



## Consumer and Practitioner Narrative

# Re-storying narrative identity: a dialogical study of mental health recovery and survival

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### Accessible summary

- Current UK mental health nursing policy is critiqued for neglecting the storied complexities of recovery-survival.
- Within a critical framework, creative non-fiction is used in a relational auto-ethnographic design to produce two short stories that demonstrate the utility of narrative re-storying in recovery-survival.
- New insights emerge for mental health nurse practice and research. These are: that narrative re-storying may help the recovery process for individuals and communities; that hybrid transcultural writing positively undermines barriers between professionals and consumers of mental health; and that all of this constitutes contemporary methodological innovation in narrative inquiry and related practice.

### Abstract

Some of the complexities of recovery and survival are arguably relatively neglected in current UK mental health nursing policy and, by association, clinical and research practice. In order to redress this, this paper, part of larger research project, will present two short stories, contextualized in a critical theoretical and methodological position. The overall significance of the argument in the paper is in its emerging benefits and implications for users of mental health services, practitioners and researchers. The central, orienting principle in the paper, cohering with all of its strands, is ‘narrative re-storying’. Organized in three parts, the first reviews selected relevant background policy and related literature, the contextual and theoretical bases of the paper, and related methodological and ethical issues. The second presents the two stories, and the third brings the paper to a close. It does so in discussing specific and global emerging implications for mental health nursing practice and research, around narrative re-storying as a recovery tool and methodological innovations that include ‘hybrid’ writing.

## Background

The Chief Nursing Officer’s Review of Mental Health Nursing in England (Department of Health 2006) pro-

ceeded from the question ‘How can mental health nursing best contribute to the care of service users in the future?’ (p. 3). The document makes clear that its recommendations need to cohere with the reviews of other future-oriented

professional groups in mental health while focusing on both the implications for both nursing practice and education, and for the organizational context of care.

The document was written on the apparently admirable basis of extensive literature reviewing and consultation with individuals, groups and organizations. This included consultancy with large numbers of mental health nurses and service users (Brimblecombe *et al.* 2007). There is recent evidence of both the widespread acceptance of the review in mental health trusts, notwithstanding its patchy implementation (Callaghan *et al.* 2012), and an ensuing critical dialogue on aspects of its methodological underpinning (Brimblecombe & Tingle 2007, Brooker 2007).

At face value, the generally positive reception of the document is not surprising. It seems non-contentious in its social engagement ethos, with a clear call to facilitate service user choice in contemporary and future-oriented services by providing information about different interventions that take account of evidence-based practice and users' views. Overall, it appears to be written on the basis of thoroughness, inclusiveness and vision.

However, from a critical social and human science perspective (Zeeman *et al.* 2014) and in line with the thrust of this paper, it remains arguably neglectful of important aspects of the complexities of lived experience of many individuals who have used mental health services (Grant *et al.* 2012a, 2012b, Grant & Leigh-Phippard 2014).

When read as narrative, the review stories relationships between nurses and service users on the basis of normative institutional psychiatric assumptions. It constructs gender-neutral, homogenized and compliant users, excised from much of their life contexts. As a relatively power-silent story, it fails to acknowledge the potential for, in Butler's (1993) terms, 'enabling violations'. This phrase refers to the ways in which people often oppose the power structures they are caught up in.

Power issues are more implicitly acknowledged in the description of mental health nursing staff. They are by default described as having privileged views about the limits of the meaning of 'recovery' by dint of the constraining and enabling contexts of their professional and environmental specialisms. In a circular argument, it is proposed that user choice should be governed according to the environment in which specific forms of mental health nursing practice are carried out. The nature of such choice is therefore described as necessarily variable, depending on the work settings in which nursing care is provided.

Privileging such an ideology of 'choice' in English mental health nursing policy arguably betrays a rhetoric of pseudo-collaboration, ultimately offered on the organizational environmental terms of institutional psychiatry. This rests on a presupposed consensus among all

stakeholders around an already established but developing and improving benevolent hierarchy. Within this hierarchy, it is anticipated that people – staff and patients or clients – will be accepting of their institutional location in the fulfilment of care and treatment.

From this policy perspective, the statement '... choice will be facilitated by providing good information about different interventions and outcomes and by asserting service users' views ...' (p. 26) glosses over the fact that the views of mental health workers and users are often described as conflictual. At both international (e.g. LeFrancois *et al.* 2013) and national (e.g. Grant *et al.* 2011) levels, conflict occurs around contested assumptions about what constitutes legitimate choices, the relational bases for choices, and the related environmental contexts and parameters in which choices are invited and made. An implication emerging from this, illustrated in the two stories below, is that users can be pulled into dominant narratives of local mental health services in the name of treatment and care in ways that ultimately prove damaging to them and give the lie to policy constructions of recovery.

From a critical perspective, 'recovery', and by implication 'survival', frequently signify ongoing liberatory struggles against invalidating societal and institutional practices, including those of institutional psychiatry (Pilgrim 2009, Grant *et al.* 2011, LeFrancois *et al.* 2013, Grant & Leigh-Phippard 2014). In this critical context, 'mental health care' becomes a recovery-survival issue when experienced as a narrative assault on the identities of mental health service users.

## Research and practice development context

The study described in this paper is part of a larger narrative inquiry project (Grant *et al.* 2012a, 2012b). Emerging from the publication of a collection of recovery and survival narratives written by contributors from the UK and the USA (Grant *et al.* 2011), it has so far been disseminated in two book chapters (Grant 2013, Grant & Leigh-Phippard 2014), a research context paper (Grant *et al.* 2012a) and two practice development papers (Grant *et al.* 2012b, Taylor *et al.* 2014).

## Theoretical background

Influenced by feminist onto-epistemological principles (Richardson 1997), the 'narrative turn' in the latter part of the 20th century heralded the celebration of reflexive, subjective, first person, culturally engaged local stories. The hitherto narrow focus on objectivity, distance and neutral abstract description in social and human science writing was rejected in favour of standpoint, engaged, deeply per-

sonal, embodied, relational, biographical, therapeutic and existential narratives (Richardson 1997, Bochner 2013).

Key assumptions of the narrative turn include that storytelling creates rather than reflects reality; guides individual and collective action in providing narrative templates for living; and promotes the values of emotionality, social activism and social justice (Riessman 2008, Bochner 2013).

Narratives are defined as the social stock of available discourses, or 'big stories', that function as a resource that people draw on in order to produce new, smaller, local stories (Frank 2010). This allows people to 're-story' – to make sense of their pasts, and guide their present and future lives (Ricoeur 1984) – individually and in community according to their local circumstances (e.g. Short *et al.* 2007, Grant & Zeeman 2012, Short 2013, Grant & Leigh-Phippard 2014).

*Narrative re-storying* can be defined as a personally and relationally transformational method of reflexive inquiry (Richardson 2000). This enables the re-interpretation and re-narration of lived experiences in line with co-evolving preferred personal and relational identities (Grant & Zeeman 2012). At an existential level, narrative re-storying can free people from what Frank (2011, p. x) describes as 'all that makes it difficult for people to tell stories in which their lives make sense'. Frank (1995) argues that re-storying is thus not only a transformational tool, but constitutes an informed ethical choice about how best to make sense of one's past, present, and future life and relationships.

At an educational level, Goodson *et al.* (2010) argue that people *learn* from their lives through the stories they tell about them. This can be triggered by transitions and crises, which interrupt normal life patterns. Equally, re-storying may be facilitated by deliberate acts of reflection on, and re-framing of, past events in relational contexts (Grant & Zeeman 2012). Scholars such as Richardson (1997, 2000) and Hunt (2013) agree that this can occur directly through the act of writing as a method of self and relational inquiry and transformational learning.

Such writing can also produce new, sometimes unexpected knowledge and life direction at emotional and cognitive levels (Hunt 2013), in the development of storied communities (Richardson 1997). We have found this to be the case in the overall research and practice development project within which this study is embedded and in the process of constructing this paper.

In summary, narrative re-storying is a simultaneously shared and individual, therapeutic, educational, existential, potentially transformational, purposive and reflexive tool for living and moving lives forward. The urge to re-story may proceed from significant or triggering life events. Equally, re-storying may be employed to help people make

better sense of, re-frame and change the significance of hitherto underexamined past life events.

The extent to which narrative re-storying has significance for relationships points up the great significance of dialogue in narrative work. Those in recovery-survival are, over time, in open-ended reflexive dialogue with themselves, and with mental health staff and others. Such dialogues contribute both to building communities of new meaning making and, hopefully, to productive connections with those who read their stories (Frank 2010).

No bottom line of reality is assumed against which to appeal to or judge the accuracy of stories as valid knowledge. Instead, it may be better to ask pragmatic questions around their consequences and uses. Stories thus present a necessary challenge to the dominance of rationally focused writing in qualitative research, arguably too removed from the contextual specifics of individual experience to do ethical justice to people's lives (Fisher & Freshwater 2014, Grant 2014).

## Methodology

Cohering with the theoretical position outlined above, the specific methodological approach taken in this paper is creative, non-fiction storytelling within a relational auto-ethnographic frame. This is well developed in the sociology of sport and exercise (Sparkes 2002, Smith 2013, Carless *et al.* 2014), and in ethnography (Angrosino 1998) and auto-ethnography (Douglas & Carless 2013, Short *et al.* 2013).

In contrast to those conventional qualitative approaches emphasizing thematic content analysis as a procedural basis for the interpretation of lived experience (Grant 2014), this study is based on different analytic assumptions. Recognizing both the importance of *what* is being told in the stories below and *how* this is being told (Smith & Sparkes 2006), the process of analysis was assumed to be inscribed within the act of crafting repeated iterations of the stories in the context of the co-evolving paper as a whole (Sparkes 2002). Smith & Sparkes (2009, p. 285) assert that 'writing, theatrical, and, for example, visual ways of understanding can be thought of as analytic in their own right', since 'for storytellers analysis is the story'.

This accords with Frank's (2010) view that the analytical thematic treatment of stories should avoid the overly technical and procedural, as this can obscure and drown them out. However, Frank does support the judicious use of thematic typologies to order and present stories. In the case of the two stories appearing in this paper, a clear typology suggested itself to all three of us at an early stage in its production, on the basis of ongoing dialogue around repeated iterations of the stories and the developing paper

as a whole. This was in the form of the trajectory: *narrative disruption*, *narrative repair* and *narrative re-storying*.

Storytelling utilizing creative non-fiction reveals subjectivities, personal meanings and dialogical connections that lead to better contextual understandings of individual and collective recovery and survival trajectories. These accord readers opportunities to gain evocative, accessible and embodied understandings of the lives of others (Bochner 2013).

Further, storytelling employing creative non-fiction aligns with Frank's (2010) conception of the ethical basis for dialogical research. This strives to respect researcher-participants as experts in their own lives, where their role is to learn from each other through dialogue. The role of the co-researchers is that of collaborative witnessing (Ellis 2013), in placing these stories in dialogue with one another and inviting readers to enter this dialogue.

## Ethical considerations

As described in Grant *et al.* (2012a), procedural ethics was achieved at the beginning of the study. More salient for this paper, dialogical relational ethical principles were constantly observed, governing the content and construction of this paper at all levels. First-person stories, told on basis of textual analysis of book chapters and subsequent interviews and dialogic collaboration, were drafted by the first author then sent back to the others for critical comments. However, at a relatively early stage, the paper as an analytical whole became the subject of ongoing dialogic development rather than focussing solely on the stories contained within it. This continued to the point at which all of us agreed that the paper was ready for submission to this journal.

This dialogical ethical rationale begs an important question: why these stories and not others, given that there were 11 narrative researcher-participants involved in the overall research project from the outset (Grant *et al.* 2011, 2012a)? There are two reasons for this: first, it would have been clearly inappropriate to have attempted to create short stories about all participants, or construct composites. Doing so would have compromised the creative non-fiction approach, and the level of concrete detail required of events that had occurred (Grant *et al.* 2011).

The second reason proceeds from Frank's (2010) distinction between the typical and the representative in narrative inquiry. Typicality is an impossible aspiration. However, Helen and Nigel are arguably *exemplars* of both narrative recovery and survival. Both have emerging hybrid identities, which draw on their insider knowledge of mental health/nursing practice, scholarship, teaching and patienthood. Helen has a relatively high profile in the

recovery movement and Nigel a long career in mental health nursing and, later, cognitive behavioural psychotherapy. Both have much experience in the narrative resources of reflexive, auto-ethnographic writing. It is axiomatic therefore that they have the transcultural, intellectual, cultural and symbolic capital to tell their tales with considerable authority.

## The stories

### Helen

#### *Narrative disruption*

I was given my medication and sent to my room, but the fact that I had received it had not been recorded. Later that evening, I experienced my arm burning, a side effect I had been experiencing while taking this medication. I asked a nurse for an ice pack to relieve this, but this was declined as I could not be experiencing side effects because there was no record of my medication having been taken. Despite insisting I had, and that the record probably had not been made because of an incident distracting the nursing staff, I was not believed. Assuming that my medication had in fact not been taken, the nurse tried to pressure me to take another dose. I refused and, as a voluntary patient, asked to be discharged, but was told that I could not until a doctor decided this was appropriate, and this could not happen for another 36 hours.

At this point, I felt that my life was changing in terms of the status of my personhood. I experienced the transition from being a respected, trusted academic to someone who was constantly disbelieved and whose agency as a human being was not taken seriously. At a later point as an outpatient, I disclosed to a psychiatrist that although I felt constantly suicidal, I was learning to manage those feelings. However, the next time I saw him he told me that he was considering a section in order to admit me and administer ECT because of expressed suicidal feelings. He made no mention of the fact that I told him I had been managing those at the previous meeting, and this reminded me that I was powerless over official stories told about me. A day after a failed attempt to section me to keep me in hospital, I went into town and got my nosed pierced. This was a ridiculous act of rebellion by a 30 something adult, but for me it signalled reasserting control over my own body (and every time I look in the mirror, it is a reminder that I was not sectioned and got control of myself and my life back).

I thus came to believe that an honest relationship with institutional psychiatric staff was dangerous, and for several years I learned to respond in a monosyllabic way and say as little as possible to avoid readmission to hospital. This amounted to my deliberately manipulating a

system I otherwise felt trapped and powerless in. Five years of silent patienthood signalled resistance to a compliant patient role.

#### *Narrative repair*

A significant strand on my road to recovery was eventually being allocated a CPN who worked within a recovery value system and who seemed to want to patiently listen to me and help me to explore my own recovery path. Through dialogue with this CPN, whom I eventually came to trust, I found therapeutic value in beginning to understand what my experiences meant and what was happening to me. This contrasted with years of being simply given a diagnosis and told I should accept treatment provided on the basis of mental health professionals knowing what was best for me and having any questioning by me of either diagnosis or treatment being regarded as further signs of illness.

All of this contributed to me feeling *helped* as opposed to simply *managed*, and as a result I gradually came to terms with the loss of my career and embraced the need to change direction. I began service user project work and have come to regard this as central to my recovery. Hearing the stories of others has made me realize the resilience and courage needed for recovery in the face of a largely unsympathetic and stigmatizing society. This has helped me in the transition from feeling ashamed about having a mental health problem to feeling proud to be a member of the mental health recovery community.

#### *Narrative re-storying*

I have been able to reclaim my academic skills in contribution to the improvement of mental health service provision while working with mental health nursing and clinical psychology students. Telling and retelling my story, verbally and in print, has enabled me to gain an increasingly richer understanding of my own experiences and confidence in them. No longer afraid of people's reactions to my stories, including mistrusting them, this consolidates for me the notion of shared/community story telling as central in narrative recovery, in terms of being therapeutic and exploratory in making sense of the past and creating a narrative template for now and the future. My story is changing and developing, as I am. I have also found it hugely therapeutic to have the opportunity to challenge the 'official' story about me that has been told and continues to be told in my medical record, but which I have no part in telling.

Finally, from previously feeling that I was treated like, and had the status of, a child, where compliance was expected and non-compliance punished, involvement in a user and recovery movement has provided more than community support. I am now able to access information – about my rights, about the system and how it should work,

about the information I should receive and my choices. Also through my committee work, I now have access to and some influence with managers and policy makers. This has helped me shift from a manipulative non-compliant stance in relation to institutional psychiatry to an assertive, empowered one, to the extent that currently I now feel well able to manage and feel in control of my symptoms and have a large amount of what might be called 'survivor optimism'.

But there are still shades of the past in the present. I am the sole service user member of a research group in a mental health Trust. During one meeting, there was discussion around the fact that the Trust Board had set a target for publications, and hence it was important to ensure that every publication made by Trust clinicians and academic partners was included in the publications list. I sat through that meeting thinking that they could ask if any of their service users involved locally in research had published anything, but this possibility did not seem to occur for them. I knew that I had publications that could be added to their list, but I had had no help from them in writing those pieces and, because it did not seem to occur to them that I might be capable of academic writing, I decided to say nothing. I was clearly not part of the conversation in any case; they were not including me in it. Someone asked 'could we include book chapters?' And I thought 'I've got a book chapter you could have (Leigh-Phippard 2011), but I'm not going to say so'. I know half a dozen users with master's degrees and I have got a PhD, but I have become used to being treated like the village idiot. In that situation, they seem to regard me and other service users in a very narrow, reductionist way: as just users without lives, without context, skills or knowledge.

#### **Nigel**

##### *Narrative disruption*

My mental health and my ability to sleep had been deteriorating slowly for 6 months, following the break up of my relationship, a loss of confidence and the security of my old self and of hope, fullness and completeness as a human being. I experienced myself as empty and I self-medicated with alcohol every evening in a pub called *The Clown*. This was always filled with people who were connected to me in one particular way – they were all disenfranchised for some reason or another. I felt that the name of the pub was ironic; perhaps all along I was being a clown in the company of other clowns?

By the time I was admitted to hospital in London, I felt in some ways that I had used up all of my narratives, but still I tried to talk about my existential and emotional difficulties with the staff on the acute ward. Most of the

time, their non-verbal expressions indicated levels of boredom that increased in direct proportion to my attempts at repeated clarification and re-clarification of what was going on for me. As a result of this, my feelings of personal worthlessness and vulnerability worsened. I felt, and was, chastised, shamed and humiliated. The worst example of this was when a young, male staff nurse came into my room late one morning. I had no idea what time it was and had just woken up, multiple hypnotics and trancs contributing to me oversleeping. Clearly irritated, he shouted at me: 'Don't you want to get better? Get up, you cunt'.

I was struck by the ironies and contradictions around the nurses' unresponsive and invalidating interpersonal styles. Once, when I walked past a line of nurses who were sat reading outside siderooms where they were employed in patients' special observations, I noticed that one of them was reading a book about therapeutic relationships. For the most part, I never felt *in* a therapeutic relationship as an equal partner. Indeed, during my time in the acute ward, I felt increasingly caught up in the stories told about me by staff, particularly what was written about me in the nursing and medical notes. One entry described me as having a personality disorder. This jarred with my wish not to be, after Stockwell, the 'unpopular patient'. I wanted to be regarded in a fair way and be validated as a person, as opposed to being in receipt of, in Goffman's sense, a spoilt identity that took no account of contextual factors. It was ironic that there were occasions when I thought the staff thought I was 'observing' them. The public phone on the ward was near the nursing office. I had told a friend of mine that if I ever mentioned Michael Argyle (the social psychologist) in a conversation, he would know that a member of staff was nearby. Just before I was discharged from the ward, one of the staff asked me who Michael Argyle was.

I was never really able to resolve the communication difficulties I had with staff generally, and specifically with the young man who verbally abused me, in any personally satisfactory way.

I was keen to try to resolve any difficulties with the young nurse who had called me a 'cunt' and wanted my stay in this hospital to be productive. Having spent many years as a charge nurse in a busy inpatient unit, I did not want to be unpopular with the staff, knowing the literature on how nurses can and do become prejudiced towards some patients, often unwittingly. In a very brief and cursory response to my attempts, he denied that this had happened in the nursing office, in the company of other nurses; invalidation compounded! However, it is worth noting that following the abuse incident, a junior staff nurse who was in the office when I raised the issues told me in private that she

had difficulties with this male nurse as well and felt disempowered to say anything in his presence.

#### *Narrative repair*

I cannot remember any examples of extended conversations with nurses, with the exception of one, apparently interested, nurse who surprised me by approaching me at one point near the end of my admission and asked me to describe the experiences I was having. This one, exceptional, conversation stays in my memory as a kind of pivotal point in my starting to re-story my feelings and experiences. I have carried on doing this because I do not ever want again to be stuck in other people's accounts about me.

All the time I was on the ward, I felt caught up the mundane smells and sights of the place. These were often stale, unchanging, a kind of metaphor for my stuckness. I remember the contrast between them and the freshness and variety of the interesting London streets when I was eventually allowed out on a day pass. I could smell and almost eat London that day. I remember walking down a long street and breathing in sweet fresh air that my body was aching for. I could feel its damp coolness on my skin as I smelt the odours of the street and heard its noises. Street noises were welcome, as was the stink of other bodies. I was able to be myself and be self-directed, to walk where I wanted and lose myself in the crowd. I felt unnoticed, unobserved. In contrast to my experiences on the ward, out here there were no nurses around to report on me and make judgements as to how I was feeling.

#### *Narrative re-storying*

Since then, more than 10 years ago now, different places have been linked to my changing levels of mood, confidence and self-worth. I believe that writing about my embodied environmental experiences in concrete detail over time, including and based on diary records, has helped me reassemble my memories in ways that have enabled me to move my life on. I think the idea of sharing stories creates opportunities for people to be more accepting, as opposed to tolerating, about why I am who I am (who 'I' am in plural as there are different 'Nigels'). This applies in reverse, too, in that my experiences have prompted me to be interested in and think about other people's stories. If I were ever to read about staff, for example, I would be curious to know what stories they have got, where they have come from and why they are nurses.

My own auto-ethnographic writing prompts the recovery of a lot of memories; always current memories about the past of course. It is all a constant reminder for me about how limited my Registered Mental Nurse (RMN) training

was. The idea about reading about people's experiences who had used mental health services was very limited then. So there is a kind of constant celebration for me about this, which is simultaneously both joyous and melancholy – melancholy in terms of being reminded about where I was at that time and place, and joyous that my life is so different now, and that it is me who has shaped this.

### Emerging implications for mental health nursing practice and research

Despite the content differences between the stories, they share key similarities relevant to dialogical narrative inquiry. Both illustrate how mental health service users can be unwillingly pulled into what have been described as 'implicit organizational narratives' (Smircich 1983, Richardson 1997) – in this case of institutional psychiatry. This term refers to the unspoken, tacit rules of their organization, which inform the assumptions and actions of staff on a day-to-day basis. From a dialogical perspective, staff socialized to these narratives are likely to have a view of their own and service users' realities that are not necessarily shared by all in the latter group.

In this context, it is not surprising that both Helen and Nigel report that their respective accounts were generally disbelieved by mental health nurses and other staff. Knowing humanistic nursing principles and practising according to tacit organizational rules around 'the way things are done around here' suggests competing curricula, the latter frequently trumping the former to a greater or lesser extent. Neither should it be surprising that this led to Nigel and Helen experiencing reduced viability as human beings and that their respective acts of rebellion and freedom seeking helped them regain control of their bodies and, by extrapolation, their lives – at least for a short time.

Their stories detail the specifics of the embodied, transcultural, social and material environments that they found themselves in and how those changed over time. These changes were linked to shifting emotions and levels of agency and viability as human beings. The importance of space and time as co-evolving phenomena links to a further important theoretical point related to implicit organisational narratives. Holquist (2002) draws on the dialogical principles outlined by Bakhtin (1981) to argue that people behave in a reasoned way according to shared and contested space-time meanings. Although common sense suggests that they are together in geographical positions at specific periods, nurses and many service users do not always coexist in the same mental health work setting in relation to their lived experiences.

Nigel and Helen clearly occupied different cognitive and emotional space-times. This is why they experienced

disturbing mismatches between the stories told about them and those they held about themselves. The propensity for many in recovery-survival and mental health staff to come into conflict in this way seems, sadly, constantly inevitable. The two nurses described by Helen and Nigel in the context of their narrative repair should be seen as exemplar relative exceptions to an arguably frequently more general rule.

A related task for mental health nursing therefore is for nurses to become reflexively more aware of, and resist, the process of socialization into implicit organizational narratives. This would enable them to make transformative, recovery-oriented relationships more readily available for the people in their care (Barker & Buchanan-Barker 2011), facilitated by the principles and practice of narrative re-storying.

This task does not lend itself to a neat, algorithmic or 'road map' model that nurses can use because the relationship between life events and narrative re-storying is complex and relatively unpredictable. Some transformational life events are indeed planned. Equally, there are life events that, given the organizational context of nursing care, could and should be expected but do not occur. In the case of the stories in this paper, Helen and Nigel describe pivotal life events that were serendipitous, happening in spite of treatment and care contexts rather than because of them.

What then are the related emerging implications for mental health nursing research? Broadly, discourses ('big stories' or 'master narratives') that define 'recovery' in ways minimally disruptive to the status quo of institutional psychiatry need to be challenged in relation to both national mental health recovery research and scholarship (Stickey & Wright 2011a,b) and international mental health recovery research agendas aspiring to social justice (Howell & Voronka 2012). In contrast to discourses that contain the constant potential to be oppressive, accounts such as Helen's and Nigel's generate possibilities for transgressive and resistance discursive positions (Chaudhry 2009). They contribute new narrative templates for people to use as resources for re-storying their lives (Richardson 1997, Adams 2008, Bochner 2013).

Taking the narrative lead for others can be politically effective and is a choice that is both ethical and pragmatic in mobilizing survivor self-determination (Richardson 1997). Although the exemplar stories in this paper demonstrate considerable transcultural, intellectual and symbolic capital on the part of their authors, work-in-progress suggests that many less advantaged people in recovery-survival can be helped to re-story their lives through creative 'Writing for Recovery' workshops (Taylor *et al.* 2014).

Recent key recovery-survivor work demonstrates increasing authority and collective assertion in stories told (e.g. Crossley & Crossley 2001, LeFrancois *et al.* 2013), contributing to the accrual and development of storied communities. This is characterized by the shaping of resistance, oppositional and transformational master narratives to an extent that future national and international policy writers may find increasingly difficult to ignore. In this context, it arguably behoves qualitative researchers to contribute to the continued growth of such master narratives in the urgent and prescient task of challenging conventional research practices by constructing inquiry around *difference* rather than assumed similarities between people (Grant 2014, Zeeman *et al.* 2014). Such action will hope-

fully enable future service users and survivors to make more personally and relationally meaningful sense of, and re-story, their experiences and developing lives on the basis of an increased stock of available narratives (Richardson 1997).

The final, overarching, contribution to narrative inquiry in mental health/nursing made in this paper is in its methodological innovations. Within a relational autoethnography, the conventional representational practices of recovery narrative scholarship have been troubled through a refusal to separate professional from consumer narratives, in a celebration of hybrid, transcultural identities. This may hopefully pave the way for future research which similarly undermines 'othering' practices.

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