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DAGMAR NARUSSON

Personal-recovery and agency-enhancing client work in the field of mental health and social rehabilitation: Perspectives of persons with lived experience and specialists

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AUTHOR'S CONTRIBUTION

STUDY I: is a study fully initiated and designed by the author. The author is fully responsible for the manuscript.

STUDY II: was initiated, designed and the data was collected by the author, also theoretical framework, results and discussion was written by author. The author consulted about the text with the co-author and consulted with the supervisor about the changes in the discussion section based on reviewer's suggestions.

STUDY III: was initiated together with the co-author. The author designed the study, and analyzed the study material. Data were derived from the Study II material. The author wrote the study results and discussion. The author consulted about the text with the co-author and supervisor.

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TERMS USED IN THE INTRODUCTORY ARTICLE

Agency – the human ability to intentionally influence one's functioning and life circumstances, including the ability to hold forethoughtful perspectives, to self-regulate, self-reactiveness, the ability to construct appropriate courses of action and regulate their execution, and also to engage in self-reflectiveness with the metacognitive capability to reflect upon oneself and the adequacy of one's thoughts and actions (Bandura, 2006: 164).

Autonomy – a state in which the person feels initiative and stands behind what he or she does; people are most autonomous when they act in accordance with their authentic interests or integrated values and desires (Chirkov et al., 2003: 98).

CHIME framework – five recovery process categories comprising **C**onnectedness, **H**ope and optimism about the future, **I**dentity, **M**eaning in life and **E**mpowerment, developed on the bases of systematic review and the modified narrative synthesis of personal recovery researches by Leamy et al. (2011: 448–551).

Dialogue: the open dialogue approach – is generated by the way in which all participants respond to each other (rapid response) and characterized by responding as fully embodied persons with voices that represent their (professional; knowledge-based) expertise as well as their personal and inner voices, through which new perspectives may occur; "the words emerging in the present moment might represent difficult experience for the help-seekers, but when participants hear own voices and feel invited to express own understanding, they may become respondents to themselves, experience being taken seriously, may become more interested in others' experiences" and motivated to maintain dialogue until genuine changes can occur (Holmesland et al., 2014: 433–434).

Disability – "results from the interaction between a person with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others" (Convention on the Rights of Persons with Disabilities (CRPD), 2006: Article 1); *impairment* – problems in body function or body structure, such as a significant deviation or loss; *body functions* – physiological functions of body system; *body structures* – anatomical parts of the body, such as organs; defining disability as an interaction means that "disability" is not an attribution of the persons (WHO ICF, n.d.; WHO, 2011: 3–5).

Dynamic patterns of client work – a dynamic partnership that assumes an appropriate interactional mode identified by the professional, based on persons' autonomy, knowledge level, and taking into consideration a "person's desire, willingness and ability to change their state of autonomy and knowledge over time"; successful partnership is a non-hierarchical collaboration where both parties share decision-making and responsibility (Verkaaik et al., 2010: 979–984).

Long-term somatic illness – "health conditions that cannot, at present, be cured, but can be controlled by medication and other therapies" (Roddis et al., 2016, Department of Health, 2010: 4).

Mental illness experience – the experience of living with psychiatric illness (and dealing with the symptoms) diagnosed according to ICD (The ICD-11 Classification of Mental and Behavioural Disorders).

Personal recovery concept – individual intra-psychic process or continuum, the subjective experience of moving beyond the role of mental health "patient", achieving personally acceptable quality of life, wellbeing and contributing to life even with on-going limitations caused by mental illness (Anthony, 1993: 15; Slade et al., 2017: 24–25).

Productive partnership framework – designed to provide a power-neutral setting that allows clients and professionals to create a jointly-owned partnership (collaboration) with genuine choice and power-sharing (Verkaaik, et al., 2010: 981–982).

Recovery-oriented support work – refers to "professionals who convey hope, share power, are available when needed, are open regarding the diversity in what helps, and are willing to stretch the boundaries of what is considered the 'professional' role; professionals dealing with the unpredictability of life in general, as well as the frequent paradoxes of an individual's recovery process"; "… is support work where the professional is conducting a reciprocal relationship and sees the service user as a person and fellow human being, not as an ill individual affected by a chronic disease" (Borg & Kristiansen, 2004: 493–504).

Relational agency – "a person's sense of relational agency refers to the belief a person has about being able to influence another person, that this influence is significant for the other, makes a difference for the other, and contributes to the construction of the relationship" (De Mol et al., 2018: 54).

Relational recovery – "a way of conceiving recovery based on the idea that human beings are interdependent creatures; that people's lives and experiences cannot be separated from the social contexts in which they are embedded" (Price-Robertson et al., 2016: 9).

Social rehabilitation (service) – a set of social rehabilitation services provided on the basis of an activity plan, rehabilitation plan or rehabilitation program for persons with disability, children in need of assistance, persons of working age with no work ability, or persons of pensionable age who have disability (Social Welfare Act, 2015).

INTRODUCTION

The aim of this thesis is to outline social rehabilitation and personal recovery-oriented mental health aspects of client work, which support the growth of personal autonomy and agency, and enhance individuals' personal recovery process, while at the same time taking into account relational and socio-cultural context-sensitive aspects.

Persons with psychiatric illness as well as persons with other disabling health conditions need support to function well in the presence of fatigue and in the presence of the negative state they're in (Seligman, 2017). Well-functioning and wellbeing in complex social environments require change, and demand a focus on building enabling conditions of life, instead of only focusing on removing the disabling conditions (Seligman, 2017). Persons with mental health difficulties (referred to hereinafter as *persons*) value wellbeing more than symptom remission (Jacob et al., 2015), and they desire to focus on living well despite of the obstacles caused by illness.

In social rehabilitation and mental health systems, there is an urgent need to respond to the expectation of supporting the person's individual process of personal recovery and adjustment in the community. The question is how to provide the person with mental health difficulties/ disabilities with professional help and support so that the person as a member of the society and as a unique personality can find for himself or herself a suitable way of living and conducting own life in the community and making an optimum contribution.

The personal (survivor) approach to recovery (as one perspective in the trichotomy of recovery) explains the best the process of creating enabling conditions of life as it emphasizes recovery from invalidation (Pilgrim, 2008). Invalidation is one of the most difficult problems. Two other perspectives in the trichotomy of recovery described by Pilgrim (2008) are the biomedical (treatment) approach, which deals with recovery from illness, and the psychiatric (clinical rehabilitation) approach, which focuses on recovery from impairment. Biomedical and clinical understandings of recovery do not give the answer to the question of how to build enabling conditions of life (Oliver et al., 2012), but the personal recovery approach does.

Stuart et al. (2017) emphasize that to further develop the initial idea of personal recovery (instead of colonizing it), one way is to seek a clearer understanding about people's experiences of recovery-oriented support and relationship. This idea highlights the need to research personal recovery from the perspective of persons with mental health difficulties, instead of focusing only on the practitioners' perspective. The professionalized idea of recovery might colonize progressive ideas of personal recovery and try to coerce individuals to conform to the idea of personal recovery as defined by professionals (Beresford, 2015, Stuart et al. 2017). The professional perspective of the personal recovery process might "homogenize or even blame individuals", or to be overly optimistic (Stuart et al., 2017: 292).

The challenge is to develop a power-neutral collaboration, and to develop partnership (Verkaaik et al., 2010) and dialogical communication (Seikkula, 2011), where both, the practitioner and the person with the disability know that they need each other to find solutions, enabling conditions and skills for flourishing – "something over and above the skills of minimizing suffering" (Seligman, 2017). The current thesis focuses on these above-mentioned considerations, which presumably interest the international audience of recovery-focused interest groups and Estonian mental health and social rehabilitation developers as well as persons with mental health difficulties.

Personal recovery with respect to other academic disciplines

The personal recovery concept is highly cross-disciplinary, which means that recovery and wellbeing are potential focuses of many disciplines (Slade, 2010: 6). In the current thesis, I touch on aspects of personal recovery that have connections with sociology, positive psychology and social work.

Sociology focuses on how the meaning of wellbeing is constructed and developed (Slade, 2010). Sociological studies currently cover aspects of social integration, the importance of social support, community ties, the power of negative cultural views (stigma) upon diagnosed individuals, the individual's ability to manage with the negative effects of a mental health diagnosis, the debate about aspects of the citizenship, access to fundamental rights, inclusion in society, and on the community as the "best setting for recovery" (Watson, 2012: 6). Watson (2012: 11) also brings attention to the idea that further research in sociology should aim to address such issues as professional discourse on recovery, personal experiences of recovery and the meanings that persons associate with it, and the social processes that occur in the context and environment of recovery. The impact of sociological research on mental health developments has been significant in the past, for example the works of Erving Goffman, which highlight the notion that the structure of mental health care (as an institution) is shaping the lives of mental health patients (dangerous effects of total institutions) (Watson, 2012). Today, sociology has potential to pay attention, through qualitative research, to personal interactions that have effects on recovery (Watson, 2012, Watson, McCranie & Wright, 2014). The reason for the change in focus is due to new trends – in recovery, persons currently value an individualized and personal recovery process rather more than a care system structure (Watson, 2012).

Positive psychology, as a modern phenomenon and as a member of the family of psychological disciplines, "balances the preoccupations of clinical psychology" and focuses "on meaning, agency, empowerment, hope and resilience" (Slade, 2010: 6). Positive psychology, in general, focus on virtues and character strengths, happiness, growth, fulfilment of capacities, development of the highest self, thriving, flourishing and functioning positively under conditions of stress; positive psychology also focuses on the need to identify positive qualities to help to overcome problems, go forward and flourish (Schrank et al., 2014: 96). Fully focusing on recovery requires a focus on wellbeing, and posi-

tive psychology provides a conceptualization of wellbeing (Schrank et al., 2014: 102). A number of other or earlier schools of thought in psychology also provide rich knowledge related to a positive, strength- or resource-oriented base (such as Roger's theory, Bandura's self-efficacy theory) (Scrank, et al., 2014: 97).

Social work as a profession approaches both to the person and environment (Starnino, 2009). Starnino (2009) focuses attention on the idea that social work, with its strong emphasis on holism, could take a leading role in enhancing understanding of the recovery approach in the mental health field, because social workers and support workers are one of the largest groups of practitioners in the field of mental health. Mental health practitioners should and can support both the reduction of mental health difficulties and the improvement of mental health itself (Slade, 2010).

Awareness of the personal recovery-orientation in Estonia and the actuality of the dissertation

This dissertation is novel because it sheds light on the unique situation in this country, which entails the adaptation of the mindset and principles of personal recovery to the mental health context and the cultural context of a post-soviet country, where old and new values concerning mental health issues are sometimes at odds. The deep-rooted cultural norms do not change, nor does cultural evolution happen at the same speed as the government introduces reforms and transforms the mental health system and services. As Inglehart and Welzel (2009: 13) point out, during the last decades Estonia has been an overachiever, "showing higher levels of democracy than the public's values would predict", which means that the correlation between society's values and the nature of the country's political institutions are in tense. I mean here that the developers of mental health services in Estonia have been focused on enhancing the mental health system in order to reduce the gap with other developed countries and implement contemporary values from Western mental health services. Yet, a segment of the mental health practitioners still focuses on the conventional clinical work of symptom remission and does not recognize principles of personal recovery. Also, a high proportion of the population has conventional views on mental health issues.

Personal recovery-oriented in-service trainings began in Estonia in 2004. Specialists from the Netherlands introduced the Comprehensive Approach for Rehabilitation methodology (also named the *CARe model*) and personal recovery principles (Den Hollander & Wilken, 2015), and started to train CARe trainers in Estonia. The trainers with the new mindset changed their career paths and moved from the public mental health sector to the non-governmental sector (EPRÜ, n.d.) and continued to develop recovery awareness, and to collaborate with experts by experience. The CARe Network supported the spread of recovery-oriented support work ideas through the network of trained practitioners. Estonian mental health and social rehabilitation specialists have also had

brief connections with Boston University (Marianne Farkas), also with specialists from Finland, Sweden and other countries (UT Pärnu College, 2009).

Over the years, the main changes related to personal recovery awareness have taken place on a voluntary basis and in the community through experts by experience and recovery-oriented practitioners (stakeholders of Wellbeing and Recovery College Estonia (Heakool, 2018), the Tallinn Mental Health Centre (vaimnetervis.ee), the Network for Recovery and Inclusion (care-academy.com)) and collaboration with universities.

At the same time, changes at the state level took place, when after regaining independence in 1991, Estonia focused on the EU accession process and finalized successful accession into the EU in 2004. One aim of the development of social system reforms at that time was to narrow the gap with other developed countries. The government focused on infrastructure changes in the special-care service sector including modernization of 1,400 special-care service places, with EU investments (EUR 56 million, through to 2020) and the development of new special-care services to allow to people with psychiatric and intellectual disabilities to achieve more independence (The Social Welfare Act, 2015, Bugarski et al., 2016, Kuuse & Toros, 2017). In 2012 Estonia ratified The United Nations Convention on the Rights of Persons with Disabilities (2006).

In recent times, brief changes in the public sector mental health field have occurred related to the personal recovery approach and support work. For the first time, the recovery concept was briefly mentioned in the Estonian Mental Health Strategy 2016–2025 (VATEK, 2016), and the need to raise recovery awareness among service providers in Estonia was highlighted (p. 55). The latest Estonian Social Welfare Act (2015, § 86) already establishes the requirements for people directly providing services (currently around 1,350 support workers). The Estonian Qualification system requirements for activity supervisors (2015) define instrumental competence in client work for front-line support workers. But both of these documents leave out the concept of recovery-orientation.

Currently, there are support workers in the Estonian mental health field who have recovery-oriented support work in-service training. But we lack information about their client work practice. Also, an analysis of special-care services in Estonia brought out the issue of sustainable solutions in client work (Bugarski et al., 2016). There is an urgent need to research and get to know, how recovery-oriented ideas spread in mental health client work, and also how partnership elements take root in the social rehabilitation field, since they are not regulated nor officially supported, but continuously introduced on a voluntary basis. This information interests Estonian mental health developers as well as the international audience of personal recovery researchers.

The aim of the dissertation

As mentioned at the beginning, **the aim of this thesis** is to outline aspects of social rehabilitation and personal recovery-oriented client work, which support the growth of personal autonomy and agency, and enhance individuals' personal

recovery process, and at the same time takes into account aspects which are relational and socio-cultural context-sensitive.

Based on the research aim, **the main research question** is as follows: which client work principles, socio-cultural context-sensitive aspects, and support work activities enhance growth of personal autonomy, agency and well-functioning in the presence of ill health?

The thesis seeks an answer to the following research sub-questions

1. What kind of client-work collaboration (partnership) patterns demonstrate effects on people's autonomy-oriented solutions, based on social rehabilitation assessments and planning reports created by practitioners in social rehabilitation services? (**Study I**).
2. Which elements in support work in the context of the Estonian mental health system enhance personal recovery for persons with mental health difficulties? (**Study II**).
3. What kind of cultural and relational context sensitive aspects have effects on the personal recovery process, based on the reflections of persons with mental health difficulties in Estonia? (**Study III**).

The composition and background of the thesis

The current thesis focuses on two groups of stakeholders' interpretations of agency and recovery-supporting relationship in rehabilitation and the mental health field. Initially the perspective of rehabilitation specialists concerning client work patterns was researched, and then the focus shifted to the perspective of people with mental health difficulties and their reflections on recovery facilitating support work.

Participants of **Study I** were rehabilitation team specialists such as social workers, psychologist, doctors, physiotherapists, etc., and participants of the **Studies II and III** were persons with long-term mental health conditions (lived experience) who had active and long-term experience with support from support workers.

Study I focused on aspects of dialogue and partnership between rehabilitation specialists and disabled persons within the rehabilitation assessment and planning process. I also studied the solutions written up in rehabilitation plans with the aim of understanding how solutions match up with persons' needs, situations, strengths, and how they support individuals' autonomy (as written up in the rehabilitation plan texts). For analyses I used narrative analysis.

In the next studies, I focused on the perspective of the persons with mental health difficulties, and on relational aspects of long-term support work collaboration.

Study II aimed to explore the reflections of persons with mental health difficulties concerning support work activities (in the mental health field) that, according to interviewees, enhanced their personal recovery process and supported their recovery journey. The personal recovery process approach was defined and framed in the research based on the CHIME framework. CHIME as

a frame covers the following personal recovery elements: Connectedness, Hope and optimism, Identity, Meaning and purpose, and Empowerment.

Study III had the purpose of exploring the reflections of persons with mental health difficulties concerning the relational and socio-cultural context-sensitive aspects of personal recovery. For the study, I used interview data collected during the Study II. I used qualitative content analysis and the discursive framing approach.

My interest towards social rehabilitation and personal recovery in the mental health field has grown during my own professional development. After I got my first degree, I started to work as a social worker in a hospital (1997). I was one of the first hospital social workers in Estonia. I consistently questioned whether I was doing my client work in the right way. In the year 2000 (when the state-regulated social rehabilitation system began) my work experience as a part of the children's clinic rehabilitation team presented more challenges. Questions remained – what does rehabilitation work mean? How should I work with vulnerable people, so as not to harm them but actually help? In 2005 I started research and developmental work in the state-coordinated rehabilitation projects PITRA I and II. Step-by-step I widened my perspective and moved from work with children and families to work with adults, and later to persons with psychiatric disabilities. In 2009 I started to contribute to social rehabilitation curriculum development at the university, which presented the opportunity to start my own interest-based research. The question about "right" modalities of client work in rehabilitation was already a long-time preoccupation with me, but finally I had the opportunity to research the issue. I started (2009) to work on the Study I, presented in this thesis. In October 2012 there was a new turning point. I started to collaborate with an international mental health community work project. I met my supervisor Jean Pierre Wilken and became familiar with the concept of personal recovery. Knowledge about the personal recovery concept and the stories of lived experience of persons with mental health difficulties were life-changing for me. I became aware that this is value-based contribution that really helps people and promotes human rights. I came to understand how much research into personal recovery and human agency enhancement interests me. In 2015 I started to study at the CARe Europe Academy. Right about the same time, I started with my own researches into personal recovery in the Estonian context. As a matter of fact, my own practice of hope, agency, connectedness and meaning-making, about which I write in the next chapters, has inspired me to do this research and also search for my personal growth process.

The introductory article is structured as follows: the first part introduces the theoretical framework of the thesis and gives an overview of the personal recovery concept and of recovery process elements, also human agency and relational agency, which have strong connections with sociology. The personal recovery concept and process is known in the mental health field, but it has roots in positive psychology (a discipline within the field of psychology), from where it has spread further to social work, psychiatry, social rehabilitation and

mental health nursing fields. The agentic perspective belongs to the psychology of human agency. The theoretical framework of current thesis also aims to give an overview of the contemporary understanding of professional boundaries, and of the open dialogue approach in the collaboration process between practitioners and persons with mental health difficulties. The perspective of professional boundaries has been an important aspect of social work ethics and client work, and has also been a relevant topic in mental health client work and community mental health developments. The dialogical perspective was developed in the field of psychiatry (originally in Finland), but has spread around Europe and developed further in the mental health field among different mental health-related disciplines.

The second part introduces the methodological framework of the three studies and focuses on the concepts of interactional stories and discursive framing. The third part of the thesis summarizes the main findings of each study. The fourth chapter includes discussion and the main conclusions.

1. THEORETICAL FRAMEWORK

1.1. The concepts of personal recovery and human agency

The notions of personal recovery and the wellbeing of persons with mental health difficulties and disabilities draws on understandings of what is needed to experience both agency and opportunity (Oades et al., 2017: 330). In the following part of the text I will give an overview of the personal recovery concept, the recovery process, human agency and their links.

1.1.1. Focus of the personal recovery concept

The personal recovery concept focuses on *living well with illness* and has been defined as a way of living a satisfying, hopeful and contributing life even with limitations caused by illness, and it is a unique continuum or process of personal growth, which changes one's attitudes, values, feelings, goals, skills and roles (Anthony, 1993: 15, Slade et al., 2017: 25). The personal recovery concept is known in the mental health field (Slade et al., 2017: 24). This concept concerns the situation of people with psychiatric diagnoses (including experience with psychosis, schizophrenia) (Shepherd et. al., 2017) and also in some cases people with long-term somatic illness, which evokes vulnerability in the mental condition.

Personal recovery is different from the traditional understanding of recovery. Traditionally, the recovery has been understood as symptom-free normality and has been handled mainly in the clinical context. Clinical recovery is based on professional-led research and practice; clinical recovery is not seen as varying between the people, because it is considered objective and to be evaluated by the expert clinician (Slade et al., 2017: 25). "Psychiatrism" in compliance with the medical model "has a hierarchical culture and structure, and it incorporates the phenomena, emotions, behavior and experience" (Beresford, 2015: 19), while the stigmatization of mental illnesses remains high (Slade et al., 2017: 2).

Personal recovery implementation in mental health work is challenging because of the medical model dominance in professional, public, political, policy and media understandings, and as a result it stigmatizes, reduces and dehumanizes experiences and issues that are important to people with psychiatric disability (Beresford, 2015).

Personal recovery is wellbeing-related (Leamy et al., 2011) and focuses on moving beyond the role of patient (Slade et al., 2017), to achieving a personally acceptable quality of life (Law & Morrison, 2014) and enhancing wellbeing in the wider community (Slade et al., 2017). Personal recovery is considered subjective and it means different things to different people (Slade & Longden, 2015: 3). The significant difference in the models is based on the understanding that personal recovery is rated by the person who is experiencing mental health

difficulties and who is, actually, the expert concerning their own life (Slade et al., 2017: 25, Slade & Longden, 2015) and not the clinician. Personal recovery is a process or a continuum, a subjective experience and not an observable state (Slade & Longden, 2015). The subjective perspective in personal recovery process is inconvenient from a policy perspective, because benefits entitlements rely on the judgment of experts, but the aim is not measurable, since the aim is the person living together with the experience of illness (Slade & Longden, 2015). Development toward a personal recovery orientation means starting with the assumption that people who experience mental illness are first and foremost people, and they need access to mainstream solutions if they have everyday problems, and treatment is only one route among others to recovery (Slade & Longden, 2015). Key processes involved in personal recovery are connectedness, hope, a positive identity, meaning and empowerment (Slade & Longden, 2015, Leamy et al., 2011). Personal recovery is more spacious and complex than clinical recovery (Stuart et al., 2017).

1.1.2. Human agency

Taking steps in the personal recovery journey requires the development of human agency (Benight et al., 2018, Benight & Bandura, 2004). The concept of *human agency* manifests itself in an ability to contribute to one's own life circumstances by being self-organizing, proactive, self-regulating and self-reflecting (De Mol et al., 2018, Benight & Bandura, 2004). When individuals act as agents then autonomy, construction, and action, are experienced in an independent, embodied way (De Mol et al., 2018, Shepherd et al., 2014).

Humans have cognitive self-regulative capacity, which enables them to create a visualized future, and to construct and to choose actions in the present to secure valued outcomes, and to overcome environmental influences (Bandura, 2006). The human ability to symbolize is the key, which enables the development of the unique capacity and power to shape life circumstances and "to transcend the dictates of immediate environment" (Bandura, 2006: 164). Self-regulation is the core of the human agency and self-regulation manifests itself in the interactional dynamics of the triadic of personal factors (self-efficacy), environmental conditions (post-traumatic social support) and behavior (avoidant coping) (Benight et al., 2017).

The agentic perspective explains the difference between personal enablement and environmental protectiveness (Benight & Bandura, 2004). Enablement allows a person to focus on personal resources to develop competencies, construct their environment and promote successful adaptation, while at the same time protectiveness cuts off contact with reality (Benight & Bandura, 2004). Enablement and agency should be looked at side by side.

According to Bandura (2006, 2018), who has done the most research on the agentic perspective, human agency involves four process. The first, for the human being, as an agent, centers around inherent intentionality, and the ability

to intentionally influence life circumstances and one' own functioning (Bandura, 2006, Bandura, 2018). *Intentions* include action plans and strategies for realizing them (Bandura, 2006). In many cases the agent has to involve other persons as participating agents, who help to realize their intentions. The realization of one's intentions covers the accommodation of one's own interests with the interests of other participating agents, because only collective/ common intention has the potential to lead to effective performance and outcome (Bandura, 2006).

The second capacity of human agency is *forethought*, which involves anticipation of outcomes of prospective actions, and through motivation derived from visualization of expected futures, to promote purposeful and *foresightful* behavior (Bandura, 2006). A better future cannot be the outcome of current behavior; instead, through visualization of the future, the person brings into the present the needed guides and motivators for new behavior (Bandura, 2006). When purposeful behavior is projected for a long time, then a "forethoughtful perspective provides direction and meaning to one's life" (Bandura, 2006: 165).

The third component of agency is *self-reactiveness*, involving the ability to construct an appropriate course of actions, and also motivate and regulate realization concerning these actions, which are very demanding and express themselves in the abilities of self-directedness and self-regulation (Bandura, 2006, Bandura, 2018).

The fourth factor in human agency is *self-reflectiveness*, which reminds us that people are not only acting, but individuals are also self-examiners of their functioning (Bandura, 2006, Bandura, 2018, Bandura, 2015). One aspect of agency is the capacity to be self-aware, (self-evaluate) and reflect on one's own personal efficacy, one's own thoughts and actions, and also to reflect on the meaning of one's actions and to make adjustments in actions if needed (Benight et al., 2017). Bandura (2006: 165) has said that "metacognitive capacity to reflect upon oneself" is the "most distinctly core property of agency". Self-efficacy beliefs are central to motivation (Benight et al., 2017).

Benight et al. (2018; 2017) widen the human agency approach with their *self-regulative shift theory*. Benight has written earlier about human agency together with Albert Bandura (Benight & Bandura, 2004), but during recent years he has been developing agentic theory further. The recently-presented self-regulative theory explains the two possible directions that trauma survivors face: a personal agency crisis (negative outcome) or a personal agency transformation (positive adaptation) (Benight et al., 2018). A personal agency crisis outcome is a negative shift in functioning, and it is interwoven with a person's perceptions of their capacity to manage their recovery, a negative emotional state, reduced coping responses, low motivational output and a diminished degree of social interaction (Benight et al., 2018). Personal agency (positive) transformation entails the effective utilization of internal as well as external resources, recovery capital and gaining systemic equilibrium, which people explain in terms suggesting that the experience has transformed them into a better person or forced personal growth (Benight et al., 2018). The critical

coping capacity threshold, which all human beings have, is a key to coping with dissonance between expected and current perceived self-efficacy; the fundamental shift occurs when the threshold (the perceived ability to gain a sense of control over recovery is perceived as impossible) is hit and "a nonlinear shift to a new impaired steady state occurs" (Benight et al., 2017: 334).

The person's sense of agency is developed and constructed during the interpersonal process within a particular context, which means that our actions have meanings to others and other people's activities have meaning to us in relationship contexts (De Mol et al., 2018). Bandura (2006) brings out proxy agency – the ability to influence other people with resources, knowledge and the means to act on behalf of persons, as well as collective agency – promotion of group attainments through an interactive, coordinative, and synergistic dynamic and performance (Bandura, 2006). Social support resources are a critical boost to individual agency following trauma (Benight et al., 2018).

One interesting addition – Stajkovic and Bandura et al. (2018) have done a meta-analysis of variables of conceptual models of the Big Five personality traits in psychology and self-efficacy (known also as *social cognitive theory* founded on an agentic perspective). They have found in their research that the *conscientiousness* and *emotional stability*, among the Big Five traits, are directly related to performance and to predictive self-efficacy (Stajkovic et al., 2018).

1.1.3. The personal recovery process (as a manifestation of agency development) – CHIME framework

The personal recovery conceptual framework was developed through a systematic review of recovery processes characteristics and narrative synthesis by Leamy et al. (2011). This empirical work culminated in the description of the five dimensions of recovery processes in this model: **C**onnectedness, **H**ope and optimism, **I**dentity, **M**eaning and purpose, and **E**mpowerment (Leamy et al., 2011: 449), summarized by the acronym CHIME, which gives the model its name. The research (Bird et al., 2014, Shanks et al., 2013, Williams et al., 2015, Stuart et al., 2017) has supported the CHIME category structure to delineate the personal recovery process experience, and realize at the same time that "recovery will involve a different combination of processes for different individuals" (Stuart et al., 2017: 302).

The CHIME framework categories help to contextualize the personal recovery process.

The first CHIME subcategory is *Connectedness.* Recovery starts when the person relates with someone or to something (Williams et al., 2015: 778, Slade, 2009: 83). Relations with other human beings (Leamy et al., 2011), even with pets (Stuart et al., 2017) and affective atmospheres (Duff, 2016) have been considered personal recovery enhancing. Relationships with family members, friends, relatives and community members develop feelings of belonging, emotional meanings (Duff, 2016) and give inspiration. The person gets support

through relationships (Slade et al., 2017), while also feeling part of the community and cultural context. Beneficial impact on recovery is derived from meeting other people with personal experience of mental health, difficulties, peer supporters and participating in support groups (Slade et al., 2017). Interpersonal relations with other community members (citizens) give mutual benefit for the reason that direct contact with people with mental health difficulties is "the most effective method of changing attitudes toward mental health problems" (Slade et al., 2017: 26) and as a result it reduces stigma.

The CHIME category *Hope and optimism about the future* emphasizes the importance of belief in the possibility of recovery (Leamy et al., 2011) and of a "deeply rooted personal belief that change, growth and recovery are possible" (Duff, 2016: 61). Hope requires mastering of agency (goal directed energy), ways of meeting goals and goal setting (Snyder, 2002). Hope is a positive motivational state, and comprises motivation to change and increased hopefulness (Snyder, 2002, Leamy et al., 2011). Having dreams, aspirations and personally-valued goals helps to sustain feelings of hope. Hope is also considered to be a collective and relational achievement (Duff, 2016), thus hope is described as a distinctive structure of feeling sustained through physical, social and material relations (Anderson, 2014). The growth of hope is related to positive thinking and valuing success, and developing coping strategies (Leamy et al., 2011).

The category *Identity* highlights to the core of the recovery process. There is a common understanding that redefining and regaining a positive sense of self (Bird et al., 2014), maintenance of positive identity (Leamy et al., 2011) and personal growth facilitates the experience of recovery (Duff, 2016). The recovery process influences different dimensions of identity. Personal identity will be enhanced through changes in goals and values, ways of being and personal characteristics, while social identity will be changed through taking valued roles, group memberships and interpersonal relationships (Oyserman et al., 2012). All these changes together create a new self-image, self-feeling and self-concept (Oyserman et al., 2012). Findings indicate that one aspect in the development of positive identity is overcoming the stigma of mental illness (Leamy et al., 2011), and another important aspect is the rebuilding of a sense of identity (Deering & Williams, 2018). In addition, it means to validate oneself as a person with something to offer to the world (Davidson et al., 2005; Stuart et al., 2017).

The CHIME model contains the notion of *Meaning and purpose in life*, which entails finding meaning in one's own mental health experience (Leamy et al., 2011), including meaning in life with the illness, and finding meaning from involvement with social groups, rewarding activities (such as employment), and helping others (Stuart et al., 2017). Helping others also covers the aspect of learning to understand other people who are sick and having hard times (Stuart et al., 2017). The notion *meaning* also involves activities such as finding valued social roles and goals, finding and working toward personally valued goals and amplifying one's own strengths, and also becoming aware of one's own values (Slade et al., 2017). The meaning and purpose category also embraces finding

meaning through spirituality and religion (Slade et al., 2017). Rebuilding life in personally meaningful ways entails taking responsibility for one's own well-being and the development of quality of life (Leamy et al., 2011).

The *Empowerment* category contributes to the recovery process with the position that it is important to take control over one's own life and "get out of bed" (Stuart et al., 2017: 299). Empowerment brings with it personal responsibility (Leamy et al., 2011). It also emphasizes the importance of recognizing one's own strengths, prioritizing strengths over deficits, focusing upon one's own strengths, and promoting resource acquisition (Slade et al., 2017). Relationships between professionals and people with mental health difficulties are a kind of *hub* or *lab*, wherein they can practice shared decision making, decisional autonomy, and also develop personal empowerment tools such as crisis preparation as well as developing mental health service delivery by participating in staff training (Slade et al., 2017) or the service design process.

The CHIME framework is a vision of the possible experience abstracted from real experience. To truly be successful, the personal recovery process requires contributions from recovery-oriented mental health practice.

1.1.4. Beyond the CHIME framework: the relational recovery process and community adaptation

Human beings are relational beings (and not simply beings in relationships) and personal recovery has a relational nature (Price-Robertson et al., 2017). *Relational being* means for humans that important experiences emerge at the intersections between people, their relationships and environments (Price-Robertson et al., 2017: 109). This reminds us that personal recovery takes place inside the context of relationships and is shaped by interactions.

Price-Robertson et al. (2017: 110) state that Anthony (1993) defined recovery as a deeply individual intra-psychic and individualistic process that occurs when people with a lived experience are successful in modifying or outgrowing their limiting thoughts, feelings and beliefs. The CHIME framework however is comparatively "less obviously individualistic", embracing as it does the element of 'connectedness' (Price-Robertson et al., 2017). Anthony's definition belongs to the 1990s and reflects the emergence of the consumer rights movement, deinstitutionalization of mental health services in the US, and new recovery approach, which "encouraged people with lived experience to assert their autonomy and challenge the many ways in which they may have been coerced or restrained by others, or subjected to abuse and oppression" (Price-Robertson et al., 2017: 111). The CHIME framework was developed later, in 2011 and Leamy et al. at that time included the relationship and connectedness elements in the personal recovery process.

Although, as Price-Robertson et al. (2017) outline, the CHIME framework encompasses the notion of *connectedness* and shows with whom the person with lived experience will (re)engage and create relationships with, at the same

time the framework does not include the aspects such as 'what is being shaped' in the relationships and 'what is doing the shaping' (p.112). It is insufficient to outline that social factors contribute to recovery and yet conceive that the recovery process is apart from these factors (Price-Robertson et al., 2017).

Positive identity and community

Identity in the personal recovery process has a relational nature. Identities are dynamically constructed and context dependent (Oyserman et al., 2012: 76).

Oyserman et al. (2012) discuss how being a self requires others who endorse and reinforce one's selfhood, and people are more capable of attaining goals in a context that provides scaffoldings than in contexts that do not. People think in contexts that are made up of others, physical spaces and language, and are sensitive to meaningful features of their immediate environment and adjust their thinking and doing to what seems contextually relevant (Oyserman et al., 2012). Identity is likely to differ from situation to situation (Oyserman et al., 2012).

What people think about themselves is influenced by meaningful features of their immediate environment, such as others' judgments, but also the potential influence of the context itself (which can change the individuals' response) (Oyserman et al., 2012). Identity is shaped in the dual-processing model, which involves both reflexive and reflective processing (Oyserman et al., 2012: 86). The self has *reflexive capacity*: thinking, being aware of thinking, taking the self as an object for thinking. This is rapid, effortless, and spreads activation of associative networks which are always operating in the background (Oyserman et al., 2012: 86). *Reflective processing* is slower and more effortful, and operates when people have time, motivation and mental capacity to engage in it (Oyserman et al., 2012: 86). What his or her own identity means to the person in the current moment depends on those aspects of self that reflexive processing brings to mind; and it also depends in large on the other information that comes to mind in context (Oyserman et al., 2012). The person with mental health difficulties might be influenced by the oppressive judgments they experience in the context of their community, which means that the reflexive process thoughts might become influenced by oppressive behavior on the part of others, and for the person it becomes difficult to act in accordance with the positive identity which they are in the process of developing. Cognitive and behavioral adjustments are often automatic, and outside of conscious awareness as to what the contexts currently seems to contribute to their sense of self (Oyserman et al., 2012).

Identities are "nested within self-concepts" (Oyserman et al., 2017: 94). *Identity-based motivation theory* implies that identities have value for people and people prefer to act according to identity (Oyserman et al., 2017). But meaning-making is not fixed, and always depends on dynamic construction (Oyserman et al., 2017; Oyserman et al., 2015). Oyserman et al. (2015) also bring out that the way that one thinks about the context may influence which aspects of the self come to mind, and depending on how the situation is considered, the self is also considered. It means that context matters and

influences the self-regulation, but people can also focus on the meaningful and use their strengths (Oyserman et al., 2017).

This means that interaction between the person with lived mental health experience and citizens in the community influence the person's positive identity development in the personal recovery journey. In the context of judgments, stigma and discrimination pose a challenge to the person with mental health difficulties in their efforts to gain positive identity.

Identities provide a meaning making lens and meaning is reciprocally is related to the identity development, and empowerment (Price-Robertson et al., 2017). Relationships are vital to recovery: they shape identity and contribute to or hinder wellbeing (Tew et al., 2012).

Community and relational recovery

The definition of mental health includes an individual's ability to make a contribution to their community (WHO, 2014).

It is equally important for an individual to realize one's own potential, cope with the normal stresses of life, work productively, and aspire to contributory relationships within their own community (WHO, 2014). Integration into the community has been recognized as an essential component of recovery, and integration implies a situation in which individuals with disabilities live and lead their daily lives "without distinction from and with the same opportunities" as people without disabilities (Bromlay et al., 2013: 673).

Ware et al. (2007) turn attention to the contradiction that persons with mental health difficulties might experience in the community. While living in the neighborhood alongside with people without disabilities, they may feel socially excluded. People with mental health difficulties may face discrimination and inequality in the community and mainstream society (Ware et al., 2007) and it is hard for them to reduce barriers alone (Coggins, 2017). Integration requires reducing barriers and creating opportunities, but ironically mental health community integration programs, instead of including people into the mainstream community, increase the individual's contact with mental health care providers, with treatments and other people with mental health difficulties for longer or shorter period (Bromlay et al., 2013).

Although mental health communities and peer communities are important for individuals, the main aim is the integration into mainstream community, and community integration entails helping people to move out of the patient roles, segregated housing and work arrangements, and enabling people to live normal adult lives in community settings (Bond et al., 2004). The research of Bromley et al. (2013) shows that people with successful lived experience describe their mental health community as a gateway to other communities.

It has been recognized that community integration cannot be a phenomenon created by mental health professionals (Bond et al., 2004), but rather it should be a community level effort, which involves strengthening communities, increasing community participation, inclusion and the sense of belonging (Coggins, 2017).

Coggins (2017: 231) emphasizes that despite the clear, positive and widely-accepted WHO definition of mental health, society still perceives mental health difficulties "as being about illness", which means that the majority understands mental health issues as something that need to be treated and which belongs to the mental health service sphere. Persons with mental health difficulties recognize how fellow citizens look down on them, instead of looking at them as persons, and how people around them categorize them as belonging to the crazy crowd (Bromlay et al., 2013). Coggins (2017: 232) says that to the contrary, dealing with mental health issues needs to be part of "everyone's day-to-day business", and the solution lies outside mental health services.

There is a need to shift community understanding about mental health to viewing it as a component of wellbeing and understanding the personal recovery process of persons with mental health difficulties as a desire to live well with illness inside the mainstream community. We have to develop communities' capacity, knowledge and skills to understand how everyone can promote and protect mental health for themselves inside their communities (Coggins, 2017). Coggins (2017) brings out very clearly the notion that mental health issues and wellbeing are complex and require individual and community activities and protection, alongside mental health services treating mental health difficulties. Communities have a vital role in enhancing personal recovery and mental health. Persons with mental health difficulties living in the mainstream communities (location based/ geographical communities) value communities that are helpful, low-risk, non-stigmatizing, and facilitative of altruism (Bromlay et al., 2013).

Persons with mental health difficulties, who are engaged in the process of personal recovery, desire to contribute to the community and help others (Bromlay et al., 2013; Jensen & Wadkins, 2007). Helping others allows enhances the process of finding meaning. Community life can include challenge, such as the stigma experience and discomfort with social contacts, and persons with mental health difficulties need skills training for community integration (Bromlay et al., 2013).

In sum, support workers are expected to help persons with mental health difficulties in two ways: to rise community awareness about mental health and to model positive-identity-congruent behavior within community interactions between community members and persons with mental health difficulties.

1.2. Recovery-oriented working relationships

The rehabilitation and recovery process toward desired wellbeing and *living well with illness* depends (among other things) on a working relationship between experts through experience (persons with mental health difficulties) and experts through training (professionals/ practitioners) (Verkaaik et al., 2010). The working relationship and partnership should be a safe relational environment, wherein people with disabilities can develop their autonomy, know-

ledge (Verkaaik et al., 2010) and personal sense of agency (human agency) (De Mol et al., 2018), which in sum has the potential to increase power and control in the individual's life. In the following part of the text I concentrate on approaches that open up elements and meanings of collaboration and partnership between practitioner and person with disability/ mental health difficulties, and also relational agency, which can be developed through a good working relationship.

1.2.1. The productive, power-neutral partnership construct and relational agency

Verkaaik et al. (2010) point out that power is a relational phenomenon, which is generated and located in relationships. They introduce the *productive partnership framework* to illustrate opportunities for developing an effective working relation. The authors assume that participation in decision-making is important to the quality of power distribution in the rehabilitation context (Verkaaik et al., 2010). First, however, the question of the of person's desired autonomy level and the availability of resources and support (for being autonomous) has to be addressed. This implies for the need for two-way communication between the professional and the person with disability, instead of practicing *parternalism*, which implies that the *patient is passive*. Alongside reciprocal communication, interaction should be based on the *informed model*, where the patient (person) receives all information available and decisions are ultimately made by the person with disability (Verkaaik et al., 2010).

As Verkaaik et al. (2010: 981) state, the productive partnership framework "is designed to provide a power-neutral setting". Power-neutral means that both the practitioner and person with disability know that they need each other to find effective solutions. The framework is based on McCormick's formulation (1996) that the practitioner's basic position is "I know a lot about the disease (condition) that the person has and I may know a little about the person who has the disease" (Verkaaik et al., 2010: 982). The practitioner therefore needs information, which is available only from the person with the disability. The consumer's base position is "I know a lot about the person who has the disease (about myself) and I may know a little about the disease that I have" (Verkaaik et al., 2010: 982). These base position statements are starting points for a partnership, where through interaction both stakeholders will work for a desired knowledge level and next, for the desired autonomy level in the person with disability. Persons with disability (experts by experience) position themselves as equal partners with health (and social) professionals – as experts with knowledge and insights (Hungerford et al., 2014). Knowledge enables experts by experience (persons with disability) to assume an important role in their rehabilitation process and to own the recovery process. Enhancement of the autonomy level results in people gaining a greater sense of, and demonstrating more resilience when faced with challenging life events (Verkaaik et al., 2010).

The current understanding is that if the expert by training (the practitioner) focuses on a power-neutral productive partnership, and the expert by experience (the person) has a willingness to strengthen their own degree of autonomy and knowledge, then the main preconditions for a good relationship and collaboration exist. But to go further, besides the growth of knowledge and autonomy, there are also other qualities that need to be given attention during the recovery-oriented working relationship.

The concept of *relational agency* emphasizes co-action of agents who both continuously construct new meanings during their transactions with one another, and it does not refer to having control of the other by "acting in strategic ways to achieve a particular outcome in the relationship" (De Mol et al., 2018: 56). The concept of *relational agency* (De Mol et al., 2018) brings along the understanding that agency can be developed further in the context of relationship, because the individualistic conception of agency is insufficient for the reason that how one perceives oneself as an agent depends on relationship context. Relational agency is connected with relational influence and it means that relational agency is constantly constructed through relational experience (De Mol et al., 2018).

In working relationships between experts by experience, who are agents and experts by profession, who are also agents, both continuously influence each other. Relational influence is the interpersonal process by which humans affect each other's emotions, thoughts and behaviors (Huston, 2002). The concept of relational agency involves autonomy, construction and action. *Autonomy* entails a greater sense of coping and wellbeing (Verkaaik et al., 2010), and acting according to one's own authentic interests or integrated values and desires (Chirkov et al., 2003). *Construction* refers to a person's capacity to make sense of their own behavior and the behaviors of others and to construct new meanings from these experiences (the process of sense-making involves both emotions and cognitions) (De Mol et al., 2018). *Action* refers to a person's ability to have an effect on other people (De Mol et al., 2018). A person's sense of relational agency has an influence on social interactions (De Mol et al., 2018). One could say, as a remark, that we should turn attention to the peculiarity that people who experience difficulties in life and who are isolated agents, have problems with perceiving themselves as influencing or being influenced (De Mol et al., 2018).

Having a sense of relational agency enables the person to experience interconnectedness and have the awareness to make a difference in the relationship (De Mol et al., 2018). Connected agents use their agency in relationships to feel connected with others, and they also take care to stay connected (De Mol et al., 2018). Relational agency could be reconstructed through dialogue, which represents the idea of influencing one another in nonlinear ways and taking into consideration both person's interpretive processes (De Mol et al., 2018).

1.2.2. Developing dialogue and boundaries

Open dialogue is based on the knowledge that human beings need response (nothing is more terrible than lack of response), to be being heard and taken seriously, and to see oneself through the eyes of the other, which means that "living persons emerge in real contact with each other and adapt to each other", and this generates a dialogical relation (Seikkula, 2011: 191) where new perspectives may occur (Seikkula, 2011).

Open dialogue is described by the Finnish psychologist Seikkula (2011), who introduced it into the mental health field, as a method and a way of living, and according to which is important the present moment is most important. It facilitates being open to the other, focusing on clients' narratives, dealing with explicit knowledge in linguistic descriptions, the implicit knowing that happens in the present moment, and focusing on response and responsiveness.

In the open dialogical approach, the practitioner's main focus is on the question of how to respond to clients' utterances "as their answers are the generators for mobilizing the client's own psychological resources" (Seikkula, 2011: 187). In open dialogue, the response of the practitioner should demonstrate that one has noticed what has been said, and when possible, opening up a new point of view on what has been said (Seikkula, 2011). In this way, dialogue becomes a healing experience in a meeting (Seikkula & Trimble, 2005). This active process of talking and listening on an equal basis (Holmesland et al., 2014) needs the integration of two key elements: the dialogic process of meetings, and the organization of a consistent treatment system (Seikkula & Trimble, 2005).

There is another important aspect of dialogue: when the client feels invited to express their own views and responses to the practitioner, they hear their own voice, and their own understanding of themselves as a personality will increase. They will have the experience of being taken seriously, and the persons may become more interested in the other's experience, which helps to enhance connections with other humans and community (Holmesland et al., 2014, Seikkula, 2008).

The concept of relationship boundaries

Besides the, development of common knowledge, understanding, shared decision-making, and developing dialogue, it is important to pay attention to boundary setting in the working relationship, and to find relationship boundaries that could support the process of personal recovery and rehabilitation.

O'Leary, Tsui and Ruch (2013) propose a **model of professional boundaries** that explains the best current developments in defining personal engagement and professional accountability, and which focus on and promote connection and use of self, instead of separation and professional distance. This model challenges the dominant discourse, which has historically been defensive and protective in nature (based on the medical model or the psycho-dynamic perspective on the therapeutic nature of relationship, or categorizing people and acting as a means of social control). Developments in humanistic psychology

and the introduction of client-centered approaches, also the emergence of post-structural approaches to social work as well as critical theory paradigms, have raised the issue of the complex nature of relationships with people who are oppressed or marginalized (O'Leary et al., 2013).

The model of professional boundaries developed by O'Leary et al. (2013) conceptualizes which issues should fit within and outside the professional boundary. The important aspect is that the boundary of a relationship surrounds and connects the worker and the client, rather than separating the two parties.

The internal boundary of the relationship includes a common understanding of the reasons for the relationship, the context of sharing information, commitment and individual preferences.

The new aspects, which O'Leary et al. (2013) locate in **the second circle of professional boundaries** hold a less pivotal role in relationship building and boundary setting, and these aspects need, in some instances boundary setting discussions, and in other instances not (for example: saying hello in other contexts, disclosure of a worker's personal details, sharing food and drink, taking of calls or meeting out of office hours). The model of O'Leary et al. (2013: 145) locates the aspects of professional relationships that are unethical and non-negotiable to the outer circle of professional boundaries.

The authors also emphasize the *dynamic nature* of professional boundaries, which demands a reflective mindset and deciding how to establish appropriate professional boundaries (O'Leary et. al. 2013: 146).

Sarah Banks (2013), the social work ethics expert and academic, explains the relationship between personal engagement and professional accountability by emphasizing that personal engagement is what makes the activities social in the social work field and the *social* involves human relationships. But Banks (2013) also warns that an inadequate understanding of personal engagement may lead to helping people for the practitioners' own satisfaction. The practitioners should recognize the nature of personal engagement and professional accountability and should consciously work out what is right to do in particular circumstances (related to professional ethics) (Banks, 2013).

Shevellar and Barringham (2016) make a distinction between *boundary violations* and *boundary crossings*, and they state that boundaries should be person-specific, time-specific, context-specific and should take into consideration individual's vulnerability. People, and particularly people with mental health difficulties, value workers who do something different from what is expected from professionals, i.e. relationships where power sharing creates trust and demonstrates respect (Shevellar & Barringham, 2016).

As Topor and Denhov (2014) explain, what is considered helpful are individualized non-expected actions, everyday actions, emotionally-charged reciprocal relationships such as where professionals sincerely desire contact, as well as genuine interest, common experience (that has nothing to do with the person's health problems), the professional is seeing something in the person, for example a desire to paint and the professional finding common interests to talk about. This means that persons should be taken as society member (not

only patients) and we need professionals who know how to engage with persons with psychiatric disabilities in their life histories and actual social situations (Topor & Denhov, 2014).

To conclude the theoretical part, I would like to attract the reader's attention to three themes related to personal well-functioning in the presence of fatigue, and to three themes in professional work that act as a catalyst for a person with disability to function well in the presence of fatigue. The three themes related to persons well-functioning are: the personal recovery process, the growth of human agency and relational agency. Professionals' support work practice should focus on three aspects: creating power-neutral partnerships, developing dynamic boundaries and dialogue in communication.

2. STUDY DESIGN: METHODOLOGICAL FRAMEWORK AND DATA

My empirical focus is on the elucidation of client work that can support the development of *human agency*, growth of *autonomy*, enhancement of the *personal recovery process,* and *living well with illness* or to say it differently – *well-functioning in the presence of ill health*. My interest was and still is how practitioners accommodate these concepts and principles in their practice in the social rehabilitation and mental health field.

The research process was initiated from my desire to get close to the actual process of client work practice without directly influencing it or directly asking practitioners about their work, and this intention led me to the concept of *interactional stories*, which I got to know more closely through Christopher Hall's lectures in the Jönköping doctoral program in Sweden.

The next step of the research was directed by the idea of learning client work practice elements from the perspective of persons with mental health difficulties. When I started to plan the study with this intent in mind, I learned about the CHIME personal recovery framework, and later about the discursive framing concept, which allowed me to understand how to use the CHIME as my research frame. My interest was also to turn attention to social and cultural aspects within the context of the development of recovery-oriented practice in Estonia, knowing that mental health system developers and institutions support the implementation of contemporary values in Western mental health services, but citizens' values do not change at the same pace (Inglehart & Welzel, 2009).

2.1. Framework: from the concept of interactional stories to the concept of discursive framing

In **Study I**, my intention was to get access to naturally-occurring interactional materials in social rehabilitation client work. I decided to use the interactional story concept. Hall et al. (2014) explicate how research based on interactional stories is often a long and multi-stage process. They also mention that getting access to delicate interactional data is easier when the researcher is known and trusted in the field.

The *concept of interactional stories* and the interactional work of storytelling comes from Hall (1997), who explains that the social work text (narrative) as an active entity reflects how people (in the current study, the specialist) package their experience. Hall and Matarese (2014) note that different approaches emphasize different aspects of narrative, but the commonality is that the narrative suggests a temporal aspect to writing, (talking) and thinking, and usually has a beginning, middle and end, wherein events in question are organized in a way that the resulting narrative has consequences for the narrator and the reader (in

the current study to the person with disability, who reads his or her rehabilitation plan).

Hall (1997) says that narrative is available in all aspects of social work communication, as well as in written descriptions. I decided to research the specialists' texts, which I considered as interactional stories. An interactional story is as an illustration, as Hall and Matarese (2014) said, or a second story, based on a social worker's personal experience of client work. Earlier, Urek (2005) studied how social workers produce stories to develop characterization of the person in the client position to justify decisions and actions through reports. Social reality is constructed through language and the interpretation of social reality is written (or spoken) to someone, and narratives as interactional stories can be found in various client documents (Urek, 2005). Every text has a speaker and the presence of the narrator underlines that the narrative is not primarily informative, but interactive, and contextually situated (Popova, 2014). Stories (texts) are best understood as a "process of patterned interaction, prospectively anticipated and retrospectively reflected upon in a participatory sense-making" between two participants: a reader and a teller; and the reader supplies the memories and the imaginings in order to inhabit this world, and "meaning lies not in words, concepts or events but intersubjective spaces" created between the participants (in the current study between ideas in the written text created by the rehabilitation team specialists and the persons who interpreted the written text, and the researcher) (Popova, 2014:12).

In the **Studies II and III** the discursive framing concept guided the research process.

I was interested in the relationship experience that persons with mental health difficulties have with their support worker. I decided to focus on reflections. But at the same time, I was aware that the personal recovery process is very unique for every person (according to definition and researches).

I was also aware that because of the fragile psyches of persons with mental health difficulties, the methodology should allow the phenomenon to be studied deeply, but at the same time, with minimal risk for people (concerning their energy and self-reflective ability). Adshead (2008) emphasizes that the researcher should be aware that research is (in its intention) non-therapeutic as it does not bring benefits to the individual, though it seeks "to be a benefit for future people with the assistance of current sufferers" (p. 144) and does not seek (primarily) to benefit the research participants themselves. The researcher should be respectful, courteous and grateful (Adshead, 2008). Persons with mental health difficulties may be affected by the external environment (including carers) and the researcher should be aware of the complex dilemmas in mental health research (Adshead, 2008).

It made me look for a suitable framework. I decided to use discursive framing and to use the CHIME (and the INSPIRE measurement structure) as a framework (Williams et al., 2015), because the complex content of personal recovery and recovery-oriented support work is outlined there in a clearly-structured and validated frame. The CHIME frame identifies recovery processes

through five categories (Leamy et al., 2011). Leamy et al. (2011) say that the framework contributes to recovery processes in two ways. First, it helps to identify evidence more easily, because the coding framework provides keywords for research and taxonomy in reviews, and second, a "framework provides a structure through which research … can be oriented" (Leamy et al., 2011: 449–450).

Frames are considered as knowledge structures that help to organize incoming perceptual information and summarizes past experience (Weick, 1995), which enables the researcher to understand and explain phenomena (Cornelissen & Werner, 2014). Framing research is mostly looked at as activation of knowledge schemas, which guide perception, inferences and actions in context (Cornelissen & Werner, 2014). Cornelissen and Werner (2014) say that frames provide bases for understanding and a mechanism of sense-making. Weick (1995) also describes how frames represent past moments of socialization, while cues are present moments of experience, and if the person can construct a relation between frames and cues, then meaning is created. At the same time frames should not be taken as rigid data structures. Instead individuals together may change frames and construct new frames, to overcome the rigidities of existing frames (Cornelissen & Werner, 2014). "The key characteristic of frames is that they contain relational conceptual information around idealized scenarios that link situations with actions and outcomes, or causes with effects" (Cornelissen & Werner, 2014: 192). This is the one distinction between frames and categories, such as categories failing to represent important structures in the physical world and human knowledge (Cornelissen & Werner, 2014).

2.2. The persons I studied

In the **Study I,** the participants were rehabilitation specialists who practiced in rehabilitation teams in South and West Estonia and participated in the rehabilitation development project in 2009. The project focused on the further training of the rehabilitation teams and the development of the university's social rehabilitation curriculum. My study was not part of the project. But since I worked with rehabilitation teams as a project manager and trainer, I decided to start my (Ph.D. thesis) research and collaborate with teams to conduct my study. Among the specialists in the rehabilitation team were social workers, psychologists, doctors, physiotherapists, nurses, speech therapists, occupational therapists, and teachers. In the first stage of the study, 70 specialists and 14 rehabilitation teams were involved. In the second phase, 48 specialists remained in the study. In the next section, I will explain, how I approached their work without direct intervention. In the next step of the research I involved three experts in the study process: a rehabilitation doctor, a psychologist and a social worker (with family therapist qualification) as the readers and interpreters of the interactional stories.

In the **Study II** and **Study III** 13 persons with mental health difficulties were interviewed. I started my research after the RAAK project (2011). The

project, which focused on community-based rehabilitation, was carried out in collaboration with researchers and service providers from the Netherlands, Hungary and Estonia. My current research was not the part of the RAAK project.

In **Studies II and III**, first, I turned to one of the service providers I had worked with during the RAAK project and asked for an opportunity to do the research among persons with mental health difficulties. I got contact with 7 interviewees. Some of the interviewees knew me already from the previous research. Second, I asked for the opportunity to collaborate with a mental health service provider in another Estonian region with whom I had never cooperated. Before the data collection (and after the ethical approval process) at the last-mentioned site, we had a friendly meeting with people with mental health difficulties and their support workers. At this meeting we paid special attention to the balance of power and interpersonal relations in order to establish our equality as human beings. Supervisor Jean Pierre Wilken participated in this meeting. I got consent from 6 interviewees from the second site to participate in the study.

The inclusion criteria for interviewees in the **Studies II and III** required them to be adults over 18, to have long-term mental illness experience, to have experience of using mental health services for more than five years but currently not receiving inpatient care, to be in regular contact with a support worker and getting everyday life support services (state-regulated services offered only if the person has been assessed as having a moderate to severe mental illness). During the research I did not ask or looked for information about their mental health diagnoses or health conditions or their clinical recovery process. I intentionally avoided contact with any information available in interviewees' medical records or other forms of their health-related information.

2.3. Application of methodology

First, I will present an overview of the **Study I**. During the research planning stage I understood from the literature that the assessment and planning procedures as well as the specialists' intentions in this process remain predominantly guided by the medical model of disability (Philips, 2004), although in some other service provision areas the partnership factor is emphasized and disabled people get greater control over service provision (Beresford, 2010). For this reason, I decided during the phase of applying the methodology to my research to focus on the data collection from the free-format assessment and planning case reports (instead of structured forms and actions). I thought that standard forms and procedures governing rehabilitation plans direct practitioners to act in ingrained ways, but free-formatting of rehabilitation plans gives freedom to act based on values. In addition, I expected that free-format assessment case reports allow one to focus on client work content and would give information on how productive partnership elements (Verkaaik et al., 2010) such as knowledge,

autonomy and time are represented in the assessment and planning content (if boundaries do not limit intentions).

Next, I describe the data gathering method and process. The social rehabilitation teams were asked to write free-format assessment case reports about one of the disabled persons who was recently, or during the research process, receiving assessment and planning services. I asked the rehabilitation specialist to keep in mind that the case report should include at least (1) the social rehabilitation aims of the person with disability, (2) an overview of the assessment results and (3) the rehabilitation intervention plan. I also asked the rehabilitation specialists to leave aside the procedural rules of the current rehabilitation system that they have considered restrictive for co-work with clients, such as a fixed-form of the rehabilitation plan, or a fixed time/space frame for client work and for writing the rehabilitation plan document. Rehabilitation specialists' teams were asked to choose one case among their current rehabilitation clients.

The **Study I** data collection process consisted in sum of four steps: (1) choosing the participating rehabilitation teams and instructing the participants, (2) collecting assessment case reports and plans, (3) selecting final case reports for Study I, (4) interpretation of case reports as interactional stories.

In the *first stage* of the data gathering, 14 case reports were collected, which represented all the age groups and for which assessment was done by 2 up to 8 specialists. In the *second stage* I selected 10 reports from the 14 case reports, where the client was over 18 of years old and in which the rehabilitation team consisted of 3 or more specialists. The cases represented both men and woman, and also people with different disabling conditions.

In the *third stage* of the study I asked three experts to interpret the case reports as interactional stories. We had three meetings from approximately 2 to 3 hours. During the meeting the case report texts were projected onto the board of the university auditorium. Experts discussed the content of the case reports and also reflected on which kinds of patterns they recognize in the texts. I as a researcher used the memo-writing to collect the ideas and questions.

The steps of data collection:

1.Instructions to the rehab specialists teams: develop client work with disabled person and create free format assessment and planning case reports

2. Collecting 14 case reports created by 49 specialists

3. Selecting 10 case reports
Criteria: client <18 years; specialists ≤3

Analysis steps:

4. Analysis 1st step: selecting textual segments representing:
partnership elements;
dialogue elements;
persons autonomy recognition

5. Analysis 2nd step: collecting selected description sequences of 10 narratives

6. Analysis 3rd step:
Expert group analysis:
social worker
psychologist
rehabilitation doctor
researcher
Issues for analysis:
construct of the client's identity and autonomy,
exploration of a client's meaning after loss,
incorporation of dialogues with clients

Fig.1 Study I: Process of data collection and analysis

Methodology of **Studies II and III**. The structured interview format for **Study II** and the semi-structured interview format for **Study III** were developed based on the personal recovery process measurement instrument *INSPIRE* (Williams et al., 2015). The measurement method was developed based on the CHIME framework. The CHIME framework was used in Studies II–III as a frame, as I mentioned already in a previous sub-chapter.

The INSPIRE quantitative measurement tool is considered to be the best available instrument to measure user-rated evaluation of services on the part of staff for individuals' personal recovery process enhancement (Williams et al., 2015). As mentioned, INSPIRE allows persons with mental health difficulties to rate staff support in their recovery process. The INSPIRE structure and sub-categories cover all the recovery process support work elements described in the CHIME framework. In the current study, the aim wasn't to rate the staff sup-

port, but instead to explore recovery-enhancing activities in support work and for this reason the INSPIRE questions were restructured to function as qualitative questions.

Based on two arguments, I made a decision to use the INSPIRE measurement structure and rephrase all the rating-focused questions into open-ended experience-evocative questions. The *first* argument comes from the Williams et al. (2015) article, wherein the authors mention that INSPIRE provides a vehicle for structured conversation. *Second*, the INSPIRE itself includes qualitative questions, such as "how did your worker support your recovery?" (Williams, et al., 2015).

In addition, I decided to choose the qualitative method and the interview for the reason that the interview allows the researcher to ascertain that participants understand the questions and the terminology used and enables a recognition of whether interviewees understand the terminology used in the questions. Recovery concept terms are rather little-known in Estonia. Also, participants lack the experience of research data collection (filling in questionnaires etc.).

Studies II and **III** interviews were conducted in 2015 during a five-month period at two different sites. The interview consisted of 3 parts in total. Two parts are represented in the table "Interview structure" and were analyzed in the Study II. The third part of the interview belongs in Study III and will be described in the next part of the text.

In **Study II** the structured interview consisted of 2 parts. The first part of the interview contained questions about support activities and covered the CHIME framework elements. Interviewees were asked for example "How your worker supports you in ... feeling supported by other people", etc. (from the CONNECTEDNESS frame); "feeling hopeful about my future", etc. (HOPE frame) (in total 21 questions).

The second part of the interview focused on relationship development activities. The questions were presented as follows: "What kind of workers' activities support relationship qualities such as ... *feeling listened to*; *feeling supported*" and "What kind of support workers activities show you that your worker ... *believes in your recovery*; ... *takes hopes and dreams seriously*, etc." (total 8 questions).

Table 1. Interview structure

1st part: **CHIME framework elements**

CHIME	*How your worker supports you in ….*
CONNECTEDNESS	*-feeling supported by other people* *-having positive relationships with other people* *-having support from other people who use services* *-feeling part of your community*
HOPE	*-feeling hopeful about your future* *-believing that you can recover* *-feeling motivated to make changes* *-having hopes and dreams for the future*
IDENTITY	*-feeling you can deal with stigma* *-feeling good about yourself* *-having spiritual beliefs respected* *-having your ethnical/cultural identity respected*
MEANING AND PURPOSE	*-understanding your mental health experience* *-doing things that mean something to you* *-rebuilding your life after difficult experience* *-having a good quality of life*
EMPOWERMENT	*-feeling in control of your life* *-being able to manage your mental health* *-trying new things* *-taking risks* *-building on your strengths*

2nd part: **relationship elements of support work**

Question/ *Quote*	Relationship elements
What kind of workers activities support relationship qualities such as …	*-feeling listened to* *-feeling supported*
What kind of support workers activities show you that worker …	*-believes in your recovery* *-takes hopes and dreams seriously* *-respects you* *-treats you as an individual* *-supports your decisions* *-keeps hopeful for you*

The central aim of **Study III** was to learn more about the individual understanding of and reflections on personal recovery notions, as well as about the social and cultural context-sensitive aspects of personal recovery. The semi-structured interview consisted of in-depth questions about connectedness, hope, identity, meaning and purpose, empowerment, relationships, and the question "what support-work relationship quality do you consider to be most important?". The in-depth questions were asked when interviewees (1) didn't understood terms, (2) found questions surprising, or (3) mentioned that it was the first time they had thought about the issue.

1. Interview design based on INSPIRE measurement

2. Agreements with service providers from two settings and selecting interviewees

3. Interviews

4. Memo-writing shortly after the interviews;
Reflective diary (during and after the interview; themes provoked during the interview)

5. Structuring transcribed interview texts of INSPIRE measurement excel

6. 1st coding of the all interview texts
Coding units: words, phrases, stories of experience;
codes gained: from used words, phrases about support work context

7. 2nd coding: careful coding with the aim of unify repetitive codes

8. 3rd coding in MAXQDA program

9. "Dirty writing" of results based on CHIME frame and coding

10. Analyzing and restructuring the results based on CHIME frame

11. Writing results based on CHIME frame

12. Selection of citations, (neutral) translation of citations

13. Expert analysis of CHIME frame-based results and selection of best illustrative citations
*I used the help of a neutral researcher from the mental health field to validate the results and to check if the neutral researcher gets the same outcome based on CHIME based analysis

14. Final overview of the results

Fig. 2. Studies II and III data collection and analysis process

2.4. Data analysis

Data gathered in **Study I** was considered as interactional stories. Case reports were studied by using a narrative analyses approach. Narrative shaping entails imposing a meaningful pattern on what would otherwise be random and disconnected elements (Salmon & Riessman, 2008). Case report texts were analyzed as narratives in the sense that they allow a recognition of (1) productive

partnership construct elements practiced during the assessment, (2) dialogue elements during the planning phase in the co-work process, and (3) maximization of decisional and executional autonomy of the person with disability in the assessment and planning co-work process.

The productive partnership framework described by Verkaaik et al. (2010) says that three variables – knowledge, autonomy and time – elucidate how productive a partnership is. The productive partnership is based on the assumptions that (1) it is as important to understand the person who has the health condition as it is to understand the health condition that the person has; (2) it is important to understand how much autonomy a disabled person wants and how well practitioners understand the level of autonomy desired by the disabled person; (3) it is important to consider that different combinations of knowledge and autonomy levels (e.g. high knowledge and high autonomy versus low knowledge and low autonomy) demand different timeframes and intensiveness related to expected outcomes (Verkaaik et al., 2010).

The dialogue in the rehabilitation process is expected to conform to the following criteria: openness, trust and active participation, as well as the ability to adjust language to the listener (including the social network), flexibility in all situations through adapting the treatment response to the unique needs of the help-seeker, toleration of uncertainty during the process, and generation of dialogue (Holmesland et al., 2014).

The concept of autonomy stresses freedom of choice and action, also the right to self-determination and privacy, informed consent and protection from interference by others (Cardol et al., 2002). Rehabilitation assessment and planning reports were considered as texts, which represent the specialists' and disabled persons' co-work during the assessment and planning. Texts were expected to reflect to what degree practitioners consider the knowledge about the social model of disability in their practice and how practitioners represent their attitude toward the person's autonomy.

During the **analysis process of Study I**, first I read the study material with the intention to identify the most significant parts of the case report, representing productive partnership, dialogue elements and recognition of the person's autonomy. Next, I looked at the discussions about the case report in the expert group, which consisted of such key issues as how specialists construct the client's identity and autonomy, how they explore a client's meaning after loss, and how specialists incorporate dialogues with clients in their descriptions following their assessment. During the expert group discussions, I documented aspects that were recognized by the experts. Afterwards, I analyzed selected description sequences of case reports again and categorized narratives according to *autonomy enhancement*, *recognition of an individual's unique characteristics* (whereby solutions respond and match with persons' individuality) and *plans that support development of new roles and qualities in the life of persons with disabilities*.

Three categories of case reports were discovered, which will be represented in the results section.

In **Studies II** and **III,** the interview material was transcribed to text. The interview texts were structured into five categories according to the CHIME frame and a relationship sub-category was positioned under the Connectedness. The codes were derived from the initial and second coding (Charmaz, 2006). During the initial coding the codes for text units were derived from text and descriptive codes were used. The aim of the analysis was to select codes in text units (line by line) for how support workers acted during the activities described by participants, related to every CHIME item and codes for activities which have had an impact on the person's recovery process. Memo writing was used to facilitate analyses and for structuring the codes and described examples of support workers' activities. For the second coding the MAXQDA program was used. Also, memo-writing and reflective diary were used to follow the analysis process and find axis codes from the material, and to document which questions gained more attention from interviewees. The final step was a return back to the initial material and, during in-depth reading, checking to see if all of the text unites that covered support and relationship topics were recognized.

In **Studies II** and **III** the interview materials were analyzed by using conventional content analysis. Conventional content analysis enables a focus on a systematic process of coding, identifying themes and patterns obtained from interviews (Hsieh & Shannon, 2005). Qualitative content analysis affords an intensive examination of language "to classify a large amount of text into an efficient number of categories that represent similar meanings" (Hsieh & Shannon, 2005: 1278). In conventional content analysis researchers derive the subcategories and names of the subcategories from the data (Hsieh & Shannon, 2005). The data analysis process starts with reading all data repeatedly to obtain the sense of the conventional content (Hsieh & Shannon, 2005). Codes are derived by reading the text word by word and by highlighting "the exact words from the text that appear to capture key thoughts or concepts" (p. 1279), and making notes of initial impressions, thoughts and analysis (Hsieh & Shannon, 2005). While the analysis continues "labels for codes emerge (that are reflective of more than one key thought)" and "come directly from the text and then become the initial coding scheme" (Hsieh & Shannon, 2005: 1279). Codes are sorted into categories and linked (Hsieh & Shannon, 2005). In addition, to prepare for reporting the findings, examples for categories and codes are identified from the data (Hsieh & Shannon, 2005).

Subsequent framing analysis allowed me, during the analysis process of **Study II,** to structure all the research material into the five larger units of the personal recovery process, i.e. Connectedness (including Relationship), Hope, Identity, Meaning and Empowerment. Inside each recovery element I structured material according to activities that provoked intrapersonal and interpersonal processes. I finally developed three frames: (1) relationship and connectedness, (2) hope and positive identity, and (3) meaning in life and empowerment. The reason for uniting the CHIME elements in the current work context, based on the knowledge derived from the research process, is that connectedness and the relationship-enhancing activities of support work are very connected, as are

identity and hope. Meaning in life and empowerment also showed some connections.

In the **Study III**, the topics which provoked questions or emotional reactions or reflections focused on the idea of recovery during the interview were explored more fully. All other elements of the analysis process remained the same as in Study II. The results structure was based on the main codes derived from the initial and second coding. Reflective diary texts, in which questions that received more attention from interviewees, were documented, were also used.

2.5. Research ethics

My intention throughout the research process was to keep in mind that every human being is valuable, and the human being comes first, not the illness or the problem (Den Hollander & Wilken, 2015). Heijst (2011) says that there are two common aspects to qualities which humans share: the way that each of them are all the same, while at the same time each of them is unique. Heijst (2011) also says that all activities in health care need to remain human-oriented and that professionals need to keep in mind that they serve humans, not dysfunctional bodies or minds, and people should never feel that they are being treated like objects.

Following the *Convention on the Rights of Persons with Disabilities and Optional Protocol* (2006: Article 3), in the research I turned attention to principles such as respect for inherent dignity, individual autonomy, non-discrimination, respect for difference, and equality (Article 5).

During the research process I intentionally did not ask persons with disabilities for information about their diagnosis, their illness symptoms, or their medical treatment. Neither did I ask for information about the persons' illness and diagnoses from specialists, nor did I read persons' medical records. I was aware that all information about health is confidential and sensitive. I focused on persons' everyday functioning and autonomy and on the relationships between the persons with disability and their practitioners (rehabilitation specialists or support workers). Case reports in **Study I** did not include information about diagnoses and medications. Further, during the interviews in **Studies II** and **III** the persons reflected on their experience with support work relationships in the context of the CHIME framework-related elements, but not their health-sensitive information. In summary: I as a researcher did not use protected personal health-related information (such as diagnoses and treatments) in composing the interviewee list or while interviewing.

In **Study I** participants of the research were informed about the research aim and process, and specialists' opportunity to contribute to the rehabilitation client work enhancement.

During the development of **Studies II** and **III,** I wrote an inquiry to The Estonian Data Protection Inspectorate and explained the research process and use of data. As a next step, the Estonian Data Inspectorate asked additional

information from me about the research and had consultations within the Inspectorate. The permission for the research was given. Next, the mental health organization providing services to the interviewees was asked permission, and informed consent was obtained from all interviewees.

The data that I collected during the studies is securely protected and can only be accessed by me. All information (in publications) about persons I have been studying is presented in such a way as to guarantee the anonymity of the individuals.

3. OVERVIEW OF FINDINGS

This chapter explores the findings of **Studies I–III.**

Study I: findings about collaboration (partnership) effects on persons' autonomy-oriented solutions in social rehabilitation

Study I findings focus on representations of the practitioner's intention to create **partnership** in the social rehabilitation assessment process and to **facilitate autonomy** in persons with disabilities, as well as to empower disabled service users in finding solutions that match their personal, environmental needs and resources, and also which concentrate on the quality of "**meaning after loss**".

The recognition of **autonomy** potential, and unique activity and participation aspects by specialists were considered in the research as markers of **partnership** for the reason that productive partnership requires action and dialogue (instead of taking a person as an object of assessment). Therefore, the usage of personal (instead of impersonal) terms in the text, the descriptions of the strength of the person and his or her context and unique solutions that support the person (or lack thereof) were analyzed as partnership and autonomy support aspects. The consideration "**meaning after loss**" was explored in the rehabilitation aims and plans in terms of how aims cover the topic of finding positive identity, valued roles in the society and recognizing (employing) vulnerability as strength.

The assessment text throughout remains the guiding document, showing the direction for rehabilitation and shaping attitudes of persons with disabilities about potential and self-efficacy. There are considerable differences in the assessment texts in terms of characterization of the disabled persons' autonomy potential and their own unique attempt to find solutions to their situation. Three categories were distinguished, as follows: *first*, the supporting persons' autonomy through partnership and rehabilitation activities, *second*, regaining previous life quality and focusing on work with shortcomings, *third*, forcing the person to change according to the defined aims of the specialist.

In some assessment texts specialists recognize and emphasize their client's autonomy and facilitate a partnership in rehabilitation, and also focus on finding meaning after loss. One contributing aspect was, for example assessment done in a person's natural environment. The rehabilitation team specialists describe in their assessment report the disabled person's own active role, their solutions for managing housework and having an active role in the village community. The specialists point out the person's unique activity: e.g. offering transportation service in a village. In this way, the team emphasizes a person's strengths and ways of using their autonomy and has adaptive resources to deal with difficult situations. Specialists are able to describe and bring out the aspects that demonstrate the person's resilience. In the rehabilitation plan, specialists focus

on a person's resources and describe the potential to find solutions that respond to a person's individual needs and selected roles.

In other assessment case reports rehabilitation specialists focus on current everyday shortcomings, as well as work and social life, and the main focus is on the problems. This demonstrates a relatively low respect toward a person's autonomy, low intention to work toward partnership and to support designing meaningful and adjusted roles.

The third group of assessment texts show the rehabilitation specialists' low respect for a person's autonomy. The texts do not mention what the person wants, prefers or likes. In the assessment text, the specialists predominantly use the impersonal voice to describe the person. In the assessment texts the person is characterized as powerless and dependent. The aim of the professional activities seems to be to stabilize the situation and "normalize" the persons, and at the same time the rehabilitation plan does not take into consideration the person's unique qualities (e.g. musical capabilities such as playing piano).

Based on this study we can conclude that in the rehabilitation process, the collaboration of practitioners and persons with disability might take different directions. The co-work in the assessment process could support persons' autonomy development, but co-work also might leave out the issue of autonomy development and the process might be driven only by practitioners' intentions.

It emerged that rehabilitation specialists' practices vary from a desire to support a persons' autonomy and the persons' own efforts and unique strengths as well as activating the person through rehabilitation activities – to low acceptance of autonomy in persons with disabilities and providing instrumental rehabilitation activities without understanding the empowering aspects of the individual.

Study II: The qualities and activities of personal recovery-oriented support work relationships

Study II findings show that **connectedness** and **relationship-enhancing** (Frame I) support activities were exemplified by qualities such as attentive and active listening, analysis-focused conversation about interactive situations involving the persons with mental health difficulties, and discussions about situations where they experienced tension or conflict or interference. A recovery-supportive relationship with a support worker is considered to be one which expresses continuity, trust, and honesty. Persons with mental health difficulties appreciate it when support workers are able to consider them persons as contributing members of a collaboration relationship in which they share stories about their life experiences, or their support workers do something beyond their usual practice (such as attending a concert organized by the client). Among the relationship elements, the interviewees considered the statement "my worker treats me as an individual, more than a 'diagnosis' or a 'label'", to be most important, as the interviewees expected the support worker to be non-judgmental and they valued behavior that reinforced the notion of equality.

Support work activities that enhance hope and positive-identity development were exemplified by: the support worker encouraging talk about dreams, about steps taken toward goals, and reminders of achievements. In such situations, interviewees appreciated the support worker being sincere and congruent (being available and agentic in relationship). It is remarkable that instrumental recognition is not helpful. Positive identity seemed to be supported by non-judgmental analysis of personal habits, actions, thoughts, identification of self- or wellbeing-destructive behavior and discussions about ways to remain hopeful. The interviewees felt that telling jokes, laughing together and maintaining a joyful atmosphere during the meetings with support workers provided hope. Interviewees considered it important to feel that the support worker is present and mindful during the sessions. They also appreciate it if the support worker is able to notice small details that the person values, or which refer to their interests and preferences. The interviewees also appreciated it when the support worker suggested novel opportunities or eye-opening reading materials' they could make use of.

Activities that enabled the discovery of meaning in life and feelings of empowerment were described as a different kind of open conversations. Trying new activities together with the support worker, especially when the support worker (herself or himself) finds the activity enjoyable, was valued. The interviews also revealed the fact that persons who considered themselves to be in the process of personal recovery valued the awareness of their mental health experience and appreciated it when support workers took seriously the dynamics of the process and understood the unique nature and flow of every individual's recovery process. The interviews indicated that the participants in the study valued hearing about the experiences of other people with mental health difficulties. The interviewees in this study found it especially helpful when support workers assisted them in holding open conversations with their relatives and helped them to explain the real characteristics of their mental health conditions to their family members.

I can conclude from this study that elements which enhance the personal recovery process are: connections with support workers that represent continuity, trust and honesty; and relationships where support workers take persons with mental health difficulties as contributors to the relationship and give opportunity for mutuality. Hope and positive identity will be enhanced by the worker's ability to be non-judgmental and discuss over habits, actions and thoughts as well as by recognizing small details. Positive identity development is evoked by the support worker's ability to reinforce the person's dynamic process of identity construction by confirming the person's positive self-image and minimizing the effects of stigmatizing or disrespectful behavior by the public. Finding meaning and feeling empowered are supported by activities such as doing novel pursuits together, sharing experiences and getting advice during insecure moments.

Study III: Cultural and relational context sensitivity related to the personal recovery process

Study III findings reflect relational and social-cultural context-sensitive aspects of personal recovery of people with mental health difficulties. The terms **recovery** and **community** raised questions among interviewees. The term *recovery* was used inconsistently, and people who are going through the process of personal recovery will at the same time reflect thoughts heard in the societal context. This means that they describe their own personal journey of recovery while simultaneously remembering situations where some mental health specialists (doctors) expressed their health condition and recovery in a clinical context, and people cannot find a rationalization for themselves concerning differences between these perspectives.

When participants gave explanations of "community", they brought in two elements: who belongs to the community, and the relations and connections between people. People with mental illness experience do not have a clear understanding about their own community, contributory relationships with the community and how to handle relationships to support their own position in the community.

Hope was considered to be a concept that seemed important, but at the same time it did not relate to their reality. Some people said that they would like to be hopeful, but they did not know how to grasp that feeling of hope. A cultural peculiarity is that "hope" means trust related to other people (in Estonian context) and other people's support on the road to personal recovery.

In the interviews with people with mental illness experience, among the seven notions that described **relationship** elements between the interviewees and their support workers, the item "my support worker respects me" often came up without much hesitation as the most important quality. People expected respect from their support workers toward their personalities and experiences. This underlines the clients' expectations that practitioners should not only respect them, but believe in their personal recovery.

To conclude, the terms *recovery*, *personal recovery* and *community* does not have unified interpretations in the Estonian context. Hope is considered to be a phenomenon that persons with mental illness experience perceive to be irrelevant to talk about, and in some cases do not have skills to achieve a feeling of hope.

4. DISCUSSION

Social rehabilitation and personal recovery-oriented mental health care in the 21st century focuses on *removing* internal disabling conditions (minimizing suffering) as well as on *building* the enabling conditions of life (dealing with negative health and building well-being) (Seligman, 2017). This shift in practice demands new presumptions and skills.

In this part of the introductory article I will discuss the results of **Studies I-III**, recovery-oriented literature and issues related to the well-functioning of human beings in the presence of fatigue. I will focus on interconnections between the personal recovery process and relational recovery, as well as on recovery-oriented value-based client work and creating connections between person with illness and their community and also cultural context-related aspects of personal recovery enhancement. Building enabling conditions of life and developing the human agency are the main concerns of social rehabilitation and mental health support work.

Recognition of human agency potential as the core of work of "building" enabling conditions of life

Study I results (based on rehabilitation assessment reports and patterns of dynamics in the assessment and planning-phase texts created by social rehabilitation practitioners) draw out patterns among the aspects that the rehabilitation specialist consider important in client work and which are represented in the rehabilitation plan. In case where the rehabilitation specialist recognizes in the assessment process such aspects as: the persons autonomy potential, knowledge and solution-focused thoughts, the person's own unique attempt to find solutions based on personal, environmental resources despite their suffering and pathologies, then the specialist may incorporate activities into the rehabilitation plan that support the person's own autonomy, selected roles and person's selected resources. We could postulate that it is important for practitioners to recognize persons as (at least potentially) well-functioning human beings, and not to limit assessment by recognizing and recording only difficulties in functioning and disabilities. Building wellbeing and the ability to "function well in the presence of fatigue" (Seligman, 2017: xii) requires understanding of human agency. Building enabling conditions in life, which include the person's body functioning, unique activity and participation elements, resources and context aspects (ICF, 2004), means that practitioners should recognize persons as agents with their own intentions, as self-organizing, proactive, self-regulating, self-reflecting beings who actively contribute to their life circumstances (Bandura, 2001). Bandura (2006) emphasizes that "to be an agent is to intentionally influence one's functioning and life circumstances" (p. 164). Agency is the product of the interplay of interpersonal, behavioral and environmental determinants. Human agency has four intrapersonal elements: intentionality (the realization of plans and strategies), forethought (visualized goals, anticipated

outcomes, purposeful behavior), self-reactiveness (ability to construct appropriate courses of actions), and self-reflectiveness (reflection upon personal efficacy) (Bandura, 2006). Belief in personal efficacy is the core belief of human agency (Bandura, 2006, Bandura, 2018).

Based on **Study I** results, and human agency theory, I propose that the practitioner's task in social rehabilitation and in personal recovery-focused mental health care, is to recognize an individual's own intentions, such as plans and plans of actions to be realized, even if these intentions and plans do not fit with the practitioner's understanding of well-functioning. Personal intentions and the person's own defined agency is an important base (thrust) for recovery, and from there it could be possible to find inspiration for the next steps in rehabilitation planning. Practitioners should also be able to recognize forethought and motivation behind behavior because these give meaning to one's life. It is helpful as well to recognize self-reactiveness, as evidenced in self-regulation, and also self-reflectiveness as the ability to reflect upon oneself. If the person has these four elements at least to some degree (the four abilities: intentionality, forethought, self-reactiveness, self-reflectiveness) then practitioners have the opportunity to reinforce self-reflection on personal efficacy (Bandura, 2018). Self-efficacy plays a special role, because it contributes to all other agentic elements. A person's belief in self-efficacy influences their goal-setting thoughts, and functioning (Bandura, 2018). People with low self-efficacy quickly give up trying. Efficacy beliefs also determine the choices people make at important decision points and their level of motivation, emotional wellbeing and performance (Bandura, 2006). Self-efficacy could be developed further (in recovery-oriented work) through experiences of overcoming obstacles, and managing failure so that it is informative rather than demoralizing ("I have not failed. I've just found 10,000 ways that won't work." Thomas Edison). Self-efficacy can also be strengthened by seeing people who are similar to oneself succeed and being persuaded to believe in themselves, which means also that self-efficacy beliefs influence persons self-motivation, goal setting, facing difficulties, outcome expectations, coping capability and choice processes (Bandura, 2012).

Human autonomy is not restricted to independent initiative. Having autonomy also means experiencing external influences, pressures or mandates to act, and autonomy should also be congruent with and endorsed by the whole self (Ryan & Deci, 2006). Because persons' functioning levels differ, it is possible to distinguish "individual differences in their tendencies toward autonomous functioning across specific domains and behaviors" (Ryan & Deci, 2006: 1563). Autonomy support refers to an environment that can support autonomy with the aim of fostering wellbeing, and this is particularly important in the mental health contexts due to its history of paternalism and control (Oades et al., 2017).

To conclude this part of the discussion I would summarize by saying that it is important for practitioners and specialists to learn to recognize a person's own intentions, their own definition of agency (including autonomy), recognize individual forethought and motivation for behavior, the personal logic of that

makes sense of the illness experience as well as their recovery process narrative (story) and their sense of self-efficacy. Through support a person can take positive steps and gain the experience of overcoming obstacles and managing their history of failure to widen their personal experience with the "taste" of self-efficacy. The main critical point in the support work context is the practitioner's ability to recognize the potential of self-efficacy, but it is also important to keep in mind that practitioners should not amplify a person's negative meaning-making.

Perceived partner responsiveness and relational agency in the context of personal recovery

Studies II and III are based on the materials of the CHIME framework of personal recovery and the discursive framing approach. Interviewees as persons in a client position emphasized their expectation of being considered as a person and not as diagnosis, and this relates to the interpersonal process called *perceived partner responsiveness* (Reis, 2014). De Mol et al. (2018) emphasize that agency is a relational construct (people experience agency in a relationship context) and agency is dependent on bi-directional transactions in the relationships.

There are two important aspects to consider related to relational agency. We should note the distinction between, *first*, human agency or agentive personhood, and *second*, relational agency. Genuine psychological agency enables the emergence of a unique form of relational being (Sugarman & Martin, 2011). People who experience difficulties in life and who are isolated agents have problems with perceiving themselves as influencing or being influenced (De Mol et al., 2018, Burkitt, 2016). Agentive personhood (human agency) is an active structuring of existence whereby agentive persons are able to self-interpret, formulate, be and become intended kinds of persons and transform social practices (Sugarman & Martin, 2011). "Only by attending carefully to the developmental context" does the emergence of agency become possible (Sugarman & Martin, 2011: 288). The practitioners' role is to support persons' growth of agency, because the personal recovery process and social rehabilitation in general, is the process of development of agency.

People need to be connected to others to be able to further develop their own agency. When a person is losing connection with the other party in the relationship and the person as an agent does not feel recognized by the other party, the person loses his or her sense of relational agency in the relationship and becomes an isolated agent (De Mol et al., 2018). This emerged from the Study II results, which showed that interviewees considered it most difficult if they didn't understand what the practitioners thought about them because their support worker did not show reactions. The isolated agent does not only become alienated from the other but also from their own emotions and cognitions due to lack of embodiment (De Mol et al., 2018). In recovery supportive practice, workers should understand that they as practitioners are also agents, which means that practitioners as agents interact with persons in client positions who

are also agents or need development of agency (autonomy, construction, action) (De Mol et al., 2018). Practitioners' activities and reflections influence their client's own agency, but also practitioners should let clients to influence them.

Relational agency is a part of any kind of social interaction, but in significant relationships it has an even stronger influence (De Mol et al., 2018). A person's sense of relational agency is constantly constructed through experiences of having relational influence on others and being relationally influenced by others (De Mol et al., 2018). The sense of relational agency does not mean having control over the other and acting in strategic ways to influence the other. Instead it could be explained through a dialectical model of influence wherein both partners are considered as agents, "who both continuously construct new meanings during their transactions with each other" (De Mol et al., 2018: 57). Partners' responses are perceived as truly responsive if they have three qualities: understanding (fosters a sense of authenticity), validation (belief that partners value and appreciate one's abilities and views), and caring (concern for one's wellbeing) (Reis, 2014). Relational agency in relational sociology recognizes agency as a relational phenomenon that is formed, enabled, constrained and constituted in the context of a social universe as the sum of manifold relations (Burkitt, 2016).

To conclude this part of the discussion I would like to emphasize that it is important that practitioners create meaningful connections with persons with disability, to take them seriously, and perceive persons with illness as agents, endowing these people with a clear perception of partner responsiveness. Research results confirm that persons expect that their practitioners not being non-participating or neutral, and instead be interactive, attentive and dialogical on an equal basis.

Relational recovery and recovery-oriented practice

Studies II and III results mainly, and Study I implicitly, indicate that the personal recovery process is influenced by social relational contexts. During the interviews, interviewees reflected that support workers activities related to all CHIME elements of the recovery process (connectedness, hope, identity, meaning and empowerment) and they recognized support workers' relational influence on them. Interviewed persons also recalled the interpersonal context of the recovery processes by describing the (strong) influence of the behavior of other persons with psychiatric illness, family members, colleagues at work, friends and community members. This reflects the reality that relational context has a strong impact on the recovery process, despite the fact that personal recovery has often been described as a deeply intrapersonal process.

Departing from the standard definition of personal recovery, which focuses on intrapersonal processes and emphasizes a deeply individual and unique process (Anthony, 1993), the CHIME framework developed in this century introduces connectedness as an element of the recovery process (Leamy et al., 2011). Further, Price-Robertson et al. (2017) turn attention to the idea that the recovery processes could potentially denote a collective phenomenon, despite the fact

that this has not been the explicit intention of the framework. Interpersonal relationships can more accurately be seen as suffusing all aspects of recovery, including experiences such as hope, identity and empowerment (Price-Robertson et al., 2017).

Price-Robertson et al. (2017) suggests that mental health care should develop, promote and implement approaches that properly acknowledge the irreducibly relational nature of recovery. They use the term *relational recovery*.

Next, I would like to go deeper and describe as an example a link that I recognized during the analyses. In the CHIME framework, the next element after **C**onnectedness is **H**ope, and related to hope interviewees indicated that what is helpful for the recovery process is support workers being sincere, congruent (being available and agentic in relationship) and encouraging talk about dreams and steps taken toward their goals. The role of the support worker is like opening a door and supporting the diversification of the person's social life, opening new horizons. This reflects not only the importance of relationship but also its connection to relational recovery. Snyder (2002: 264) says that "to not connect with others, in many ways, is not to hope". Hope is defined as a positive motivational state that is based on an interactively-derived sense of successful agency (goal-directed energy), and clear pathways (planning to meet goals). Goals, pathways and agency – this is the trilogy of hope (Snyder, 2002). I recognized that Snyder describes agency as an interactively derived element. Snyder also emphasizes the helper's role by bringing out that helper and client can work on new ways to interpret any event, along with discussing ways to cope with similar future events (Snyder, 2002: 253).

Hope and therapeutic alliance are strongly correlated according to Snyder (2002), and I think that this could be widened to a different kind of working alliance in the mental health context. To go further, Snyder says that "victimization can rob people of their hope", and if we label people according to their pathologies, then the "labeled person may not be open to the full range of goal pursuits in life" (Snyder, 2002: 253), noting also that "neglect is a passive killer of hopeful thought" (Snyder, 2002: 262). Snyder (2002) says that a person's pathways and agentic thinking are learned in childhood (and later), and most people lack hope, because they were not taught to think in this manner, or to put it in a positive way: hope is learned; we learn hopeful, goal-directed thinking in the context of other people. Hope can be raised if taught to persons (Snyder, 2002: 262). Relational context, therefore, influences hope-related activities. Snyder (2002) also brings out that the emotions of high-hopers' are consistently flavored with friendliness, happiness and confidence, which helps to explain why interviewees related hope in the context of their support workers relationship to a positive atmosphere, workers turning attentions to positive steps, and making jokes together.

Both my research results and Snyder's hope theory (Snyder, 2002), confirm that relationships and working alliances in the mental health context matter when a person is trying to derive hope during the personal recovery process. The practitioner's role is to function as hope-holders in the person's recovery

process. Snyder (2002: 268) said, “the helping relationship is one of the prime arenas for future hope research and applications”.

Another interesting aspect is that hope and the perception of the future in a language context may influence the way human beings think and behave (Roberts, Winters & Chen, 2015). Although in this current study I did not study the correlation between language and thinking, I realized that attention should be turned to this topic in future studies. Chen’s (2013) research describes ways in which language allows speaking about the future and has an impact on people’s thought and action, which means that speakers of languages that do not make a distinction between the present and the future tense (like Estonians) act differently (Roberts et al., 2015, Chen et al. 2017). Roberts et al. (2015) turn attention to the aspect that behavior correlates significantly with cultural traits (language is an integral component of culture), and linguistic concepts influence how people differentiate time and store information. In other words, “language may shape speakers’ representation of reality” (Chen et al., 2017: 322). Language affects thinking because it requires speakers to “encode different aspects of their experiences when speaking, e.g. future-referencing of events”, and affects representation of reality (Chen et al., 2017: 322). Chen et al. (2017: 323) bring out that speakers of ‘weak future-time-reference languages’ “are able to distinguish between the future and the present using their language, but they are not required to do so each time they speak” and “thus may be less precise about the difference between the present and the future”.

Relational recovery and *hopeful*, goal directed *thinking* also have links. Persons need more good and effective relationships than they get solely with support workers (or mental health workers). The CHIME framework (Leamy et al., 2011) explains that the recovery processes category *hope and optimism about the future* embraces the element of hope-inspiring relationships (p.448). Slade and Wallace (2017: 27) say that for developing hope, interventions should include fostering positive relationships and peer support.

Studies II and **III** results indicate that persons have concerns related to relationships with parents, other family members, friends, roommates, colleagues at work with whom they have intensive contacts, and with relationships which influence everyday coping. Snyder (2002) says that coping is a regulative thought process. Persons need relational recovery to be able to go on in the process of personal recovery (especially related to hope and optimism about the future). Finally, hope is related to building enabling conditions for life, because hope would help people to cope with pains and disabilities (Snyder, 2002: 260).

Identity, in the CHIME recovery process framework, has a firm connection with relationships. Price-Robertson et al. (2017) say that the social world is the very medium through which personal transformation becomes possible, and through social relationships individuals are able to redefine themselves as a persons with problems but also with abilities. In **Study II** persons described positive influence on them when a support worker participated in important situations such as applying for benefits or social housing, or discussions with family members, and when they diminished the discriminative behavior of

others; also when the person told stories about situations involving discrimination and the worker responded with sincerity, reflecting about other's not being right and taking away reasons for self-discrimination. Practitioners' human rights-based explanations have an impact as scaffoldings and have influence on positive identity development. People's thoughts about themselves are influenced by their immediate environment (and the situation that is influencing the persons) (Oyserman, Elmore & Smith, 2012). Self and identity are social products in at least three ways. *First*, people take ideas about what is possible, what is important, what needs to be explained from the social context – from what matters to others (Oyserman et al., 2012: 76). This means that people are likely to define themselves in terms of what is relevant in their time and place. *Second*, other people endorse and reinforce one's selfhood, and this means that people feel more capable of attaining their goals, in contexts that provide scaffoldings than in contexts that do not. *Third*, the aspects of one's self and identity that matter in the moment are determined by what is relevant in the moment; people change their behavior to get others to view them as they view themselves (Oyserman, et al. 2012).

Identity is closely related to **M**eaning-making, because identities provide an anchor for meaning-making, provide a meaning-making lens and focuses one's attention (Oyserman, Elmore & Smith, 2012). A sense of purpose can be gained from amplifying strengths (Slade & Wallace, 2017). Providing staff with goal-setting training improves the quality of the goal plans they are able to support (Slade & Wallace, 2017). Supporting people to becoming aware of their goals can ensure that goals are meaningful to the individual (Slade & Wallace, 2017). Meaning-making aspects that appeared in Studies II and III are related to an understanding of the individual's own mental illness experience. Park and Ai (2006) emphasize that after trauma, cognitive processing such as acceptance, active coping, seeking emotional and instrumental support are useful – in short: growth might follow the trauma, and it is related to aspects of positive adjustment. Growth results from the process of meaning-making; and meaning-making involves working through the stressful encounters, which helps the person to get to a more integrated understanding and identify redeeming features (Park & Ai, 2006, Park & Fenster, 2004). Meaning-making and positive change following trauma could possibly involve reorienting lives, reconsidering ultimate priorities, as well as individuals seeing their identities more clearly, taking better care of themselves and having courage to try new things (Park, 2004; Park & Ai, 2006). Interviewees described the importance of understanding their health conditions and symptoms in terms of which ones they could control or change, as well as which ones they have to accept because these are not under their control. They also appreciated it when the support worker recognized meaning-making processing and offered support (discussions with positive affect) or suggested trying new activities (in some case activities to try together). Meaning-making, and growth based on meaning-making will have an effect on a person's self-efficacy. Meaning-making is a long process, which according to interviewees' experiences involves a trustful

relationship and conversations with their mental health worker about their mental health condition. It can involve suggesting reading materials, help with understanding the mental illness construct and dynamic, reflection on other people's experience, processing their own experience, reflecting on their own thoughts and behavior and create meaning and personal logic out of the experience. Meaning-making is an essential facet of wellbeing (Steger, 2017), and meaning in life is perceived as greater during days when people feel closest and most connected to others (Steger, 2017, Steger & Kashdan, 2009).

Focus on **E**mpowerment in recovery-oriented practice means supporting people in taking a more active role in their recovery and exercising greater choice and control in social situations (Slade & Wallace, 2017). Being empowered is the outcome of gaining meaning, and growth of hope, and at the same time the feeling of having power and courage also gives new opportunities for empowerment for the person in the recovery process. **Study II** results indicate that a person in the recovery process experiences empowerment in cases where they are active as a peer support worker, have reflective discussions about their illness with their support worker, and if their support worker asks for advice or explanations about their mental health experience that helps the worker to understand other persons in a client's position. As interviewees reflected, it gives the feeling of being involved in the provision of better support work. Slade and Wallace (2017) also affirm that empowerment can be supported by involvement in the development and delivery of mental health services, and also training of staff.

Recovery-oriented relationships: co-creation

Many recovery process aspects have meaning within the context of relationships. While thinking about Study I–III results and the recovery framework, and the way to interpret ("translate") these aspects of recovery into support practice, I realized that personal recovery-oriented practice should turn attention to the growth of agency, hope (to learn high-hope), identity (dual-processing model) development and to relational recovery, but also there should be something that gives to the person a feeling of being recognized as a unique human being. This was evident because people in many cases reminisced during the interviews about authentic moments, when they realized that meaning is not in the instrumental act, but in being recognized in authentic ways and which influenced them to recognize themselves as unique persons as agents. Maybe if practitioners use their agency in an individualized way and if persons recognize that, then the persons themselves may start to search for their own agentic powers?

I realized also that meaning was derived from small things. Topor et al. (2018) say that small things might be just ordinary things, but they occur in unordinary contexts, and they might be seen as conditions that create some space for actions, co-creations and relations between practitioner and person. Heijst (2011) describes acts that are valuable *in se*, and she names them, based on Rudolf Ginter's idea of *expressionate acts*. "The value of such acts is not a matter of functional utility but lies in what is expressed and in the person who is

expressing" (Heijst, 2011: 119). She also mentions that the acting person is fully present and presents by one's own act something valuable to the surrounding world, even if "not being able to influence the course of events" (Heijst, 2011: 120). An expressionate act carries in itself two values: the *first value* is a relatedness to the other, and *the second* is an acknowledgement of the worth of the other. An expressionate act is one that is loaded with the affection and has a relational quality (Heijst, 2011). Heijst (2011: 120) mulls over the question: "how is human action defined?" and realizes that if "action derives meaning from the degree of influence someone has over the course of events, then health professionals can do little for the patient who is chronically ill"; but if we assume that acts might be expressions of value in and of themselves, it does make sense that the practitioner is there for the person. Small things or expressionate acts may mean stretching the boundaries between worker and client (as boundaries have been understood in the conventional boundary settings).

Meaning through action – what makes it possible? Here it is important to emphasize that practitioners should focus on the inherent value in carrying out behaviors and practices (Gordon & Oades, 2017). Gordon and Oades' (2017: 320) concept of *value-in-use* "posits that consumer value is realized during the consumption experience". Focus on creating values through social marketing and health service provision "has synergies with creating wellbeing" (Gordon & Oades, 2017: 320). Service provision in mental health should have a social value aspect, which means relations with others (groups) and the "impact on self-worth of engaging with something" (Gordon & Oades, 2017: 320). Creation of value (during the provision of services) "is oriented towards fostering wellbeing" and fostering equitable, sustainable, healthy and productive societies and individuals (Gordin & Oades, 2017: 320–321). So, I think that practitioners' values make it possible to co-create relational agency and context, which is needed for the support of people's recovery process. Support workers or mental health practitioners' own agency should be recognized as an expression of values, the co-creation of values and spreading the values in the wider context (such as community).

Practitioners' ability to support client' growth of agency could start from recognizing individuals' intentions, their thoughts about the current situation and the future (forethought), which means being present during the meetings, respecting person, being interested, also listening, seeing and recognizing, and showing engagement. The practitioners' and clients' collaboration situation could function as a safe environment in which to develop relational agency, which later, step-by-step, could transfer to relationships with other people, including community members. Because only if the recovery process covers the relational recovery aspect is the recovery process resilient, and the positive identity that is derived is then more resilient in the community context as well. The impetus for using resilient relational recovery in the community context arises from the recovery-oriented relationship with the support worker.

5. CONCLUSIONS

The aim of this thesis is to outline social rehabilitation and personal recovery-oriented aspects of client work in the mental health field that support the growth of personal autonomy and agency, and to explore support work activities that enhance the personal recovery process and support the recovery journey based on the reflections of persons who have experienced mental health difficulties. I also turned attention to relational and socio-cultural (including language) context-sensitive aspects of personal recovery, again basing these on the reflections of persons with mental health difficulties.

In **Study I** I have used the concept of interactional stories and the narrative approach to explore partnership and dialogical collaboration elements represented in rehabilitation assessment and planning texts. In **Studies II-III**, I used discursive framing and frames as knowledge structures that were derived from Connectedness-Hope-Identity-Meaning-Empowerment, the (CHIME) personal recovery process framework. The productive partnership framework and the dialogical approach abstract (represent) the aspects of social rehabilitation client work and approaches that help to understand autonomy-enhancing collaborative patterns in the collaboration between persons with disability and rehabilitation practitioners. The concepts of personal recovery, relational recovery and relational agency helped me to understand the recovery-oriented support work relationship, client work boundary elements, and effective elements of client work activities.

The conclusions of the research are as follows:

1. The social rehabilitation specialist's ability to recognize autonomy potential, strengths and adaptive resources of persons with disability, and develop a partnership during the client work (rehabilitation assessment and planning) process has effects on the person's autonomy-oriented solutions in social rehabilitation plans.

Social rehabilitation specialists have a clear option to focus, in the rehabilitation assessment process, on the persons' problems, shortcomings and disabling aspects – or to focus on abilities, strenghts, and on resources available in the person's (with disability) context and environment.

Study I findings indicate that if practitioners develop partnerships with the persons with disability, and recognize and learn to understand their unique situational characteristics and resources, then practitioners can, together with the individual, develop the plan that is best suited to the currently available context resources that support the person's functioning in roles which the person has chosen for themselves, and supports autonomy. When assessment focuses on shortcomings and problems in functioning and even if the assessment text contains some unique resources of the person, which are however left behind, and the main aim of rehabilitation seems to be to maintain the status quo, then practitioners' written rehabilitation plans do not show the

potential to find solutions that correspond to the unique person's own needs and wishes. A third group of assessment texts represent practices, where specialists focus only on shortcomings of body functioning and on the person's life history. Such texts represent distance between persons with disability and practitioners (using impersonal voice in descriptions of the situation), where the person, by implication, is powerless and dependent on health and rehabilitation services. In this kind of rehabilitation specialist assessment practice, they do not take into considerations persons' unique qualities and do not recognize persons' own wishes, showing specialist's low respects toward the persons' autonomy.

2. The qualities and activities of a personal recovery-oriented support work relationship include trust, mutuality, reinforcement of equality, being non-judgmental, reducing stigma and self-stigma in client-worker or client-worker-third person conversations, recognizing dynamics of the person's own recovery process, and trying new activities together.
Research outcomes indicate that persons with mental health difficulties could achieve connectedness with people (and places), and relationships with their support worker when the support worker is attentive, listens actively and facilitates analysis-focused discussion. These open discussions give the person opportunity to understand tensions or conflict situations. Relationships can be enhanced when the support worker recognizes the person as a contributing partner and as a unique individual.

Hope and positive identity could be developed further when the support worker encourages the person to talk about dreams and steps taken and to take toward goals. Helpful for identity development is non-judgmental analysis of habits, identification of wellbeing destructive or enhancing behavior, and maintaining a hopeful stance. Meaning in life and a feeling of empowerment could be gained when persons try new activities or the worker and person together try new activities and find it joyful. Persons start to create meaning when they get more information about their mental health condition and raise their awareness about their own experience and recovery journey dynamics.

3. Personal recovery is cultural- and relational-context sensitive. Fostering ideas of human agency, autonomy, personal recovery and relational recovery in mental health work (including support work) could open up the ways for overcoming the structural obstacles to inclusion into the community.
Based on **Study III** results, it can be concluded that persons with disability could strive towards relational recovery if support workers believe in the possibility of personal and relational recovery of their clients, and practitioners respect the personalities and experiences of persons with mental health difficulties.

Currently, the terms *personal recovery* and *community* do not have unified and common meaning in Estonian society, and for this reason persons with mental health difficulties do not use them consistently.

Socio-cultural context peculiarity arises when persons with disability answer questions about hope and being hopeful. Hopefulness seemed important, but persons do not have awareness as to keep hopeful. What also emerged was that hope and feeling hopeful are related to trust in other people and other people's support in the personal recovery process.

Research on recovery-oriented client work and findings about collaboration (partnership) effects on a persons' autonomy-oriented solutions in social rehabilitation indicate the need for further researches and a more thorough study of the content qualities of social rehabilitation and recovery-oriented support work in mental health client work.

In the discussion section I have argued that practitioners' abilities and skills to support growth of human agency and autonomy have important value for the life quality and functioning (including functioning in the community and neighborhood) of persons with disabilities and mental health difficulties. These are the characteristics that should exemplify the qualities of social rehabilitation and mental health service provision. The research into personal recovery processes and recovery-oriented support work, especially that focused on socio-cultural aspects of recovery and recovery-oriented support, and relational recovery, could introduce knowledge about opportunities to develop cultural context-sensitive recovery-oriented support, and also information concerning which concepts and terms have socio-cultural specific meanings and interpretations.

REFERENCES

Adshead, G. (2008). Studying the mind: ethical issues and guidance in mental health research. *Clinical Ethics*, Vol. 3, pp. 141–144. DOI:10.1258/ce.2008.008026

Anderson., B. (2014). *Encountering Affect: Capacities, Apparatuses, Conditions*. London: Ashgate, pp. 1–208

Anthony, W. (1993). Recovery from mental illness: the guiding vision of the mental health services system in the 1990s. *Psychosocial rehabilitation journal*, Vol. 16(4), pp. 11–23

Bandura, A. (2001). Social Cognitive Theory: An Agentic Perspective. *Annual Review of Psychology*, 52, pp. 1–26. DOI:10.1146/annurev.psych.52.1.1

Bandura, A. (2006). Towards a Psychology of Human Agency. *Perspectives on Psychological Science*, Vol. 1, pp. 164–180. DOI:10.1111/j.17456916.2006.00011.x.

Bandura, A. (2012). On the Functional Properties of Perceived Self-Efficacy Revisited. *Journal of Management*, 38, 1, pp. 9–44. DOI:10.1177/0149206311410606

Bandura, A. (2015). On deconstructing commentaries regarding alternative theories of personality. *Journal of Management*, Vol. 41, pp. 1025–1044

Bandura, A. (2018). Toward a Psychology of Human Agency: Pathways and Reflections. *Perspectives on Psychological Science*, Vol. 13 (2), pp. 130–136. DOI:10.1177/17456916176992802

Banks, S. (2013). Negotiating personal engagement and professional accountability: professional wisdom and ethics work. *European Journal of Social Work,* Vol.16, no 5, pp. 587–604. DOI:10.1080/13691457.2012.732931

Beresford, P. (2010). Re-Examining Relationship Between Experience, Knowledge, Ideas and Research: A Key Role for Recipients of State Welfare and Their Movement. *Social Work and Society*, Vol. 8, 1

Beresford P. (2015). From 'recovery' to reclaiming madness. *Clinical Psychology Forum*, Vol. 268, pp. 16–20

Benight, C.C. & Bandura, A. (2004). Social cognitive theory of posttraumatic recovery: the role of perceived self-efficacy. *Behaviour Research and Therapy*, Vol. 42, pp. 1129–1148. DOI:10.1016/j.brat.2003.08.008

Benight, C.C., Harwell, A. & Shoji, K. (2018). Self-Regulation Shift Theory: A Dynamic Personal Agency Approach to Recovery Capital and Methodological Suggestions. *Frontiers in Psychology*, Vol. 9, 1738, pp. 1–8. DOI:10.3389/fpsyg.2018.01738

Benight, C.C., Shoji, K. & Delahanty, L. (2017). Self-Regulation Shift Theory: A Dynamic Systems Approach to Traumatic Stress. *Journal of Traumatic Stress,* Vol. 30, pp. 333–342. DOI:10.1002/jts.22208

Bird, V., Leamy, M., Tew, J., Le Boutillier, C., Williams, J. & Slade, M. (2014). Fit for purpose? Validation of a conceptual framework for personal recovery with current mental health consumers. *Australian and New Zealand Journal of Psychiatry*, Vol. 48, 7, pp. 644–653

Bond, G.R., Salyers, M.P., Rollins, A.L., Rapp, C.A. & Zipple, A.M. (2004). How Evidence-Based Practices Contribute to community Integration. *Community Mental Health Journal*, Vol. 40, 6, pp. 569–588. DOI:10.1007/s10597-004-6130-8

Borg, M. & Kristiansen, K. (2004). Recovery-oriented professionals: Helping relationships in mental health services. *Journal of Mental Health*, Vol. 13, 5, pp. 493–505

Bromley, E., Gabrielian, S., Brekke, B., Pahwa, R., Daly, K. A., Brekke, J. S. & Braslow, J. T. (2013). Experiencing community: perspectives of individuals diagnosed as having serious mental illness. *Psychiatric services (Washington, D.C.)*, Vol. 64, 7, pp. 672–679

Bugarszki, Z., Medar, M., van Ewijk, J. P., Wilken, J. P., Narusson, D., Saia, K., Kriisk, K., Kiis, A., Susi, M., Sooniste, I. & Rahu, A. (2016). *Uuring psüühilise erivajadusega inimestele suunatud erihoolekandesüsteemi ümberkorraldamiseks ja tõhustamiseks teiste riikide praktikate alusel. Lõppraport*

Burkitt, I. (2016). Relational agency: Relational sociology, agency and interaction. *European Journal of Social Theory*, Vol. 19, 3, pp. 322–339. DOI:10.1177/1368431015591426

Cardol, M., De Jong, B.A. & Ward, C.D. (2002). On autonomy and participation in rehabilitation. *Disability and rehabilitation*, Vol. 24, 18, pp. 970–974

Charmaz, K. (2006). *Constructing Grounded Theory, A Practical Guide through Qualitative Analysis.* SAGE Publications, London

Chen, M.K. (2013). The Effect of language on economic behavior: Evidence from savings rates, health behaviors, and retirement assets. *American Economic Review*, Vol. 103, 2, pp. 690–731, DOI:10.1257/aer.103.2.690

Chen, S., Cronqvist, H., Ni, S. & Zhang, F. (2017). Language and corporate savings behavior. *Journal of Corporate Finance,* Vol. 46, pp. 320–341, DOI:10.1016/j.corpfin.2017.07.009

Chirkov, V., Ryan, R.M,. Kim, Y. & Kaplan, U. (2003). Differentiating autonomy from individualism and independence: a self-determination theory perspective on internalization of cultural orientations and well-being. *Journal of Personality and Social Psychology*. Vol. 84, pp. 97–110.

Coggins, T. (2017). Community Level: Translating Wellbeing Policy, Theory and Evidence into Practice. In: Slade, M., Oades, L., Jarden, A,. editors. *Wellbeing, Recovery and Mental Health.* 2017. Cambridge, Cambridge University Press, pp. 231–244

Convention on the Rights of Persons with Disabilities (CRPD), (2006). United Nations, Department of Economics and Social Affairs. https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/convention-on-the-rights-of-persons-with-disabilities-2.html

Cornelissen, J.P. & Werner, M.D. (2014). Putting Framing in Perspective: A Review of Framing and Frame Analysis across the Management and Organizational Literature. *The Academy of Management Annuals*, Vol. 8, 1, pp. 181–235, DOI:10.1017/S2045796012000133

CRPD *Disability language guidelines* (n.d.). https://www.unescwa.org/sites/www.unescwa.org/files/page_attachments/guidelines-_disability_language_english_version.pdf

Davidson, L, O'Connell, M.J., Tondora, J., Lawless, M. & Evans, A.C. (2005). Recovery in serious mental illness: A new wine or just a new bottle? *Professional Psychology: Research and Practice*, Vol. 36, pp. 480–487

Deegan, P. E. (1988). Recovery: The lived experience of rehabilitation. *Psychosocial Rehabilitation Journal,* Vol. 11*,* 4, pp. 11–19. DOI:10.1037/h0099565

Deering, K. & Williams, J. (2018). What activities might facilitate personal recovery for adults who continue to self-harm? A meta-synthesis employing the connectedness/hope and optimism/identity/meaning/empowerment framework. *Journal of Mental Health Nursing*, Vol. 27, pp. 483–497, DOI:10.1111/inm.12387

De Mol, J., Reijmers, E., Verhofstadt, L. & Kuczynski, L. (2018). Reconstructing a Sense of Relational Agency in Family Therapy. *Australian and New Zealand Journal of Family Therapy*, Vol. 39, pp. 54-66, DOI:10.1002/anzf.1278

Den Hollander, D. & Wilken, J.P. (2015). *Supporting Recovery and Inclusion. Working with the CARe model.* SWP Publisher, pp. 1–197

Department of Health. (2010). *Improving the health and well-being of people with long term conditions. World class services for people with long term conditions – information tool for commissioners*. London, Crown

Duff, C. (2016). Atmospheres of recovery: Assemblages of health. *Environment and Planning*, Vol. 48, 1, pp. 58–74, DOI:10.1177/0308518X15603222

EPIK (Eesti Puuetega Inimeste Koda) (2018). ÜRO puuetega inimeste õiguste konventsiooni täitmise variraport. *Puuetega inimeste eluolu Eestis*, pp. 1–146

Estonian Social Welfare Act (2015). Act, Riigikogu

Gordon, R. & Oades, L.G. (2017). Social Marekting of Wellbeing. In: *Wellbeing, Recovery and Mental Health*. Eds Slade M, Oades L, Jarden A, Cambridge, Cambridge University Press, pp. 311–323

Hall, C. (1997). *Social Work as Narrative. Storytelling and persuasion in professional texts.* Ashgate Publishing Company

Hall, C. & Matarese, M. (2014). Narrative. In: *Analysing social work communication. Discourse in practice*. Eds Hall, C., Juhila, K., Matarese, M., Nijnatten, C., pp. 79–97

Heijst, A. (2011). *Professional Loving Care. An Ethical View of the Healthcare Sector*, Peeters

Holmesland, A.-L., Seikkula, J. & Hopfenbeck, M. (2014). Inter-agency work in Open Dialogue: the significance of listening and authenticity. *Journal of Interprofessional Care*, Vol. 28, 5, pp. 433–439, DOI:10.3109/13561820.2014.901939

Hsieh, H.F. & Shannon, S.E. (2005). Three Approaches to Qualitative Content Analysis. *Qualitative Health Research*, Vol. 15, 9, pp.1277–1288

Hungerford, C. & Fox, C. (2014). Consumer's perceptions of Recovery-oriented mental health services: An Australian case-study analysis. *Nursing & health sciences*, Vol. 16, 2, pp. 209–215

Huston, T.L. (2002). Power. In: *Close Relationships*. Eds Kelley, H.H., Berschied, E., Christensen, A., Harvey, J., Huston, T.L., Levinger, G., McClintock, E., Peplau, L.A. & Peterson D.R., New York, Freeman, pp. 169–219

ICF. *International Classification of Functioning, Disability and Health* (2004). https://www.who.int/classifications/icf/en/

Inglehart, R. & Welzel, C. (2009). How Development Leads to Democracy. *Foreign Affairs,* Vol. 88, 2, pp. 33–48

Jacob, K.S. (2015). Recovery model of mental illness: A complementary approach to psychiatric care. *Indian Journal of Psychological Medicine*, Vol. 37, 2, pp. 117–119

Jensen, L.W. & Wadkins T.A. (2007). Mental health success stories: Finding paths to recovery. *Issues of Mental Health Nursing*, Vol. 28, pp. 325–340

Kuuse, R. & Toros, K. (2017). Estonian social policy: from Soviet heritage to understanding the principles of deinstitutionalization. *European Journal of Social Work*, Vol. 20, DOI:10.1080/13691457.2017.1357024

Law, H. & Morrison, A.P. (2014). Recovery in psychosis: a Delphi study with experts by experience. *Schizophrenia Bulletin*, Vol. 40, 6, pp. 1347–1355, DOI:10.1093/schbul/sbu047

Leamy, M., Bird, V., Le Boutillier, C., Williams, J. & Slade, M. (2011). Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. *British Journal of Psychiatry*, Vol. 199, pp. 445–452, DOI:10.1192/ bjp.bp. 110.083733

Masso, M., Nurmela, K. & Foster, D. (2016). *Industrial relations and workplace adaptation. Supporting industrial relations in the field of workplace adaptation to enable the employment of older or disabled populations: Literature review*. Praxis Center for Policy Studies in Estonia, pp. 1–52

McCormick, J. (1996). Death of the personal doctor. *Lancet*, 348, pp. 667–668

Narusson, D. (2013). The Disabled person's and rehabilitation specialist's dialogue within the rehabilitation assessment and planning process: Analysis based on assessment case reports. *Journal of Social Policy and Social Work in Transition*, Vol. 2, pp. 10–30, DOI:10.1921/5304030202

Narusson, D. & Wilken, J.P. (2018). Recovery in the Community: Relational and Cultural Sensitivity. *Journal of Recovery in Mental Health*, Vol. 2, 1, pp. 68–81, https://jps.library.utoronto.ca/index.php/rmh/article/view/31915

Narusson, D., & Wilken, J.P. (2019). Recovery-oriented support work: the perspective of people with lived experience. *Journal of Mental Health Training, Education and Practice* (under review)

Oades, L.G., Deane, F.P. & Crowe, T.P. (2017). Collaborative Recovery Model. In: *Wellbeing, Recovery and Mental Health*. Eds Slade, M., Oades, L., Jarden, A, Cambridge, Cambridge University Press, pp. 99–110

O'Leary, P., Tsui, M. S., & Ruch, G. (2012). The boundaries of the social work relationship revisited: Towards a connected, inclusive and dynamic conceptualisation. *British Journal of Social Work*, Vol. 43, 1, pp. 135–153.

Oliver, M., Sapey, B. & Thomas, P. (2012). *Social work with disabled people.* 4th ed. Palgrave Macmillan, pp. 1–189

Oyserman, D., Destin, M. & Novin, S. (2015). The Context-Sensitive Future Self: Possible Selves Motivate in Context, Not Otherwise. *Self and Identity,* Vol. 14, 2, pp.173–188, DOI:10.1080/15298868.2014.965733

Oyserman, D., Elmore, K. & Smith, G. (2012). Self, Self-Concept, and Identity. In: *Handbook of Self and Identity*. Eds Leary, M.R, Tangney, J.P., New York, The Guildford Press, pp. 69–104

Oyserman, D., Lewis, N.A., Yan, V.X., Fisher, O., O'Donnell, C. & Horowitz, E. (2017). An Identity-Based Motivational Framework for Self-Regulation. *Psychological Inquiry,* Vol. 28, 2–3, pp. 139–147, DOI:10.1080/1047840X.2017.1337406

Popova, Y.B. (2014). Narrativity and enaction: the social nature of literary narrative understanding. (Hypothesis and theory article). *Frontiers in Psychology. Cognitive Science*, Vol. 5, pp. 1–14, DOI: 10.3389/fpsyg.2014.00895

Park, C. L. (2004). The notion of stress-related growth: Problems and prospects. *Psychological Inquiry*, Vol. 15, pp. 69–76

Park, C.L. & Ai, A.L. (2006). Meaning Making and Growth: New Directions for Research on Survivors of Trauma. *Journal of Loss and Trauma*. Vol. 11, pp. 389–407, DOI:10.1080/15325020600685295

Park, C. L. & Fenster, J. A. (2004). Stress-related growth: Predictors and processes. *Journal of Social and Clinical Psychology*, Vol. 23, pp. 195–215

Phillips, D. (2004). The Dynamics of Partnership and Professionals in the Lives of People with learning Difficulties. In: *Disability Policy and Practice: applying the Social Model*. Eds Barnes, C., Mercer G., The Disability Press, pp. 160–174

Pilgrim, D. (2008). `Recovery' and current mental health policy. *Chronic Illness*, Vol. 4, 4, pp. 295–304, DOI:10.1177/1742395308097863

Price-Robertson, R., Obradovic, A. & Morgan, B. (2017). Relational recovery: beyond individualism in the recovery approach. *Advances in Mental Health,* Vol. 15, 2, pp. 108–120, DOI:10.1080/18387357.2016.1243014

Reis, H. T. (2014). Responsiveness: Affective interdependence in close relationships. *Mechanisms of social connection: From brain to group*, pp. 255–271

Roberts, S.G., Winters, J. & Chen, K. (2015). Future Tense and Economic Decisions: Controlling for Cultural Evolution. PLoS ONE, Vol. 10, pp. 1–46, DOI:10.1371/journal.pone.0132145

Roddis, J.K., Holloway, I., Bond, C. & Galvin, K.T. (2016). Living with a long-term condition: Understanding well-being for individuals with thrombophilia or asthma. *International Journal of Qualitative Studies in Health and Well-being*, Vol. 11. DOI:10.3402/qhw.v11.31530

Ryan, R.M. & Deci, E.L. (2006). Self-Regulation and the Problem of Human Autonomy: Does Psycology Need Choice, Self-Determination, and Will? *Journal of Personality,* Vol. 74, 6, pp. 1557–1585, DOI:10.1111/j.1467-6494.2006.00420

Salmon, P. & Riessman, C.K. (2008). Looking back on narratives research: An Exchange. In: *Doing Narrative Research*. Eds Andrews M., Squire C., Tamboukou, M., Sage.

Schrank, B., Brownell, T., Tylee, A. & Slade, M. (2014). Positive Psychology: An Approach to Supporting Recovery in Mental Illness. *East Asian Archives of Psychiatry*, Vol. 24, 3, pp. 95–103

Shanks, V., Williams, J., Leamy, M., Le Boutillier, C. & Slade, M. (2013). Measures of personal recovery: A systematic review. *Psychiatric Services*, Vol. 64, 10, pp. 974–980

Shepherd, G., Boardman, J., Rinaldi, M. & Roberts, G. (2014). *Supporting recovery in mental health services: Quality and Outcomes. Implementing Recovery through Organisational Change,* London

Shevellar, L. & Barringham, N. (2016). Working in Complexity: Ethics and Boundaries in Community Work and Mental Health. *Australian Social Work,* Vol. 69, 2, pp.181–193, DOI:10.1080/0312407X.2015.1071861

Seikkula, J. (2011). Becoming dialogical: Psychotherapy or a way of life? *The Australian and New Zealand Journal of Family Therapy*, Vol. 32, pp. 179–193

Seikkula, J. (2008). Inner and outer voices in the present moment of family and network therapy. *Journal of Family Therapy*, Vol. 30, pp. 478–491

Seikkula, J., & Trimble, D. (2005). Healing elements of therapeutic conversation: Dialogue as an embodiment of love. *Family process*, Vol. 44, 4, pp. 461–475 DOI:10.1111/j.1545-5300.2005.00072.x

Seligman, M. (2017). Foreword. In: *Wellbeing, Recovery and Mental Health*. Eds Slade, M., Oades ,L., Jarden, A., Cambridge, Cambridge University Press, p. xi–xiii

Slade, M. (2010). Mental illness and well-being: the central importance of positive psychology and recovery approaches. *BMC Health Service Research*, Vol. 10, 26, pp. 1–14

Slade, M. & Longden, E. (2015). *The empirical evidence about mental health and recovery: how likely, how long, what helps?* Published by MI Fellowship, pp. 1–31

Slade, M., Oades, L. & Jarden, A. (2017). *Wellbeing, Recovery and Mental Health*. Cambridge University Press, pp. 1–332

Slade, M. & Wallace, G. (2017). Recovery and Mental Health. In: *Wellbeing, Recovery and Mental Health.* Eds Slade, M., Oades ,L., Jarden, A., Cambridge, Cambridge University Press. pp. 24–34

Snyder, C.R. (2002). Hope theory: Rainbows in the Mind. *Psychological Inquiry*, Vol. 13, 4. pp. 249–275, DOI:10.1207/S15327965PLI1304_01

The Social Welfare Development Plan 2016–2023. (2016). Tallinn: Ministry of Social Affairs. Retrieved August, 19, 2018, from http://www.sm.ee/et/heaolu-arengukava-2016–2023

Stajkovic, A.D., Bandura, A., Locke, E.A., Lee, D. & Sergent, K. (2018). Test of three conceptual models of influence of the big five personality traits and self-efficacy on academic performance: A meta-analytic path-analysis. *Personality and Individual Differences,* Vol. 120, pp. 238–245, DOI:10.1016/j.paid.2017.08.014

Steger, M.F. (2017). Meaning in Life and Wellbeing. In: Slade M, Oades L, Jarden A, editors. Wellbeing, Recovery and Mental Health. 2017. Cambridge: Cambridge University Press. pp. 75–85

Steger, M. F., & Kashdan, T. B. (2009). Depression and everyday social activity, belonging, and well-being. *Journal of counseling psychology*, Vol. 56, 2, pp. 289

Stuart, S.R., Tansey, L. & Quayle, E. (2017). What we talk about when we talk about recovery: a systematic review and best-fit framework synthesis of qualitative literature. *Journal of Mental Health*, Vol. 26, 3, pp. 291–304, DOI:10.1080/ 09638237.2016.1222056

Sugarman, J., & Martin, J. (2011). Theorizing relational agency. *Journal of Constructivist Psychology*, Vol. 24, pp. 283–289. DOI:10.1080/10720537.2011.593455

The ICD-11 Classification of Mental and Behavioural Disorders (n.d.a.) https://icd.who.int. World Health Organization

The United Nations Convention on the Rights of Persons with Disabilities (2006)

Tew, J., Ramon, S., Slade, M., Bird, V., Melton, J., & Le Boutillier, C. (2012). Social factors and recovery from mental health difficulties: a review of the evidence. *British Journal of Social Work,* Vol. 42, 3, pp. 443–460, DOI:10.1093/bjsw/bcr076

Topor, A. & Denhov, A. (2015). Going beyond: Users' experiences of helping professionals. *Psychosis*, Vol. 7, 3, pp. 228–236, DOI:10.1080/17522439.2014.956784

Topor, A., Bøe, T. D., & Larsen, I. B. (2018). Small things, micro-affirmations and helpful professionals everyday recovery-orientated practices according to persons with mental health problems. *Community mental health journal*, Vol. 54, 8, pp. 1212–1220, DOI:10.1007/s10597-018-0245-9

Urek, M. (2005) Making a case in social work: the construction of an unsuitable mother, *Qualitative Social Work,* Vol. 4, 4, pp. 451-467

UT Pärnu College (2009). *Rehabilitation specialists training*. http://video.pc.ut.ee/yritused/reha/

VATEK (2016). *Mental Health Strategy 2016 – 2025*

Verkaaik, J., Sinnott, A., Cassidy, B., Freeman, C. & Kunowski, T. (2010). The productive partnership framework: harnessing health consumer knowledge and autonomy to create and predict successful rehabilitation outcomes. *Disability and Rehabilitation*, Vol. 32, 12, pp. 978–985

Starnino, V.R. (2009). An Integral Approach to Mental Health Recovery: Implications for Social Work. *Journal of Human Behavior in the Social Environment*, Vol. 19, 7, pp. 820–842, DOI:10.1080/10911350902988019

Ware, N.C., Hopper, K. & Tugenberg, T. (2007). Connectedness and citizenship: redefining social integration. *Psychiatric Services*, Vol. 58, pp. 469–474

Watson, D.P. (2012). The Evolving Understanding of Recovery: What the Sociology of Mental Health has to Offer. *Humanity Sociology*, Vol. 36, 4. pp. 290–308, DOI:10.1177/0160597612458904

Watson D.P., McCranie A. & Wright E.R. (2014). Everything Old Is New Again: Recovery and Serious Mental Illness. In: *Sociology of Mental Health*. Eds Turner, R., Link, B, Briefs in Sociology, Springer, Cham

Weick, K.E. (1995). *Sensemaking in organisations*, Thousand Oaks, CA, Sage

WHO, World Health Organisation (2011). *World report on disability 2011.* https://www.who.int/disabilities/world_report/2011/report.pdf

WHO (2014). *The definition of mental health* http://www.who.int/features/factfiles/mental_health/en/

Wilken, J.P., Bugarszki, Z., Hanga, K., Narusson, D., Saia, K. & Medar, M. (2017). Community orientation of services for persons with a psychiatric disability Comparison between Estonia, Hungary and the Netherlands. *European Journal of Social Work*, Vol. 20, pp. 1−12, DOI:10.1080/13691457.2017.1289896

Williams, J., Leamy, M., Bird, V., Le Boutillier, C., Norton, S., Pesola, F. & Slade, M. (2015). Development and evaluation of a measure to identify mental health service support for recovery (INSPIRE). *Social Psychiatry and Psychiatric Epidemiology*, Vol. 50, pp. 777–786. DOI:10.1007/s00127-014-0983-0

Wellbeing and Recovery College Estonia. Heakool (2018). http://heakool.ee

SUMMARY IN ESTONIAN

Personaalset taastumist ja agentsust toetav klienditöö vaimse tervise ja sotsiaalse rehabilitatsiooni valdkonnas: vaimse tervise raskustega inimeste ja spetsialistide perspektiivid

Sissejuhatus

Vaimse tervise ja sotsiaalse rehabilitatsiooni valdkonna klienditöö suunad on avardunud, sest ühiskond ja inimeste ootused on aja jooksul muutunud. Uuenenud arusaamadega kooskõla otsides on hakatud väärtustama inimeste personaalse taastumise protsessi ning kliendi ja spetsialisti koostööd, mis on orienteeritud toimevõimekuse ehk agentsuse ja iseseisvuse ehk autonoomia edendamisele. Eeltoodust lähtudes on doktoritöö fookusse seatud sotsiaalse rehabilitatsiooni ja vaimse tervise klienditöö aspektid, mis toetavad inimeste iseseisvuse ja toimevõimekuse arengut ning personaalse taastumise protsessi, kuid mis on samal ajal suhete ja keskkonna ning sotsiaal-kultuurilise konteksti tundlikud.

Haiguse ja vaimse tervise raskuste kestmisel on tähtis, et inimesed keskenduksid elamisväärse elu kujundamisele ja leiaksid võimalusi, kuidas igapäevaelus hästi toime tulla ja saavutada heaolu, kuigi tervislikust olukorrast tulenevad mitmesugused raskused. Vaimse tervise raskustega inimese heaolu on seotud personaalse taastumise protsessiga. Sellist taastumist võib käsitleda kolmest vaatepunktist: 1) biomeditsiinilisest vaatepunktist lähtudes keskendutakse haigusest terveks saamisele, 2) kliinilise rehabilitatsiooni ja psühhiaatria korral tegeldakse haiguse põhjustatud kahjustustest taastumisega ning 3) personaalse taastumise korral otsib inimene väljapääsu olukorrast, kus teda ei peeta täisväärtuslikuks ühiskonnaliikmeks, ja tal tuleb leida võimalusi, kuidas igapäevaelu raskustest hoolimata muuta elu elamisväärseks ja saavutada respekteeritus ühiskonnas (Pilgrim, 2008). Kaks esimest vaatepunkti ei anna vastust küsimusele, kuidas luua täisväärtuslikku elu võimaldavad tingimused ühiskonnas ja kogukonnas, seevastu personaalse taastumise valdkond annab vastused ja lähtub eeldusest, et iga inimese personaalse taastumise protsess on unikaalne ja oma protsessi kulu üle teeb otsuseid või annab hinnanguid tema ise. Samas vajab ta selles protsessis spetsialistide tuge. Vaimse tervise valdkonna praktikutele valmistab aga raskusi see, kuidas arendada partnerlussuhteid ja leida klienditöö tegevusi, mis toetaksid personaalse taastumise protsessi.

Eesmärk

Doktoritöö eesmärk oli tuua välja personaalsele taastumisele orienteeritud vaimse tervise valdkonna ja sotsiaalse rehabilitatsiooni spetsialistide klienditöö tegevuste aspektid, mis toetavad inimese iseseisvust ja toimevõimekuse arengut ning personaalse taastumise protsessi, kuid mis võtavad samal ajal arvesse suhete ja sotsiaal-kultuurilise konteksti tundlikkust.

Doktoritöö põhineb ülevaateartiklil ja kolmel rahvusvahelistes eelretsenseeritavates ajakirjades avaldatud artiklil. Eestikeelses lühikokkuvõttes tutvustan väitekirja kirjandusülevaates käsitletud personaalse taastumise, toimevõimekuse ning ka partnerlusel ja väärtuspõhisel käitumisel rajaneva klienditöö aspekte, samuti uurimistöös kasutatud kvalitatiivseid andmete kogumise ja analüüsimise meetodeid, uurimistulemusi ning diskussiooni põhiteese.

Uudsus

Doktoritöö teemakäsitluse teeb uudseks asjaolu, et uurimuses pööran tähelepanu võimalustele toetada personaalse taastumise protsessi ühiskonnas, kus vaimse tervise raskustega (ehk psüühikahäire diagnoosi saanud) inimestesse suhtumise, nendega käitumise ja abistamise suhtes valitsevad erinevad vaated. Vaimse tervise ja sotsiaalse rehabilitatsiooni valdkonna eestvedajad on võtnud omaks lääneriikide põhimõtted ning otsivad võimalusi tasandada kiiresti vahet vaimse tervise teenuste kvaliteedis (võrreldes läänega). Seevastu on tavainimeste väärtuspõhine suhtumine vaimse tervise raskustega või puuetega inimestesse väga visa muutuma, mida tõendab ka see, et halvustamine, hirmud, alavääristamine ning oskamatus käituda kaaskodanikuna ja töökohas kolleegina pole kuskile kadunud. Samas on see ka arusaadav, sest kultuurinormid (väärtused) on püsivad, inertsed ega käi ühes rütmis reformidega. Tulemuseks on aga pinged, millega tuleb vaimse tervise raskustega inimestel hakkama saada. Olukord on keeruline eriti just nende jaoks, kes tahavad saavutada iseseisvust, tegelevad oma personaalse taastumise protsessiga ja püüavad leida oma kohta ühiskonnas kõrvuti kõigi kodanikega. Suure surve all on ka tegevusjuhendajad ja teised spetsialistid, kes toetavad järjepidevalt vaimse tervise raskustega inimeste toimetulekut igapäevaeluga ja nende personaalset taastumist. Spetsialistidele on parajaks proovikiviks järgida oma töös personaalse taastumise põhimõtteid olukorras, kus avalikkus ei ole neid printsiipe täiel määral omaks võtnud. Seevastu lääneriikides töötavad vaimse tervise valdkonna spetsialistid ei puutu eespool kirjeldatud kontekstiga kas üldse või vähemalt mitte sel määral kokku.

Doktoritöö teemakäsitlus pakub huvi vaimse tervise ja sotsiaalse rehabilitatsiooni spetsialistidele nii Eestis kui ka teistes riikides, mis läbivad samu protsesse. Ingleharti ja Weizeli (2009: 13) sõnul esindavad Eesti (ka Läti, Leedu, Ungari jt) avaliku sektori väärtused rohkem eneseväljenduslikke väärtusi, kui rahva väärtused lubaksid ennustada, seejuures rõhutavad nad, et Eesti on üle-

pingutaja või ülesaavutaja (*overachiever*) rollis, mis tähendab, et inimeste ellujäämisväärtustest pole piisavalt edasi kujunenud eneseväljenduslikud väärtused, mille on riik demokraatia arendamise nimel avalikus sektoris omaks võtnud. Samas, kuna Eesti on vastu võtnud ÜRO puuetega inimeste õiguste konventsiooni, on riik ja rahvas otsustanud lähtuda inimõigustest ning seega tagasiteed ei ole.

Personaalse taastumise ja toimevõimekuse aspektid teaduskirjanduse põhjal

Taastumise mõistet on valdkonniti käsitletud eri viisil. Doktoritöös keskendun personaalsele taastumisele, mis on seotud heaoluga (*wellbeing*). *Personaalne taastumine* tähistab inimese muutumise ja arengu protsessi, mille vältel kujundab ta uue(d) rolli(d) (patsiendi rolli asendumine ühiskonnaliikme ja õigusikohustusi omava kodaniku rolliga, aga ka pereliikme vm rolliga) ning saavutab elamisväärse elukvaliteedi (aktsepteeritav elukoht, võimalused töötamiseks ja/või uute oskuste omandamiseks, vastastikused hoolivad suhted). Ühtlasi muutuvad selle protsessi vältel inimese väärtused. Kuna elu ei ole staatiline, vaid dünaamiline, tuleb arvestada, et personaalne taastumine on järjepidev pingutus – igapäevane toimetulek vaimse tervise raskustega ja vajadus täita ühiskonnas oma kohustusi (kohati tugeva stigmatiseerimise ja mõistmatuse tingimustes) on keeruline ülesanne, millega tuleb tegelda elu lõpuni.

Uurimused on näidanud, et vaimse tervise raskustega inimesed väärtustavad elukestvat personaalse taastumise protsessi kõrgelt. Leamy jt (2011) kirjeldavad oma analüütilises ülevaates, et taastumise korral tuleb ühtaegu tegelda viie alaprotsessiga: 1) hoida seotust inimeste ja keskkonnaga, 2) arendada lootust väljendavaid eesmärke ja käitumist, 3) kujundada uut identiteeti ehk minapilti ja muuta enesesse suhtumist, 4) leida elule tähendus, jätmata kõrvale haiguskogemust, 5) leida elujõudu, saavutada oma elu üle kontroll. Need viis alaprotsessi (*connetedness* – seotus, *hope* – lootus, *identity* – identiteet, *meaning* – tähendus, *empowerment* – võimustumine) on personaalse taastumise põhielemendid ning moodustavad doktoriväitekirja uurimuse ühe peamise raamistiku.

21. sajandi teise kümnendi diskussioonides on eeltoodule lisatud, et inimesed on suhteolevused (*relational beings*) ja vaimse tervise raskustega inimestel on tähtis saada taas osaks inimsuhete süsteemidest. See ei hõlma üksnes seotust teiste inimestega, vaid ka teiste inimeste seas oma iseseisvuse piiritlemist, inimkooslustes orgaanilise koha leidmist. Viimati mainitu mõjutab suuresti positiivse identiteedi ja kogukonnas väärtustatud positsiooni kujundamist. Identiteet kujuneb duaalse protsessi käigus: selle üks osa on inimese ettekujutus endast ja teine osa ümbritsevatelt inimestelt saadud vastus ehk ettekujutus, kuidas kõrvalseisjad näevad teda (Oyserman *et al.*, 2017; Price-Robertson *et al.*, 2017; Tew *et al.*, 2012). Seega vormib suhete kaudu kogetu identiteeti.

Toimevõimekuse ehk agentsuse arendamine toetab personaalse taastumise protsessi ja teeb võimalikuks olukorra, kus võimed/võimekus (*enablement*)

saavutavad ülekaalu puude (*disability*) üle. Toimevõimekus väljendub võimekuses olla iseorganiseeriv ja proaktiivne ning eneseregulatsiooni- ja refleksiooni-oskustega. Seejuures on Bandura (2006, 2018) hinnangul agentsuseks vaja nelja protsessi: 1) inimese kavatsust (sh mõtteid strateegia kohta, et saavutada soovitu), 2) tulevikku kujundavat käitumist, 3) võimet leida toimivamaid tegutsemisviise, enesejuhtimist ning 4) refleksiooni (võimet reflekteerida enesetõhususe, mõtete, käitumise ja selle tähenduse üle ning teha kohandusi). Benight jt (2018, 2017) on täiendanud toimevõimekuse käsitlust eneseregulatsiooni pöörde teooriaga, tuues esile, et toimevõimekuse positiivne areng toob kaasa transformatsiooni, kus sisemised ja välised ressursid ning taastumise kapital ühendatakse ning toimub mittelineaarne, võimendatud areng (kogemus, mille kohta inimesed ütlevad, et see on teinud neist parema inimese). Seda protsessi nimetatakse ka kriitilise toimevõimekuse lävepaku ületamiseks.

Klienditöö kaudu on võimalik anda positiivne tõuge inimese personaalse taastumise, toimevõimekuse arendamise ja eneseregulatsiooni pöörde saavutamise protsessile. Üliloluline on, et spetsialistid ei töötaks nendele protsessidele vastu. Neutraalset klienditööd ei ole olemas, sest kui klienditöö ei toeta inimese toimevõimekuse arengut, siis see hoopis kahjustab seda. Toimevõimekuse arendamisele keskenduv klienditöö põhineb produktiivsel partnerlusel (Verkaaik *et al.*, 2010), tasakaalus võimupositsioonide otsimisel, koostöösuhte piiride dünaamilisel määramisel (vastandina konventsionaalsusele), avatud dialoogi hoidmise põhimõtetel (Seikkula, 2013) ja üksteise elukontekstis vastastikku osalemisel ehk seotusel (Topor, Denhov, 2014).

Uurimisküsimused ja -meetodid

Väitekirjas otsitakse vastuseid järgmistele uurimisküsimustele.

I. Millised inimese autonoomia arendamisele orienteeritud koostöö ehk partnerlussuhte mustrid peegelduvad inimese sotsiaalse rehabilitatsiooni hindamis- ja tegevuskavade tekstides?

II. Millised klienditöö elemendid toetavad vaimse tervise raskustega inimeste refleksiooni kohaselt nende personaalse taastumise protsessi?

III. Millised kultuuri- ja suhtekonteksti eriaspektid avaldavad vaimse tervise raskustega inimeste perspektiivist mõju personaalse taastumise protsessile?

Esimesele uurimisküsimusele vastuseid otsides tuginesin interaktiivsete lugude kontseptsioonile (*concept of interactional stories*), st käsitasin kliendi hindamise ja tegevusplaani tekste, mille olid kirjutanud rehabilitatsioonispetsialistid kehtivate piirangute vabalt ja oma parima ettekujutuse kohaselt, kui interaktiivseid loomulikult tekkivaid tekste, mis väljendavad klienditöö kogemust, ning tegin tekstide narratiivse analüüsi. Kokku analüüsisin esimeses etapis 14 teksti ja teises etapis 10 inimese kohta koostatud tekste (välja jäid alla 18-aastaste lastega tehtud hinnangud ja ühe või kahe spetsialisti koostatud hindamistekstid). Lood ehk tekstid on (sotsiaaltöö) interaktsiooni mustrite väljendus ja annavad

osalusprotsessile retrospektiivselt tähenduse, mis ei ole kirja pandud mitte sõnades, vaid teksti intersubjektiivses ruumis (Popova, 2014).

Teisele ja kolmandale küsimusele vastamiseks kasutasin diskursiivse raamistiku kontseptsiooni (*discursive framing concept*). Esmalt tegin struktureeritud intervjuud 13 inimesega, kellel on psüühikahäire. Intervjuu põhines Suurbritannias välja töötatud INSPIRE-küsimustikul, mis on praeguse seisuga parim personaalse taastumise protsessi mõõtevahend (Williams *et al.*, 2015), kuid siinse uuringu tarbeks kujundasin suletud küsimused ümber avatud küsimusteks. Samuti palusin uuritavatel kirjeldada, kuidas vaimse tervise spetsialist (tegevusjuhendaja) toetab järjepideva tegevuse kaudu nende taastumist, ja käsitleda neid taastumise aspekte, mille korral oli keeruline taastumise protsessi osi mõista, nt konteksti ehk keskkonna eripära tõttu. Seejärel analüüsisin kogutud materjali CHIME personaalse taastumise teoreetilises raamistikus (*connectedness* – seotus, *hope* – lootus, *identity* – identiteet, *meaning* – tähendus, *empowerment* – võimustumine) ning otsisin personaalse taastumise toetamise elemente klienditöös ja kultuuri- ja suhtekontekstile omaseid aspekte. Iga CHIME alaprotsessi kohta oli intervjuus 4–5 avatud küsimust, samuti sisaldas intervjuu 8 küsimust töötaja ja kliendi suhte kohta, mis CHIME raamistikus kuuluvad seotuse kategooriasse.

Tulemused ja järeldused uurimisküsimuste kaupa

I. Inimese toimevõimekuse määra ja toimevõimekuse arenguala märkamine on elamisväärse elu ülesehitamise toetamise tingimus.

Tekstides, mille olid sotsiaalse rehabilitatsiooni valdkonna praktikud koostanud nii kliendi kohta kui ka kliendi jaoks, tuli välja kolm narratiivi tüüpi. Esiteks esines tekste, mis väljendasid inimese autonoomia toetamist partnerlussuhte loomise ning inimese või tema kogukonna/keskkonna ressursside ja rehabilitatsioonivõimaluste kombineerimise kaudu. Teiseks, rehabilitatsioonitööd iseloomustasid tekstid, mille keskmes oli inimese (kliendi) varasema elukvaliteedi taastamine või olemasoleva hoidmine ning keskendumine esmajoones puudele ehk hädade, raskustega toimetulekule. Kolmandaks leidus tekste, kus spetsialistid olid oma professionaalsest vaatest lähtudes määranud kindlaks eesmärgid ja jätnud kõrvale inimese unikaalsed loomulikud ressursid.

Inimese heaolu ja kestva haavatavuse või raskustega toimetuleku arendamisele fookustatud töös on vaja mõista toimevõimekust ja seda, et toimevõimekus on nii inimestevahelise suhtluse, inimese käitumisvalikute kui ka keskkonna tunnuste koosmõju tulem. Partnerlus kliendi ja spetsialisti vahel arendab kliendi autonoomiat. Praktikute kohustus on märgata inimeste kavatsusi, tulevikku suunatud mõtlemise märke, motivatsioonikäitumist ja viisi, kuidas määratletakse oma toimevõimekust. Rehabilitatsioonitöö kaudu saavad praktikud mõjutada inimese usku oma enesetõhususse esimesest hetkest alates. Agentsuse ja iseseisvuse edendamine rehabilitatsioonitöös on võimalik, kui praktikud on partnerlussuhtele orienteeritud ja kujundavad toimiva koostöö. Vastastikune

siiras partnerlussuhe põhineb selgelt tunnetatud vajadusel koostöö järele. Seda peegeldab hästi olukord, kus spetsialistid tunnistavad ja usuvad, et nad võivad tunda funktsioneerimise arendamise protsesse ja rehabilitatsioonimeetmeid, kuid nad ei tea, milline on konkreetse inimese jaoks parim võimalik lahendus, ning inimene tunnistab, et ta on teadlik sellest, kuidas tema elusituatsioon ja kontekst üksteist mõjutavad, kuid ta ei tea, mil viisil olukorrast välja tulla. Selline partnerlus ei ole enam kantud kõrgelennulistest ideedest, vaid see on mõlema osalise tajutud hädavajadus. Spetsialist tajub, et ta ei saa oma tööd hästi teha, kui ta ei pinguta partnerlussuhte saavutamise nimel, ja kliendi rollis inimene mõistab, et tal on vaja teha koostööd spetsialistiga.

II. Partneri vastamisvalmiduse kogemine ja suhte-toimevõimekuse kujundamine on inimese personaalse taastumise protsessi olulised komponendid.
Personaalse taastumise protsessi arengut seotuse ja suhete valdkonnas toetab see, kui spetsialistid tunnistavad inimese samaväärsust, suhtes on vastastikusus ehk retsiprooksus ning spetsialisti teod on tähendusrikkad just vaatlusaluse suhte kontekstis ja väljendavad väärtusi. Vaimse tervise raskustega inimeste arvates on lootuse hoidmisel ja edendamisel ning positiivse identiteedi arendamisel tähtis, et praktik märkaks ja tunnustaks edusamme, hoiaks lootust, rakendaks kohaolu (elusamuse) põhimõtteid, edastaks positiivset identiteeti toetavaid sõnumeid ja pakuks stigmatiseerimise korral konstruktiivset tuge. Elu tähenduse ja elujõu leidmisel ning oma elu üle suurema kontrolli kujundamisel on abiks diskussioonid haiguse tundmaõppimise, haiguskogemusele tähenduse andmise üle ja võimalus teha koos praktikuga uudseid, identiteeti avardavaid tegevusi. Toimevõimekuse areng sõltub kahesuunalise, kuid ka tähendusliku transaktsiooni olemasolust suhtes. Suhtlussituatsioonis peab spetsialisti ja kliendi kahesuunaline suhtlus vastama kolmele tingimusele, milleks on mõistmine ehk autentsustunde tugevdamine; valideerimine ehk uskumine partneri väärtuslikkusse, tema perspektiivi ja võimete oluliseks pidamine; hoolimine ehk üksteise heaolu pärast muretsemine (Reis, 2014). Personaalse taastumise protsessi ja toimevõimekuse toetamine on väärtustepõhised tegevused ning eeldavad praktikult suurt loovust, paindlikkust ja iseenda toimevõimekuse arendamist. Teise inimese toimevõimekuse arendamist saabki toetada vaid selline inimene, kes arendab ja rakendab oma toimevõimekust.

III. Personaalse taastumise protsessi toetamisel tuleb arvestada sotsiaalse, kultuuri- ja suhtekonteksti aspektidega ning suhtekontekstis ka vajadusega toetada taastumist.
Personaalse taastumise protsessi mõjutab sotsiaalne ja kultuurikontekst. Kõigepealt on oluline, mis tähendus on kultuurikontekstis teatud nähtustel ning mis seos on nähtustel ja mõistetel. Nähtused ja mõisted mõjutavad inimeste mõtlemist ja käitumist, seega ka vaimse tervise raskustega inimeste personaalse taastumise protsessi. Uurimuse tulemused näitavad, et personaalse taastumise mõistel ei ole Eesti kultuurikontekstis veel selgeid piirjooni, samuti ei ole neid kogukonna mõistel. Kuna varasemal perioodil on vaimse tervise raskustega

inimeste mõtteid taastumise kohta mõjutanud psühhiaatria ja erialade kliinilise taastumise käsitlus, siis intervjuudes inimesed liikusid („ujusid“) rääkimise käigus ühest teise (kliinilise käsitluse juurest personaalse taastumise teema juurde), hoidmata selget piiri. Kogukonna mõistet käsitledes arutleti tihti, mida mõistetakse kogukonnana, ja räägiti, keda peetakse oma kogukonna liikmeks.

Lootuse tähenduse puhul ilmnes, et ei teata, kuidas saavutada lootusetunnet, ja et lootus on tugevasti seotud teiste inimeste usaldamisega. Mõnel juhul avaldasid uuringus osalejad arvamust, et lootusest on ebasobiv rääkida. Snyderi (2002) uurimuse kohaselt on lootusekäitumist võimalik õpetada. Veelgi enam, lootusetunne ning praktiku ja inimese koostöösuhe on tugevas korrelatsioonis (Snyder, 2002). Inimene saab selle koostöösuhte kaudu õppida, kuidas leida võimalusi seada suurt lootust arendavaid eesmärke ja neid saavutada (Snyder, 2002). Praktiku roll on luua koostöö, mis võimaldab inimesel näha oma uut horisonti ja sotsiaalse elu mitmekesistumise võimalusi. Kuna identiteet on sotsiaalne produkt, saab praktik tugevasti mõjutada inimese positiivse identiteedi kujundamist, kuna inimene võtab omaks selle, mis on teda ümbritsevas sotsiaalses kontekstis parasjagu asjakohane. Praktikud saavad toetada nii kerksa (säilenõtke) suhtekonteksti taastumise (*relational recovery*) kui ka personaalse taastumise protsessi, kui nad oma toimevõimekust kasutades väljendavad ja taasloovad töös väärtusi ning on kogukonnas oma väärtusepõhise käitumisega nähtavad.

PUBLICATIONS

CURRICULUM VITAE

Name	Dagmar Narusson
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Education:

2017–2019	University of Tartu, PhD programme in Sociology
2002–2016	University of Tallinn, PhD programme in Social Work
2005	University of Tampere, PhD programme in Social Work
2004	University of Firenze, PhD progamme in Social Work
1998–2002	University of Tartu, Master's programme in Social Work and Social Policy
1993–1997	University of Tartu, BA programme in Social Work

Language skills:

Estonian	native speaker
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Professional employment:

2017–present	University of Tartu, Institute of Social Studies, assistant in Social Work
2014–2017	University of Tartu, Institute of Social Studies, lecturer in Social Work
2005–2013	University of Tartu, Pärnu College, lecturer in Social Rehabilitation and Social Work
1997–2005	Tartu University Clinicum, Child Clinic, social worker, rehabilitation team coordinator
1992–1998	Elva Children's Home

Main research areas:

Personal recovery studies, recovery-oriented support work, coaching for recovery, social rehabilitation, assessment in social rehabilitation, disability studies, community work, community-based solutions for newcomers, social work client work, social work with vulnerable people, novel solutions in social work, environmental sustainability and social work

Membership in organisations:

2019–present	member of the CARe Network Ambassadors

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Additional Publications, related to the doctoral thesis:

Narusson, D. (2020). Coaching for Recovery in Estonia.

Narusson, D. (2019). Nõustamine sotsiaalalal. Kõrgkooli õpik. Tartu Ülikooli Kirjastus (*avaldamisel*)

Õunmaa, B., Narusson, D. (2019). Remand Prisoners' Perceptions of Recovery in Closed Settings. *Journal of Recovery in Mental Health*, *2*(2–3), 5–20. https://jps.library.utoronto.ca/index.php/rmh/article/view/32740

Narusson, D., Geurden, L., Kool, H. (2018). Promoting Mental Health: Engagement with the Environment as a Source of Solution and Inspiration. In: Social Work: Promoting Community and Environmental Sustainability. 243−254. IFSW.

Narusson, D., Geurden, L., Kool, H. (2018). Vaimse tervise edendamine: keskkonnaga seotus kui lahenduste ja inspiratsiooni allikas. In: Social Work: Promoting Community and Environmental Sustainability, 354–371. IFSW.

Wilken, J.P., Bugarski, Z., Hanga, K., Narusson, D., Saia, K., Medar, M. (2018). Community orientation of services of persons with a psychiatric disability. Comparison between Estonia, Hungary and the Netherlands. European Journal of Social Work, Vol. 21, 4, 509–520.

Narusson, D. (2017). Head praktikad toetavad sotsiaalset kaasatust ja kestlikke kogukondi. Sotsiaaltöö, 1, 23–2.

Wilken, J.P., Hanga, K., Bugarski, Z., van Gijzel, S., Karbounaris, S., Kondor, Z., Medar, M., Narusson, D., Saia, K. (2015). Stories of Recoevry and Participation: experiences and challenges. 1–62.

Wilken, J.P., Admiraal, L., Bugarski, Z., Leenders, F., Medar, M., Narusson, D., Saia, K., Hanga, K. (2014). Improving community support of persons with disabilities. A study in three European countries. 1–82

Narusson, D., Medar, M., (2014). Puude kontseptuaalne käsitlus. The conceptualization of disability. Puudega inimeste sotsiaalne lõimumine. Social intergration of disabled people. 6–24. Tallinn, Statistikaamet.

Tambaum, T., Medar, M., Narusson, D. (2014). Sotsiaalne sidusus. Sakkeus, L.; Medar, M. (EditorsAbbr). Puudega inimeste sotsiaalne lõimumine. Social Integration of Disabled Persons 121−138. Tallinn: Statistikaamet.10.13140/2.1.4379.0400.

Kangro, M., Kinsigo, K., Maasoo, K., Kõresaar, M., Tamberg, M., Aland, L., Narusson, D., Strömpl, J. (2014). Rehabilitatsiooniteenused sõltlastele tartu linnas. Uurimuse aruanne, 1–50.

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1998–2002	Tartu Ülikool, sotsiaaltöö magistriõpe
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Keelteoskus:

Eesti keel	emakeel
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2017–praeguseni	Tartu Ülikool, ühiskonnateaduste instituut, sotsiaaltöö assistent
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1997–2005	Tartu Ülikooli Kliinikumi Laste Kliinik, sotsiaaltöötaja ja rehabilitatsioonimeeskonna koordinaator
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Peamised uurimisvaldkonnad:

Personaalne taastumine, personaalset taastumist toetav klienditöö, mõttetreening taastumise toetamiseks, sotsiaalne rehabilitatsioon, kliendi vajaduste hindamine rehabilitatsioonis, *disability* uuringud, kogukonnatöö, kogukonna-põhised lahendused rändetaustaga inimeste lõimumise toetamisel, sotsiaaltöö klienditöö, sotsiaaltöö haavatavate inimestega, uudsed lahendused sotsiaaltöös, keskkonna kestlikkus ja sotsiaaltöö

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Doktoritöö teemaga seotud täiendavad publikatsioonid:

Narusson, D. (2020). Coaching for Recovery in Estonia.

Narusson, D. (2019). Nõustamine sotsiaalalal. Kõrgkooli õpik. Tartu Ülikooli Kirjastus (*avaldamisel*)

Õunmaa, B., Narusson, D. (2019). Remand Prisoners' Perceptions of Recovery in Closed Settings. *Journal of Recovery in Mental Health*, *2*(2–3), 5–20. https://jps.library.utoronto.ca/index.php/rmh/article/view/32740

Narusson,D., Geurden, L., Kool, H. (2018). Promoting Mental Health: Engagement with the Environment as a Source of Solution and Inspiration. In: Social Work: Promoting Community and Environmental Sustainability. 243−254. IFSW.

Narusson, D., Geurden, L., Kool, H. (2018). Vaimse tervise edendamine: keskkonnaga seotus kui lahenduste ja inspiratsiooni allikas. In: Social Work: Promoting Community and Environmental Sustainability, 354–371. IFSW.

Wilken, J.P., Bugarski, Z., Hanga, K., Narusson, D., Saia, K., Medar, M. (2018). Community orientation of services of persons with a psychiatric disability. Comparison between Estonia, Hungary and the Netherlands. European Journal of Social Work, Vol. 21, 4, 509–520.

Narusson, D. (2017). Head praktikad toetavad sotsiaalset kaasatust ja kestlikke kogukondi. Sotsiaaltöö, 1, 23–2.

Wilken, J.P., Hanga, K., Bugarski, Z., van Gijzel, S., Karbounaris, S., Kondor, Z., Medar, M., Narusson, D., Saia, K. (2015). Stories of Recoevry and Participation: experiences and challenges. 1–62.

Wilken, J.P., Admiraal, L., Bugarski, Z., Leenders, F., Medar, M., Narusson, D., Saia, K., Hanga, K. (2014). Improving community support of personas with disabilities. A study in three European countries. 1−82.

Narusson, D., Medar, M., (2014). Puude kontseptuaalne käsitlus. The conceptualization of disability. Puudega inimeste sotsiaalne lõimumine. Social intergration of disabled people. 6–24. Tallinn, Statistikaamet.

Tambaum, T., Medar, M., Narusson, D. (2014). Sotsiaalne sidusus. Sakkeus, L., Medar, M. (Editors). Puuetega inimeste sotsiaalne lõimumine. Social Integration of Disabled Persons 121–138. Tallinn, Statistikaamet 10.13140/2.1.4379.0400.

Kangro, M., Kinsigo, K., Maasoo, K., Kõressaar, M., Tamberg, M., Aland, L., Narusson, D., Strömpl, J. (2014). Rehabilitatsiooniteenused sõltlastele Tartu linnas. Uurimuse aruanne. 1−50.

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