Micro-affirmations and Recovery for Persons with Mental Health and Alcohol and Drug Problems: User and Professional Experience-Based Practice and Knowledge

Alain Topor^{1,2} • Ninive von Greiff¹ • Lisa Skogens¹

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Abstract

Recurrent factors contributing to a recovery process from co-occurring mental health and addiction problems mentioned by users and professionals have been analyzed as part of working alliances and helpful relationships. Still, we lack knowledge about how helpful relationships are developed in daily practice. In this article, we focus on the concrete construction of professional helpful relationships. Forty persons in recovery and fifteen professionals were interviewed. The interviews were analyzed according to thematic analysis, resulting in three themes presented as paradoxes (1) My own decision, but with the help of others; (2) The need for structures and going beyond them; and (3) Small trivial things of great importance. Micro-affirmations have a central role in creating helpful relationships by confirming the individuals involved as more than solely users or professionals. More attention and appreciation should be paid to practices involving micro-affirmations.

Keywords Helpful relationships · Working alliance · Co-occurring disorders · Mental health · Drug abuse · Micro-affirmations

When a person with schizophrenia who has improved relates that the most important source of that improvement was “someone who cared”, it is poor science just to ignore that report because of difficulties in measurement or because it does not fit into one of our accepted theoretical schemes.

John Strauss, [2014](#)

✉ Alain Topor
alain.topor@socarb.su.se

¹ Department of Social Work, Stockholm University, SE-106 91 Stockholm, Sweden

² Department of Psychosocial Health, University of Agder, Grimstad, Norway

Background

A number of studies look at contributing factors to an improvement/recovery process from mental health problems (Borg and Kristiansen 2004; Topor and Denhov 2012; Tew et al. 2012), alcohol and other drugs (AOD) problems (Bergmark 2008; Orford et al. 2006), and co-occurring mental health and AOD problems (Ness et al. 2014).

Recurrent factors mentioned by users and professionals are a feeling of being seen, heard, and respected as human beings (Rise et al. 2014; Shevellar and Barringham 2016; Brekke et al. 2018). These factors have been analyzed as part of therapeutic or working alliances and helpful relationships (Ljungberg et al. 2015), and as contributing to the efficacy of the interventions of professionals (McCabe and Priebe 2004; Skatvedt 2017).

In a review of studies on helpful relationships (Ljungberg et al. 2015), users stressed the importance of the professionals' formal status, knowledge, and capacity to mediate different resources.

Doing something that is perceived as going beyond what is normally expected is recurrent in studies of the descriptions of helpful professionals given by users (Borg and Kristiansen 2004; Ware et al. 2004). These are often called “small,” “little,” or “trivial” things in the interviews and have been analyzed as “micro-affirmations” (Rowe 2008; Topor et al. 2018). Micro-affirmations are characterized by their “everydayness” and spontaneous character (Skatvedt 2017). They often take the shape of words, gestures, and actions affirming a common human ground between the professional and the user. The impact of small things is described in terms of an improved sense of self, beyond being just a patient, a drug addict, and a user. (Topor and Denhov 2012).

Studies of non-helpful professional relationships are scarce but might highlight helpful relationships from a different angle. Users mainly stress rigid schedules, rules, and routines following an approach that hinders them from forging a helpful relationship (Ljungberg et al. 2016; Persson and Wästerfors 2009; see also Goffman 1961).

It seems that it is the combination of the professionals' formal status in a specific organization and, at the same time, of them going beyond the strict division between staff/professionals and patients/clients/users that might create the experience of being seen and respected. However, we still lack knowledge about how helpful relationships are developed in everyday life. In this article, we focus on the concrete construction of professional helpful relationships according to both users with co-occurring mental health and AOD problems and professionals working with users with these problems.

Method

Data were collected in a project about facilitating factors for sustained recovery from co-occurring mental health and AOD problems in the region of Stockholm. Forty users in recovery and 15 professionals were interviewed according to a design developed by Orford et al. (2006).

Users were recruited through professionals at both social and psychiatric in- and “outpatient” services. The participants had to have experienced a positive change concerning their problems and this change had to be confirmed by a professional. Professionals were contacted at the same services and the inclusion criterion was experience of working in this field.

The group of users consisted of 13 women and 27 men aged between 26 and 62. Drug use was the most common substance abuse problem followed by alcohol and mixed alcohol and drug abuse. The users described their co-occurring mental health problems as follows: bipolar disorder/depression/anxiety/social phobia/psychosis, neuropsychiatric problems (ADD/ADHD/Asperger syndrome), unspecified, and PTSD.

At the time of the interviews, almost half of the participants had some type of occupation or were on parental leave. Most were receiving some form of sickness benefit. A majority lived alone, while others lived with a partner and/or children. A majority had their own home, usually with some kind of housing subsidy. Some lived in supported housing or in a “training apartment”. The focus of the users’ interviews was about what they perceived as important for initiating and maintaining their recovery process. The interviews lasted 20–40 min.

The group of professionals consisted of 11 women and four men, aged between 39 and 61. They had between 8 and 28 years of experience working with users with co-occurring problems. They were educated social workers, doctors, nurses, and assistant nurses. They worked in different roles in nine different services such as residential facilities, supported housing in a user’s own home, social cooperatives, and specialized treatment teams. The interviews with the staff were about their own experience to help and support such a positive change and lasted about 1 h.

Interview data was collected during the years 2016 and 2017. The interviews took place at a convenient place for the interviewees, most chose the treatment unit and some the research team office. Before the interviews, the participants were informed anew of the study. The main aim of the interviews was to collect narratives of experiences in context, striving to connect detailed stories to reflections about the role of the experiences for the person interviewed (Bertaux 2005). The interviews were audio recorded, and subsequently transcribed in reports based on the interviewees’ own words by another research team member, and finally reviewed against the recorded interview by the interviewer. Small talk and part not connected to the aim of the study were excluded. The three authors conducted interviews and wrote reports.

For the present article, the interviews were analyzed according to the six steps of thematic analysis described by Braun and Clarke (2006). First, the reports were read separately by the authors and this was followed by a joint discussion and preliminary themes were formulated. The first author went on reading and re-reading the interviews, re-arranging themes, and creating new themes. During this process, the research team held several meetings to discuss the results of the analysis process and finally decided to formulate the themes as paradoxical statements reflecting the ambiguity of the experiences and reflections collected. Illustrative quotes from the interviews were selected; some of them are presented here extensively, as we wanted to present both the actions in their situational context and the interviewees’ reflections about them. Quotes from users are followed by Arabic numbers referring to a specific interviewee. Quotes from professionals are followed by Roman numbers. For a more detailed description of the methodology, see Skogens et al. (2018).

The different paradigms present in the field of mental health necessitate thoughtful choices regarding the terminology used. In this article, we adhere to Wolch and Philos’ contribution (2000) about older terms today associated with insults and modern terms associated with a medical model and will, when not quoting external sources, use the term “user” to refer to patients, clients, survivors, and “professional” for everybody enlisted to help, support, treat, and care for the users.

The study was approved by the Regional Ethical Review Board in Stockholm (no. 2016/269-31/5).

Findings

Even in the present study, interviewees referred to the importance of a working alliance and its ingredients for starting and maintaining a recovery process:

It's about how you're treated, the interaction and a good alliance. We work hard to make people feel that they are seen, heard, and to ensure that everybody can make their voice heard in the decision-making process. (I)

The three themes we analyzed were formulated in terms of contradictions and paradoxes that were managed in different ways by the participants. In this way, we wanted to capture the tensions present along to the co-creation of improvement: My own decision, but with the help of others; the need for a structure and of going beyond it, and small trivial things of great importance.

My Own Decision, but with the Help of Others

Most users presented changes as being the result of their own will. For different reasons, such as age, family, near-death experience, the gap between experience of a decent life, and a state of decay, a decision for change was taken.

Nobody told me to stay sober. I made up my own mind. I make all my own decisions, for my own sake.

On the other hand, still according to the same users, change would not have been possible without the help of others.

You need a strong will of your own. Then you need help from society, but help doesn't make you change. It lays into yourself. Here, the staff looks at you as if you're a person in need of help.

Even if the professionals were aware of the importance of the user's own decision, they also stressed the need to support the users in accomplishing their own decision. The strong sense of self, described regarding the importance of self in starting the process of change, seems to be present but also a lack of faith in one's own worth/but also a lack of self-esteem.

I've met a therapist who believes in me, and makes me believe in myself too. When you have this trust, it becomes a little bit easier to stop doubting all the time. You ask a question, get an answer, and believe in that answer.

To take a further step in the recovery process, the user sometimes has to decide to have faith in the professional who relates to him/her as someone worthy of trust. In this process, the

professional might end up arguing “against” the person to make him/her persevere on his/her difficult path to recovery.

Many feel that they’re a pain and that they’re not important enough. So it’s important to give them a clear message that you’re interested in them. You call a patient who hasn’t shown up to an appointment and ask: “How are you? What can I do for you?” In this way, the patient understands that you wish them well. (XIII)

Finally, the different steps in this complex and composite process affect the person’s sense of self.

I’ve done most of it by myself, and that feels really good. I have more faith in myself and I feel that I have grown as a person. Nobody else can do the job for you, but it’s easier if you get some support; if you have some good people around you. (7)

Experiences of concrete improvements, in terms of their living conditions (e.g., housing and financial situation), lead to a strengthening of the person’s faith in him/herself and in the professional. This seems to create the basis for a helpful relationship and a sustained recovery process.

The Need for Structures and Going Beyond Them

Users and professionals stressed the importance of structures and routines both for a recovery process in an institutional setting and to ensure that the users stick to it in their everyday lives in the community. However, they also spoke about situations where professionals or institutions stretched their limits for the sake of the individual user. These actions were as important as the structures and routines that they were going beyond.

XI summarized some of the basic components of an institutional structure: “You have to be professional and treat everybody in the same way”, and continued, “but with some you can feel a special connection” and went on to describe one such situation:

When I started working here, two users I knew from my previous workplace moved with me, because they wanted me as their care contact. They thought that I was a good form of support for them. One of them felt that I really cared about his situation and wanted to help him. Straight after our first meeting, he wanted to stay with me. Then I managed to become his care contact.

XI points at how the helpful relationship she had developed with two users made them change institutional setting when she got a new job and how she acted so that one of them was able to become accepted at the new institution; hardly, the kind of behavior she practiced for all her users. When asked about how she built such a relationship on, she answered:

We went for walks every day and talked about his background and upbringing. It’s easier to build a relationship in a natural way outside the institution. You meet other people and you have different subjects to talk about. You become more equal.

The fact that structures, and people prepared to go beyond them, are present at the same time was described as being important for the development of a user's faith in him/herself:

I had never looked for treatment earlier and I had heard that they lock you up and you're treated badly. You have to sign a lot of papers and follow a lot of rules. If you break them ... When I came here, I was really honest with the staff and they accepted that. I was given some privileges and never needed to follow all the rules. I got the feeling that if I made some progress, then they let me continue. That was very important to me. Here, I gained their trust, which I had never got from my parents. To be trusted to go to the shop by myself, and then to gain more trust to do other things because I managed the previous step. I made it a part of me. A long time after I had left, I came back here. They made me feel that I was an important person to them: I believe that was really important. (15)

The capacity of the professionals to go beyond the rules and routines of their institution and to give her "privileges" was understood by this woman as a sign of faith in her. A trust that she never experienced before.

Rules and structures are meant to create predictability and equality between different people according to criteria such as diagnosis. Micro-affirmations are mostly a personal affair between a user and a professional. Therefore, they cannot be transformed into new routines without affecting their personal character. According to VI:

Different professionals have different ways of working. I have a colleague who gives his phone number to users and tells them to call him whenever they need to. This is appreciated, but does not suit everybody.

Somewhere between rigidly sticking to routines and a lack of structures, II tries to explain how you can handle this contradiction:

You always have to think in different ways based on what the patient wants and says. Things can change and then we have to adapt our plans accordingly. But at the same time, we have to hold on to the structure, help them to remember what they've told us earlier and not just adapt to the latest emergency.

Thus, going beyond a structure does not mean rejecting a need for rules and structures. Instead, it might be possible to interpret this practice as an opportunity to be taken when dealing with people and not just with them as patients and clients, reduced to their addiction and diagnosis.

Some interviews reflected that certain institutions are in the process of changing their rules from a zero tolerance of relapse to a practice of sustained support regardless of relapses. The shift and the different cultures and their consequences could be illustrated through 6's story:

I have used drugs since I was eight, when I was seriously abused. I never wanted to use drugs, but I had to stay alive. I was sent to different institutions, but it never worked because they never gave me a chance. If you have a relapse, they kick you out. When I came to (name of the institution), they gave me a chance and believed in me. You cannot press an "on-off" button and then you're off the drugs. I was there one week and then

had my first relapse and was gone for a week. Then I was back again for one week and so on for four months. But they kept working with me. I felt safe, and then I didn't need to do that anymore. I've often been let down in my life and needed to be cautious, anxious and nervous. I needed to see that they really believed in me before I could open up a little and start to believe in myself. It's not just about making a decision. If that were the case, I could have done that long ago, and then I wouldn't have been on drugs. Here, I found competent staff.

How do they show it?

They give you chances. They don't kick you out. They let me be but fought with me. They did not neglect me or my relapses. After a while, things started to happen. The other places I know had strict and weird rules. Here, I was welcomed back.

From the descriptions of both users and professionals, a new practice is emerging that could be summarized in this way: "They allowed me to fail," meaning that a relapse was not automatically synonymous with the obligation to leave the service and end the relationships that had been established with the professionals.

Small Trivial Things of Great Importance

When asked for descriptions of situations that they have experienced as helpful for their improvement process, the stories presented by users were mostly characterized by a lack of drama, even when the context sometimes was a matter of life and death. They mentioned what might be perceived as trivial things; and so did the professionals. Often, the actions described were related to a positive appreciation of the other as a human being. In its most simple expression, a helpful situation could consist of a gesture.

I had broken off all my relationships, so I came here and someone put his hand on my shoulder and asked: "How are you today?" Then you feel you can cool down. You have a human relationship. (38)

A similar experience was described by a professional:

They are heroes. I am so impressed. Knowledge is not enough, you have to see the person and respect him/her. The positive encounter! To make you feel that I see you. Many have not been smiled at during the whole day, so when I meet them I say: "Hi Carl, nice to see you". Then you build on that. Small things building trust. (XV)

A user described his own recovery work and the importance of him dealing with his addiction, but also his need for support; to "be seen."

I could handle the alcohol myself. Then I got some professional help. This help was more about having somebody who sees you. I have an appointment with a nurse once a week to take a blood sample, and we sit down and have a chat. She's simply a good person. My care worker comes to my home. He always needs to go to the loo when he visits me ... (20)

Users mentioned the importance of a combination of a formal relationship with time for a chat about other aspects of life besides illness and addiction. By using the person's toilet, the care worker shows

himself not only as a professional, but also as a human being with needs that the user can help satisfy, thus giving fine words like reciprocity and sharing humanity a concrete meaning.

The experience of “being listened to” gets a concrete expression in the trivial stories conveyed by the users:

I met a psychologist. He could refer to things I had mentioned months ago. He remembered – that was really important. It got more personal, so I started to trust him and told him about my life. (32)

Sometimes the recognition of the other as a fellow human being goes against the users’ identity, which has been influenced by experiences of stigma and longer periods of living in “in-patient” institutions. V works as a home carer. Thus, his workplace is the home of the users; a home that traditionally is perceived as a private, intimate place outside the beady eye of the authorities. Here, he describes how he works to maintain normality:

I knock on their door and say hello when they open the door, that’s important. I am visiting this person in his/her home. Some tell me: “You don’t have to take your shoes off”, but then I say: “You’d take your shoes off if you came to my home”. Some people are quite institutionalized. Anyway, I say hi, take my shoes off and then we sit in the kitchen and start to talk/chat. These small things are important. Relationships are built on them.

Taking your shoes off when you enter somebody’s home is common behavior in Sweden. In this quote, we can see a conscious emphasis on detail in building a good relationship. Both users and professionals recognize the importance of detail upholding the user as a human being. Creating this special experience was mostly described in the context of a one-on-one relationship, but could also exist at an institutional level:

After a while, they might say that they’ve been treated with respect and that we do things for them. How we treat them is important, that we welcome them and offer them coffee. We care about creating a nice atmosphere. A lot of the alliance relies on coffee breaks. (VIII)

Shared humanity is an abstract concept, until it is put into practice. XI reflected about the fact that she herself was a dog owner; “I have a dog myself, so I know what that might mean to somebody”, when telling a story about the importance of a dog for a user, but primarily a fellow dog owner; a human being.

It’s about a woman with alcohol problems. When she moved in, her son looked after her dog, but then he couldn’t do that anymore and I helped her out. I had an acquaintance who was able to look after the dog. I think it helped her to know that her dog was being looked after and that she could visit it. Later she rented a small cottage and took back the dog and I believe it went well for her there. She was motivated to leave our institution and take her dog back. Looking after it, going for walks etc. helped her to remain sober. (XI)

In this situation and relationship, it is clear that XI is able to identify with the user and understands what it would have been like for her if she had ignored what was happening to her dog, if she had been in the user’s shoes. In this situation, she mobilizes her own social network

to find a solution, even if she works in an institution that stresses the need for equal treatment and for general rules and structures.

Discussion

Recovery has been described as both a personal and a social process (Anthony 1993; Topor et al. 2011). In this article, we focus on the concrete construction of helpful social relationships between professionals and users with co-occurring mental health and AOD problems.

The findings we have presented were analyzed in a context where users and professionals mentioned different medical and psychotherapeutic interventions and diverse forms of peer-support as being both helpful for and a hindrance to their recovery process.

Our efforts to concretize what was regarded as helpful, and wording this in terms of methods or impressions of being seen, heard, and respected, resulted in a collection of short stories about encounters between agents. The practice-based knowledge in these stories could not be reduced either into a simple application of so-called evidence-based methods or a one-sided claim of the user as the only expert about his/her situation. Thus, we have chosen to present our results in the shape of three paradoxes that we will now place in a broader context.

Beyond Diagnosis

The first paradox consists of the central role users gave themselves in their own recovery process, and, at the same time, the recognition that, without the help of others, this process would have been much harder or even impossible.

This paradox has to be understood in relation to biomedical knowledge. The study is about people with a diagnosis, for which the clinical definitions include an impaired sense of reality, of volition, of the capacity to relate to others and to the self (American Psychiatric Association 2013). At the same time, in our interviews, these individuals described themselves as agents of change in their own lives, in collaboration with others.

Furthermore, the professionals interviewed agreed with the users' descriptions and spoke of them, without denying their difficulties or the fact that a recovery process entailed huge challenges, as "heroes." Nevertheless, sometimes the professionals had to transform themselves into lobbyists for the changes previously decided by the users. In the construction of a working alliance, both sides have to accept and confirm the other (in the relationship) as a full negotiating partner (sense of self), who is able to make decisions (volition), and apply them in the real world (reality).

Beyond Rules and Regulations

On the one hand, the second paradox consists of an agreement between users and professionals on the need for structures and routines for a recovery process. On the other hand, it consists of descriptions of important situations characterized by professionals doing small things and thus, sometimes, going beyond the rules and routines of their institutions.

These were situations where the professional moved from the institutional register of equality (of treatment), where the rules apply to everybody, to a register of individuality, the creation of a rule only valid in relation to a specific user (Borg and Kristiansen 2004; Topor

and Denhov 2012). Going beyond rules for a specific user in the framework of a special relationship seemed to be based on the perception of the other beyond his/her user status, but also beyond the perception of oneself as a professional according to the traditional role description.

The traditional professional role has been put into question in different studies on recovery and empowerment. Post-asylum landscapes open for a renegotiation of the relationships between users and professionals (Juhila et al. 2016), where professionals might be “trained to avoid the very behavior that some people say is helpful to their recovery,” (Shevellar and Barringham 2016). El-Guebaldy (2012) writes about a “delicate balance” (7) that must be managed between institutional and ethical aspects and “recovery relationships” (7). This need for a new balance is also mentioned by Rise et al. (2014), who write about “the need for safe, stable and predictable care and support on the one hand, and on the other encouraging and facilitating increased empowerment, responsibility and influence ...” (138) through tailored services. In the same vein, Reed, Josephsson, and Alsaker (2018) write about the tension between institutional rules and the needs of the users, demanding negotiations.

An example of changing institutional rules was mentioned both by users and professionals regarding relapses. In earlier practice, relapse meant that the user was excluded from the actual institution. Now, at least in some institutions, relapses are considered as moments in a process where it is important not to break the development of a working alliance between the user and professionals. Thus, structures and routines that once were a sign of a professional approach are now outdated.

As Osborn and Stein (2016) state, moving from total institutions to community-based services “needs to be accompanied by a larger shift in professional culture regarding what it means to be a professional helper” (765).

An important role for professionals working with people with severe mental health problems might be to offer them “more usual or normal experiences ...” (Frank and Davidson 2014, 26) thus helping them to develop greater self-esteem. The acts of professionals that are characterized as small things seem to be able to restore a sense of individuality to the person and thus become an important issue in the wake of the disappointment connected to the failure of evidence-based scheduled interventions to produce tangible improvements for the population’s health (Every-Palmer and Howick 2014).

Beyond Illness

The third paradox consists, on the one hand, of the users having different kinds of “severe mental illnesses” and AOD problems that are commonly assumed to be “chronic” and “severe” (Harding et al. 1992; El-Guebaldy 2012). This characterization is still used despite the development of efficient and so-called evidence-based interventions. On the other hand, people with one or the other or both kinds of problems seem to recover, even if these recoveries do not seem to be connected to specific interventions (Warner 2004; UKATT Research Team 2005).

Our findings could be seen as a concretization of some common factors described both from users’ and professionals’ perspectives. We have collected stories about helpful situations and relationships constructed through mundane actions, trivial words, and simple gestures characterized by their everydayness. Giving importance to the care of a dog, following the culturally accepted way of entering a person’s home, or giving your phone number are not usually mentioned as part of the creation of a working alliance and cannot be defined as specific interventions. Our findings might appear to be too simple bearing in mind the huge challenges the users and professionals face. This might be a reason why they are often defined as small, simple and micro, or as “subjugated knowledge” (Foucault 1976/1980).

If micro-affirmations and other small things play such an important role in the recovery process of people with severe health problems, they challenge the biomedical model. Priebe, Burns, and Craig (2013) wrote about “the abundant evidence of the importance of personal relationships in shaping both cause and cure of disorders” and went on to discuss a social paradigm they characterized with a focus on “what happens between people rather than what is wrong with an individual wholly detached from a social context” (p. 320). Small things are about what happens between people.

Limitations

It was not the aim of this study, and it might not even be possible, to establish a causal relationship/link between small things and recovery from SMI, either AOD or both combined. The results we have presented here rely on the experiences of a number of users and professionals, but, as they agreed to participate in our study, they might not be representative for all users and professionals. Nevertheless, the presence of such stories in both users’ and professionals’ narratives about helpful moments in paths to recovery should be able to raise the interest in their presence and what they tell us.

Compliance with Ethical Standards

The study was approved by the Regional Ethical Review Board in Stockholm (no. 2016/269-31/5).

Conflict of Interest The authors declare that they have no conflict of interest.

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