov av hjelp uten intensiv behandling?*
- *Hvor samarbeidende eller villige til å samarbeide må pasienten være for å få tilbud om hjelp fra teamet?*
- *Hvilke gatekeeping funksjoner finnes? (Er det nødvendig at et teammedlem møter pasienten personlig før inntak/henvisning, eller kan dette gjøres på telefon? Deltar teammedlemmer i alle former for henvisninger om akutt psykisk helsehjelp i DPS'et)?*

6. Hvordan skal brukere kunne henvende seg til AAT for å be om hjelp?
Underpunkter:
- *På hvilke måter skal henvisinger kunne aksepteres? (Fra personen selv, pårørende, kommunale psykiske helsetjenester?)*
- *Hvor bør det første møtet finne sted?*
- *Hvem bør delta i det første møtet? (F. eks. et felles møte med henviser(e)).*
- *Hvordan bør teamets tjenestetilbud bli annonsert til andre profesjonelle og brukere?*

7. Hvordan bør AAT være organisert?
Underpunkter:
- *Åpningstider? (Tilgjengelige og ambulante fagpersoner eller bare telefonkontakt om natten)?*
- *Tverrfaglig sammensetning?*
- *Spørsmål knyttet til organisering og ledelse?*
- *Antall fagpersoner i teamet? (Basert på et totalt antall saker (caseloads) i teamet eller knyttet til hvert enkelt teammedlems arbeidsmengde)?*
- *Arbeide i team eller som individuelle fagpersoner?*

Intervjuguide – fagpersoner og fageksperter

8. Hvordan skal teamet samarbeide med andre kommunale tjenester?
Underpunkter:
- *Samarbeid med akuttavdelinger? (Tilstedeværelse på inntaksmøter? Felles bruk av personalet? Felles ledelse?) Mottaksenheter?*
- *Klinisk samarbeid med andre tjenestetilbud: kommunale psykiske helsetjenester? Mottakstjenester i kommunene? Felles møter med andre involverte tjenester ved start og avslutning av tilbudet fra teamet: alltid eller under hvilke omstendigheter?*
- *Samlokalisering med andre tjenestetilbud?*

9. Når skal pasienter bli utskrevet fra teamet?
Underpunkter:
- *Tidsbegrenset tilbud?*
- *Pasientens eget valg?*
- *Reduksjon eller bedring knyttet til målbare endringer av symptomer eller farer?*
- *Bør behov for oppfølging (F. eks. tilbud fra kommunale psykiske helsetjenester) være på plass før kontakten med teamet avsluttes?*

10. Hvilke former for kliniske tjenestetilbud bør teamet tilby?
Underpunkter:
- *Er det en form eller modell for hjelp som bør benyttes?*
- *Pasientens egne valg bør være bestemmende?*
- *Hvilke er de mest sentrale intervensjoner et team bør kunne tilby?*
- *Er det spesielle former for intervensjoner et team ikke bør delta i eller tilby?*

11. Er det andre forhold du vil legge til knyttet hva som kan være et teams "best practice" og hvordan dette kan oppnås?

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