



## Practice development

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## The book, the stories, the people: an ongoing dialogic narrative inquiry study combining a practice development project. Part 1: the research context

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**Keywords:** dialogic narrative inquiry, mental health nursing, mental health recovery, practice development

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Accepted for publication: 13 April 2012

doi: 10.1111/j.1365-2850.2012.01922.x

### Accessible summary

- The idea for this research and practice development project emerged from the production of a recently published book of recovery narratives, written by a community of people broadly working in the mental health recovery movement.
- The research component of this project, described in this paper, sits within: narrative inquiry as a moral endeavour in the human sciences; the pedagogy of suffering in the sociology of health and illness; and mental health narrative recovery.
- Two inter-related data sources will be used in the research. The first is chapters contributed by authors to the book. The second is interview data from those authors.
- Integrative textual and interview transcript analysis will extend to the end of 2012.
- The research component of this project represents a commitment to a *mental health nursing* practice allied to recovery as narrative healing as opposed to forms of *psychiatric nursing* which endorse and tacitly support abuses committed in the name of institutional psychiatry.

### Abstract

This paper, part one of a two paper report, describes key aspects of the research context of an ongoing practice development project, conducted on two UK sites. The paper begins with a discussion of the project's origins within a community of people working in the recovery paradigm, including the contributory strand of the first author's recovery and survivor writing. The discussion then turns to three inter-related areas within which the research component sits and which provide it

with philosophical, theoretical and conceptual coherence. Each area will be unpacked and its significance explained. This will provide a platform for discussing the focus, methodology and methods of the research, and related assumptions governing both data collection and analysis. The paper concludes with a research commitment to a *mental health nursing* practice allied to recovery as narrative healing. Links are made to the second paper which describes the context and specifics of a *Writing for Recovery* project for users, survivors and carers. This shares with, and builds on, the overall project's research context and its assumptions.

## Introduction

The idea for this research and practice development project emerged from the production of a recently published book of recovery narratives written by a community of people broadly working in the recovery movement (Grant *et al.* 2011). Included within this community are UK-based users, carers and survivors, mental health/nursing scholars and scholar-survivors.

The authors of both parts of this project report, who also contributed chapters to the book, got to know one another and other contributors through dialogue – telling and sharing their stories – as the book took shape. This resulted in a developing synergy and emergence of a recovery writing community based on two sites on the south coast of England. At the University of Brighton, Grant and Leigh-Phippard respectively represent an ongoing collaboration between mental health nursing academics and the carer and user group (CUSER) who contribute to the educational preparation of mental health nursing students. Equivalent representation is provided by Biley at the University of Bournemouth, working in collaboration with Walker, Chair of the Dorset Mental Health Forum.

A further contributory strand to this research and practice development work preceded and included the time period within which the book was developed and published, and influenced its shape and some of its content. This was the first author's autoethnographic research on his own breakdown, recovery and survivor experiences (Grant 2006, 2010a,b, Short *et al.* 2007).

While engaged in this, he developed a growing appreciation for the sociological significance of illness and healing stories (Frank 1995, 2000, 2002, 2005, 2010a,b, Grant *et al.*, 2011). Immersion in

all this work further consolidated his growing disillusionment with biomedical representations of human distress and recovery. He came to believe that the ways in which these arguably strip people from their social and cultural contexts and, at worst, make totalizing claims about their identities, conflict with key recovery values in mental health and mental health nursing (Frank 2005, Barker & Buchanan-Barker 2011, Grant 2011a,b). In Grant (2011b, p. 3), he thus advocated for:

... stories which put the colour into what otherwise might be monochrome portrayals of human distress and resilience ... (this) book is needed because most formal texts describing 'mental health problems' ... fail to get over what it ... *means*, or *feels like* to have or care for someone with mental health problems, or suffer in response to abuse, in the context of a life ... such 'expert' accounts often lead to a self-fulfilling prophecy: individuals who are *only* conceptualized, described and experienced by readers in a one-dimensional way – as *just* their illness, or *just* their disorder – are often treated as if *that's all they are*, all of the time.

## Contextual basis of the research component

Emerging from the above strands, the research component of this project sits philosophically and theoretically within the following areas: narrative inquiry as a moral endeavour within the human sciences; the pedagogy of suffering in the sociology of health and illness; and the recovery movements in mental health in relation to narrative. The discussion will now turn to unpack, explain and discuss the relevance of each of these contexts in turn.

### Narrative inquiry as a moral endeavour

Emerging in the latter part of the 20th century, the ‘narrative turn’ in the human sciences has increasingly challenged a single, monolithic conception of what should constitute scholarly work in favour of a developing pluralism. Specifically critiqued are traditional forms of writing, by authors who engage in ‘God’s eye’ representation, such third person forms aspire to objectivity and aim to instruct readers. In contrast to this work, highly reflexive, first person accounts now proliferate, which celebrate subjectivity and aim for connection with readers (Denzin & Lincoln 2008, Grant 2010a,b).

This challenge to traditional representational practices corresponds to a burgeoning of interpretive paradigm research projects, and a corresponding shift of focus towards local stories (Riessman 1993, 2008, Bochner 2001). Based on and grounded in the specifics of lived experience, local stories promote values of emotionality and social activism. They thus further present a counterpoint to the dominance of traditional, rationally-focused writing, which is often arguably too removed from day-to-day cultural life to do ethical justice to the specifics of individual experience.

The narrative turn in the human sciences also welcomes a related change in researcher value position in rejecting distanced spectator forms of writing in favour of embodied, emotional, culturally engaged storytelling (Bochner 2001).

### Theoretical assumptions about the significance of narratives

Such stories – synonymous with narratives for the purposes of the research component of the project – aim to capture and shape the significance of human experiences, within a time frame that deals with events in sequence into the future (Ricoeur 1984, Bochner 2001). In this sense, stories aid in the construction and reconstruction of individual and socially shared memory. They do this by having a dual function in terms of constituting memory-in-action and repository sites for the location of memories (Frank 2010a).

Narrative, therefore, plays an important role in self- and social-understanding and determination. We tell stories to make sense of ourselves and our experiences over the course of time, and to help us seek meanings to cope with our changing circum-

stances. Such narratives are existential, in that they reflect our desire to grasp or seize the possibilities of meaning and to imbue life with imagination and creativity.

These stories are also moral in representing the ongoing attempts of people in their struggles to both live well and make the best sense of their lives. This is reflected in the perpetual search for the ideal of authentic living, within which people orientate their lives to things that matter to them, including validation and recognition from others whose values they share. Such hope-imbued narratives are therefore therapeutic in that they provide storytellers and readers/listeners with a sense of the *legibility* of lives that have resonance, have come from somewhere and have a future direction (Frank 2002).

However, apparently ‘personal’ narratives are always dialogic in that individual subjectivities contain a multiplicity of other historically and culturally situated voices, which are more or less resisted or embraced at the level of personal story (Bakhtin 1981, Holquist 2002, Frank 2005). So, in relation to their social characteristics, stories always locate people in relation to others and social location is the core of narrative identity. In this sense, stories play a symbiotic role in creating the social (Frank 2010a,b) and in linking personal troubles to public issues (Frank 2002).

With regard to the question of whether or not narratives are historically accurate, it is useful to consider this issue pragmatically. From this position, the question is not whether narratives convey the way things actually are or were, but *what narratives do, what consequences they have, and what uses they can be put to?* Narrative is true to experience insofar as experience presents itself in a way that is saturated with the possibilities of meaning, in terms of its inscription within time, place and culture (Bochner 2001).

### The pedagogy of suffering in the sociology of health and illness

The discussion so far positions the research component of this paper within a human science purposefully directed towards empathy, caring and identification with the suffering of others, and helping suffering individuals move their lives forward through story writing and telling. This coheres with an explicit social justice agenda which offers community solidarity, promotes healing and

helps those with marginalized identities achieve agency (Frank 2002).

In this social justice context, Frank (2000, p. 136) states a manifesto position: 'to make ill people's stories more highly credited primarily among the ill themselves and then among those who care for them'. This agenda is clearly politically activist, and aims to shift the dominant cultural conception of illness away from passivity – the ill person as the victim of disease, then the recipient of care – towards activity.

Building on all of these assumptions, it is further held that 'experts by experience' have something very important to teach (Grant 2011b). One of the main lessons is around the struggle between personal and cultural meanings. Inevitably, mental health users and survivors must negotiate the spaces between lay and professional discourses of dysfunction. It is within these spaces that dominant understandings of suffering are constructed, defined and hold sway, as does the situated significance of the experiences of individuals within wider, shared, communities of suffering. This struggle is therefore personal, relational, cultural and political (Bochner 2001).

This struggle is also moral, as one of the main challenges of an illness is to construct a story that can transform a stigmatized existence into a good and meaningful personal and interpersonal life (Frank 1995, Grant 2010b).

The above set of assumptions and values are important, as the stories which convey them are arguably often silenced (Frank 1995, Bochner 2001), sanitized, or treated reductively to serve biomedical or psychotherapeutic research and theoretical, and related policy, agendas (Grant 2011a). This jars with the value position that people with mental health difficulties want to know that their suffering matters. Turning their experiences into stories is a way of making such experiences meaningful, is a defence against suffering in silence, and constitutes a kind of secular healing ritual where comfort, reassurance and support is gained by sharing suffering stories with others (Frank 1995, Bochner 2001).

In terms of healing the wounds to self-image by reducing stigmatization, Bochner (2001) argues that validating the lived experience of the afflicted body through personal narrative simultaneously reduces the power of discourses of 'invalidity' associated with illness and disability. This facilitates a refusal of the fate that is often assigned by default to

those with physical or mental health disabilities. Moreover, the therapeutic benefits of redemptive understanding are conferred on those who tell their stories.

Shifting to the relationship between storyteller and reader, illness narratives require an active and reflexive audience who are willing to enter into dialogue with the writer and the story. The fusion of horizons of understanding between storyteller/writer and reader results in an engaged, dialogic partnership and standpoint role for the reader or hearer of the story.

### Narrative recovery

The above discussion on the historical significance of narrative in the human sciences, and the theoretical assumptions associated with this, clearly articulates a role for narrative in recovery. Pilgrim (2009a) argues that 'recovery' broadly refers to the extent to which individuals with mental health difficulties regain or attain lives that have meaning. This may occur in the context of either the reduction or disappearance of elements of experience associated with these difficulties, such as symptoms, or their continued presence.

However, the variability of what this might mean in different recovery stories generally (Stickle & Wright 2011a,b), and specifically (Grant *et al.* 2011), reflects a contested, often polarized conceptual terrain. A significant point of contestation for the research context of this project is between 'recovery' narratives which are couched in, governed by, and endorse, the assumptions, language and practices of institutional psychiatry, and those written by survivors which document its abuses. Such latter, oppositional, forms reflect a conceptual appropriation of the recovery concept as signifying recovery from invalidating societal and institutional practices (Pilgrim 2009b). The collection of personal narratives in Grant *et al.* (2011) illustrates this narrative polarization, as well as representing borderland cultural positions (Rosaldo 1993). In borderland stories, contributors simultaneously describe the benefits of patienthood while critiquing specific aspects of institutional psychiatry on the basis of their experiences.

In relation to narrative theory, outlined earlier, master (policy) narratives are always more or less likely to inform local (organizational) cultural stories and related practices. Thus, many mental

health nurses may frame 'recovery' on the basis of a policy-speak which simultaneously privileges the practices and assumptions of institutional psychiatry while implicitly supporting an ultimately stigmatizing stance towards users and survivors (Goffman 1963). Current mental health nursing policy in the UK, for example, articulates recovery within a 'values to action' master narrative (DH 2006). The language used in this document assumes the relevance of, and explicitly endorses, the cultural hegemony of biomedical interpretations of the recovery concept and related institutional practices. So, although 'recovery' is argued as fundamental to 'valuing the principle of equality', a contradiction is introduced between the possibility of full membership of society for service users and the 'limitations caused by illness . . .' (p. 17).

A further contradiction is anticipated in the sentence 'To work effectively in partnership with service users and carers, it is essential that MHNs are able to . . . offer meaningful choice . . .' (p. 18). Although the question begged, meaningful on whose terms (?), is not answered, later in the document, in the context of 'Strengthening relationships with service users and carers' (p. 26), it is argued that such choice should be governed by the environmental circumstances in which mental health nursing practice is carried out. Thus, 'The exact nature of choice may be different depending on the setting, for example when working with people with severe dementia or in high secure settings.' (p. 26).

A possible implication emerging from this, frequently and well illustrated in the stories in Grant *et al.* (2011), is that service users are sometimes pulled into the dominant narratives of local mental health services in the name of 'recovery' in ways which compound and worsen their existing mental health difficulties. Dominant institutional narratives are likely to be composed in part by local and central policies and locally mediated narratives of evidence-based, custom- and practice-based, and conceptually based (e.g. mental health nursing models) practice in an uneasy, tensile narrative coexistence (Duncan-Grant 2001, Mills 2003). Further, such narratives are also likely to be further mutated and re-inscribed within more or less taken for granted, socially constructed, organizationally mediated rules and norms (Pfeffer 1981, Morgan 1997, Duncan-Grant 2001, Mills 2003). In short, tacitly accepted and well-rehearsed dominant organizational stories, containing multiple and often

contradictory sub-narratives, will often guide mental health nurses' practice.

Such practice may undermine the relevance of, and effectively trump, individual user narratives. The statement '... choice will be facilitated by providing good information about different interventions and outcomes and by ascertaining service users' views . . .' (DH 2006, p. 26) glosses over the fact that institutional psychiatric and service user narratives do not always happily cohere, given that a delimited range of interventions in relation to outcomes will be implicitly treated as fundamental to practice, in an important sense irrespective of users' views. As evidenced in Grant *et al.* (2011), the shared assumptions of mental health staff about what constitutes an appropriate intervention may well be privileged over users' views in persuasion or compliance narratives, and tacitly underscored at local, and national policy, levels.

It is not surprising, therefore, that in the context of the most recent literature reviews of the contemporary recovery movement in mental health in the UK, Stickley & Wright (2011a,b) describe the status of recovery narratives as 'grey literature', sidelined and relegated to either non-peer reviewed journals, frequently as single stories, or books. In relation to representational politics (Grant 2011a,b), Stickley and Wright argue that this position may facilitate the continued exclusivity of biomedical and evidence-based research agendas (also represented by co-evolving policy) in determining master narratives of recovery.

With regard to the importance of narrative inquiry for mental health nursing, our emergent standpoint position is that the dominance of such master narratives arguably undermines the ethics of recovery in the following inter-related ways. The significance and importance of the uniquely personal experience of having, recovering from and surviving mental health problems is obscured, as are the relational, social, material and environmental processes and structures within which those suffering from mental health problems are inscribed.

Equally obscured is the important recovery dimension of people attaining a sense of personal and relational identity, experienced as relatively separate from their mental health problems, disabilities or patienthood. Finally, and with regard to all of these undermining issues, the purpose of mental health nursing in working in a facilitative way to help people live their lives as they see fit, and in as whole a way as possible, becomes less impor-

tant than a psychiatric nursing practice supportive of the normative agenda of institutional psychiatry (Frank 2005, Biley & Galvin 2007, Barker & Buchanan-Barker 2011, Grant 2011a,b, Biley 2011, Biley & Walker 2011, Stickley & Wright 2011b).

## Research focus and data analysis

Two inter-related data sources will be used in the research component of this practice development project. The first is chapters contributed by authors in Grant *et al.* (2011) who have already given informed consent for their work to be used. The second is interview data from those authors who live local to both universities and who have consented to be interviewed about their experiences around writing their chapters.

Textual data are already available in the public domain as the book was published in mid-May 2011, and qualitative secondary analysis (Heaton 2004) of this material began in September 2011. This analysis is guided by a synthesis of dialogic narrative analytic principles from the work of Frank (2002, 2005, 2010a) and Riessman (2008), the aim of which is to explore the narrative characteristics of participants' chapters in relation to:

- **Themes:** What themes within and between stories serve to position them rather than exhaust their meanings?
- **Cultural resources:** What cultural resources do narratives draw on, including the relationship between the environments reported in the story and the type of story told?
- **Guiding lives:** How do stories and storytelling help people move forward with their lives, in terms of stories helping in: the process of memory reassemblage; teaching people who they are, including working towards more viable selves; and their lines of motivation?
- **Story interpellation:** To what extent are storytellers caught up in the stories others tell about them? In what ways do some stories silence other stories?
- **Moral impulse:** How is the way that the story is told the apparent best way for the storyteller to represent their lives and sort out what makes some modes of lives higher or better?
- **Personal, relational and community values:** How does the story detail practices within which a storyteller claims an identity? And how does the identity claimed link to

values that go beyond the self? How are dialogic relationships the topic, content and goal of the story? How do groups of stories build communities in terms of shared disenchantments?

- **Hermeneutic commitment:** What might the story mean within the horizons of the researcher and within the horizons of the storyteller and other audiences? Who is the story told for, and why is it told this way? How is blame allocated?

The overall research question guiding the schedule for interview data collection is: What is the reported impact on, and significance for, participants of writing their stories of their own mental health issues, at an individual level and in the context of the community of others' stories in Grant *et al.* (2011)?

It is anticipated that interview data will be collected in the first half of 2012 and that integrated textual and interview transcript analysis will extend to the end of 2012. The results of this research, carried out by first author and second author respectively, will be written up for a subsequent research article which will be submitted to this journal.

## Narrative data collection and analysis: key assumptions

The following assumptions, cohering with dialogic narrative inquiry and with the philosophical, theoretical and conceptual contexts of this research, underpin narrative data collection and analysis. Researcher standpoint position in relation to participants' narratives necessitates the need for both researchers to be politically and ethically reflexive in accounting for aspects of their lives and experience which are shared with these narratives (Frank 2000).

Taking such a standpoint role requires self-consciousness about how fate and life choices have positioned the researchers in relation to participants' narratives. Researcher standpoint position also coheres with an assumption of the significance of narrative morality: that telling and listening to stories are ethical acts in advancing personal and communal development and social justice (Frank 1995, 2005, 2010a, Bochner 2001).

Researcher standpoint position also involves researchers thinking *with*, as opposed to *about*, stories (Frank 1995, 2005, 2010a, Bochner 2001).

Thinking with stories privileges emotional over rational ways of knowing, and connection between writers and readers rather than instruction of the latter group. Frank argues that thinking with stories constitutes an empathic act of mutual emotional resonance between writers and readers:

To think with a story is to experience it affecting one's own life and to find in that effect a certain truth of one's life. Thus . . . people's illness stories are not 'data' to support various propositions that I advance. Instead, the stories are the materials that I use to model theorizing – and living – with stories. (Frank 1995, p. 23)

The research component of this project thus seeks to take an explicitly *dialogic* stance towards narrative analysis. Following Frank (2005, 2010a), in turn based on the work of Bakhtin (1981, 1984, Holquist 2002), the aim of this stance is to research the written and reported identities of research participants in ways that cohere with, and are respectfully committed to, narrative representational ethics. From this position, it will be assumed that participants are more than the analysis of their narratives and that such analysis will not exhaust possibilities for the onward development of their lives.

Complementing the aspirations of the mental health recovery movement, this means that narrative analysis should be characterized by a perpetual openness to a participant's capacity to become someone other than who s/he already is. In narrative terms, people are not fixed in representations of their words and need not be the victims of biographies written for them by others.

Further, as argued earlier, it is acknowledged that no one speaks solely with their own voice. Participants will draw on other voices, including those of researchers, to tell their stories. This reflects a further assumption: that life, imbued with meaning by stories, is relationally constituted. Voices, including those of mental health professionals, are embraced or resisted differentially.

Participants' access to narrative resources will depend on their social location – for example, what stories are told among the people they associate with or are assimilated from broader cultures; what stories are taken seriously; and what stories can be

exchanged as tokens of membership of social groups. In this sense, participant's stories, no matter how apparently personal they seem, will depend on shared narrative resources.

Narratives used in this strand of the research will not represent a surrogate for a *more real* 'outside' reality. They are constituted in dialogue and will call forth other narratives – from participants, from researchers, and from future audiences in the dissemination of the research. In this overall context, the research will hopefully instigate reflections that will lead all stakeholders in it to positively change their lives in various ways. Therefore, narrative analysis can only look towards an open future and narrative research participates in its shaping.

## Conclusion

In keeping with the assumptions of dialogic narrative analysis, and the philosophical, theoretical and conceptual principles sketched out earlier, the research component of this project complements the manifesto position of Barker & Buchanan-Barker (2011). This is in its commitment to a *mental health nursing* practice allied to recovery as narrative healing as opposed to forms of *psychiatric nursing* which endorse and tacitly support abuses committed in the name of institutional psychiatry. This commitment is underpinned by a recovery ethic which aims broadly to enable a portrayal of recovery and survival stories in all their complexity, ambiguity and contradictions. This further underscores the importance of narrative ethics more generally. Simultaneously at the level of an individual life, while contributing to the developing story of the recovery movements overall, narrative ethics refers to a ' . . . commitment to shaping oneself as a human being. Specific stories are the media of this shaping, and the shaping itself is the story of a life.' (Frank 1995, p. 158).

Finally, this work will theoretically, philosophically, conceptually and aspirationally inform the practice development of *Writing for Recovery* groups for mental health service users, survivors and carers in Dorset and East Sussex, the subject of part 2 of this practice development study.

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