Before Recovery: A Blind Spot in Recovery Research? Users' Narratives about the Origins and Development of their Mental Health and/or Addiction Problems

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Abstract

Objective: Recently, the position of persons with mental health and drug problems has evolved from victim of an illness to holder of an experience-based knowledge (EBK). Studies about recovery are often based on recovery narratives. However, focusing on components of the recovery process—parts of this EBK concerned with the causes, onset, and journey before the proper recovery process—risks forming a blind spot. In this study, we aim to analyze service users' EBK about recovery, the backgrounds and causes of the problems, and how they related these conditions to their recovery journey.
Research Design and Methods: We interviewed 29 persons in recovery. Data were analyzed by using thematic analysis.
Results: We found that a childhood characterized by violence and abuse reoccurred in the stories. The child's situation was not addressed by schools, social agencies, or neighbours, creating an experience of social isolation and invisibility. Mental health distress and drug abuse were described as ways of managing these situations, until these became problems in themselves. The recovery journey started in a situation of despair and with a decision to stop using the developed threat response. For many, this meant going back to a situation of loneliness and invisibility before finding places and people and allowing experiences of being part of a positive context where they could also contribute.
Conclusions: There is a risk of a blind spot in recovery research. EBK should be used to develop recovery-oriented services and also preventive interventions directed toward the social and psychological conditions in which children are raised.

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Introduction

To describe a person's recovery journey could be seen as the discovery or creation of a coherent story about this person's path from distress to an improved life situation and sense of self.[1, 2] The fact that researchers have been interested in these stories is the result of the conquest of a status of citizens by people who, for a long time, have been kept apart from society, not only physically but also in terms of civil rights.[3] However, the overall research has been concerned with the contributing elements to the recovery process. This includes the person's struggle to regain power over their own life, feelings, and relations, but also how their social network, families, friends, and professionals could participate in this conquest.[4-9]

Two aspects of recovery stories have attracted less attention, although they might be well-known by scholars making or reading interviews with people in recovery or who have recovered. The first concerns unhelpful persons and hindering circumstances around the user.[10-13] The second concerns the person's own perception of the development of the problems and distress they have been coping with.[14]

These parts of recovery interviews are sometimes mentioned in different studies[2, 15] but seldom elaborated, as research is commonly focused on developing helpful professional practices and recovery-oriented services.[5, 16-19] However, the publication of users' negative experiences has a long history and has been defined as "narrative of protest" and also as "atrocity stories."[20-23] Still, these are rarely used as a source of knowledge about the background of mental health and/or addiction problems.

However, the importance of creating a coherent and meaningful narrative to (re)create a common thread has been mentioned in research literature.[24, 25] Meaning is also important among the common factors explaining how different psychotherapeutic interventions, despite different theoretical orientations, might be helpful.[26] (Re)creating a meaningful story about one's life by explaining the break in one's life story caused by the illness/problem/distress is also about finding a rationale for the recovery process.[2] (Re)creating meaning might transform recovery into a discovery journey, in search of lost time.

Today, there are several understandings of madness in the psychiatric field. The end of the decennium of the brain was followed by the century of the brain and the bio-medical, which is still dominant. Traditional psychoanalytical theory has been replaced by more relational theories around attachment. Cognitivist theories hypothesize about maladaptive schemas or maladaptive information processing. Few of these theories refer to users' experiences, and if they do, these experiences are primarily mediated through the respective theory's lens.

Thus, despite the growing interest in users' EBK, we lack studies about how people with their own experience describe the background of their recovery journey.[27, 28] As is pointed out by Wang, et al., "[F]ew studies have focused on the recovery process in the context

of trauma, and the influences of past trauma seldom attract attention in terms of client's recovery."[28]

Aim and Questions

Recovery narratives are often formulated in terms of a journey the person had to do to find themself.[1, 29, 30] Most attention has been given to the recovery aspects of this journey. In this article, we will focus on the initial part of the recovery journey, before recovery, and even before the crisis initiating the journey.

The overall aim of this study is to explore a blind spot in recovery research about how users describe the causes of their original problems. More precisely, our aim is to analyze how persons in a recovery process describe the backgrounds and causes of their problems and how they relate these conditions to their recovery journey.

We try to answer the following questions:

- How do persons in a recovery process describe the background to their problems?
- How do persons in a recovery process describe their problem's function/role in their life?
- How do persons in a recovery process describe their recovery journey?

We also aimed to reflect on the narrative we co-constructed in interaction with our participants.

Research Design and Methods

We accommodate the data collection to the participants' wishes. From the beginning we planned to implement individual and focus group interviews, but in some cases, participants preferred to be interviewed together in a dual interview. We think that these different settings added richness to the collected interviews. We acknowledge that the process of putting lived experience into words is influenced by the interaction between different participants in the group interviews and the researcher and between the participant and the researcher, mainly in the individual interviews. Focus group and dual interviews were based on dialogue and the dynamics between the participants in the group and the stories they told each other, even when they deviated from the strict focus agreed upon.[31]

We recruited participants from social arenas established particularly for people with mental health and/or addiction challenges in Norwegian municipalities. We asked the managers of the places to inform the members about our research and invite people to participate in the study. People who wanted to participate received written information. We invited participants who considered themselves as recovered, not necessarily in the sense of clinical recovery, but in the sense of having achieved a better life.

Totals of 16 women and 13 men were interviewed in the context of their choice—two individual, two dual, and four focus group interviews. The interviews lasted between 60 and 90 minutes and resulted in 174 pages of transcribed text.

The collected interviews were analyzed using thematic analysis developed by Braun and Clarke and the six steps they formulated in the analysis process. The authors read the interviews several times and discussed their notes and thus created preliminary themes in a series of meetings.[32, 33] Braun and Clarke are clear that themes are not waiting to be found in the collected interviews, but are created by researchers. In our case, it was an advantage that we represented different professions and theoretical starting points. Preliminary themes were formulated, reformulated, and integrated into one another and finally split. Subthemes were developed. From the beginning, both themes and subthemes were anchored in quotes from the interviews.

In the following findings section, we present a rather large number of quotes, some of them relatively extensive. Our purpose is not to convince the reader of our analysis through quantity, but to reflect the qualitative diversity and nuances in the stories we collected. In this way, we also strive to problematize our own tendency to create a one-dimensional narrative. However, we are conscious that thematic analysis involves a de-contextualization of the individual's specific experience.

Although we were clear in the information to the interviewees about our interest in their experiences of recovery, one theme that struck us was their reoccurring descriptions of the background to, and even the reasons for, their "journey through madness (and/or addiction)."[34] Regarding recovery studies, this contextualization could be seen as a blind spot even if it consisted of important knowledge about "how it started" but also a slightly different understanding of important aspects of their experiences of recovery facilitators. Therefore, we decided to focus our attention toward this topic, which became the overarching theme of the study. We formulated the following themes: I) Before recovery: Experiences of violence, loneliness, and invisibility; II) Before recovery: Drug use and mental health problems as solutions; III) The necessity of change: New choices, new directions; IV) Being in recovery: The importance of being seen and heard—through actions and words; V) Being in recovery: Going beyond early destructive experiences.

Ethical Considerations

The Norwegian Centre for Research Data (NSD) assessed the project (ref 535168), and the Ethics Committee of of the Faculty of Health and Sport Sciences at the University of Agder provided research permission. The participants received oral and written information. It was important that they did not feel obligated to participate; therefore, we asked the managers to ask them on our behalf. When contacting the managers, we emphasized that participation was voluntary. All the participants gave informed voluntary consent. Regarding confidentiality, all participants are anonymous.

Results

Based on a thematic analysis, we constructed a narrative of before and in recovery, starting with childhood conditions marked by violence, abuse, and invisibility. What are perceived as problems—drug abuse and mental health problems—were presented as threat responses and/or ways to cope with the initial problems. These ways of coping made it possible for the person to face loneliness and other challenges and threats. However, with the passing of time, these "solutions" became in turn even worse problems than the initial ones they were meant to manage. Confronted with life-threatening situations, the person managed to seize an opportunity to escape from these solutions/problems. Escaping meant a return to social isolation and loneliness as a step in the recovery journey. The journey went on to a situation marked with a connection to a special person or group of persons and places and a feeling of being appreciated and seen as a contributing person. The present situation was described in terms of connectedness and being part of an ideal family, exactly the contrary to the life history's starting point.

Before recovery: Experiences of violence, loneliness, and invisibility

Experience of violence

Participants in this study talked about experiencing different forms of violence from an early age. Violence was directed to the person, both psychologically and physically. Violence was also part of the parents' relationship, mostly the mother being abused by the father. Drug abuse and mental health problems were part of the environment through their childhood.

> "I had a rough childhood with violence, assaults, and neglect. While growing up, I tried all the time to do my best both in school and in my spare time. I tried to adjust to everybody around but didn't succeed because all I faced was resistance. I was bullied, beaten, threatened, spat at, locked into a sandbox."

> "I grew up in a home where my father was a drunkard, and my grandfather was a child molester. Additionally, I was teased at school. Everything was dark."

They spoke about violence at home but also at school. Thus, the predators were parents, siblings, and schoolmates. In many cases, our participants had no secure place to escape to and fear dominated their everyday life.

> "I experienced my father as a monster, the big bad wolf in the family who scared me. I was afraid to sleep at night, because normally it happened while we children were in bed. Mostly he took it out on mom."

Some spoke about trying to take care of things at home and about their efforts to avoid provoking their parents' anger and to prevent the emergence of violent situations between the parents:

> "I kept watch in front of the bedroom door as long as I can remember. I was a small girl. Sitting there all time. Wrapped up in the duvet, every night I kept watch in front of the door to stop dad laying hands on mom when he was onshore."

The experience of different forms of violence during childhood is reoccurring in most stories, but there are also contradicting narratives:

> "I had two caring parents who always struggled to protect me. In that respect, I haven't missed out on anything."

Experience of abandonment, loneliness, and invisibility

Participants said that consequences of growing up under such difficult conditions were social isolation and loneliness, an experience of not fitting in, and being excluded by schoolmates.

> "I was without friends. And if I made some 'friends' as a child and adolescent, it turned out they were not my friends. Quite simply, they went behind my back and they were mean if I didn't do what they told me to. If I didn't follow the herd, I was not one of them."

But they were also isolated in their own family:

> "My parents were not involved in my life like parents nowadays are. I was left alone. They didn't believe in me."

Thus, loneliness was both a physical reality and a mental and emotional state integrated in one's sense of self.

This isolation in the private sphere was deepened when it comes to the wider social world and authorities. Schools, social and mental health childcare services, and also neighbours, remained distrustful and passive despite the obvious misconducts. They did not intervene to protect the vulnerable children.

> "At 17, I went to the GP [and said]: 'It is difficult at home. My mom is drinking, and I want you to know that.' I was told to pull myself together: 'You have to behave!' I was always a terrible child. But nobody asked why I was like that, right? When you hear things like that, you lose your confidence. Because at that time, nobody at school took any action. They just, sort of, turned a blind eye to what was happening at home."

In one case, the negligence of the authorities resulted, years later, in a formal recognition of the damage caused by their blindness to the conditions in which the child was being raised.

> "There was plenty of violence and intoxication. Plenty of police. Plenty of nonsense. My mother was admitted to hospital at least once a month because of violence. Yet, oddly enough, nobody cared. But some years ago, we got compensation for a lost childhood. The child welfare service in the municipality apologized profusely and admitted they should have done something when we were little. It was good to get this affirmed. Because in fact, somebody should have taken responsibility when our parents were not able to take care of us."

Often, neighbours were well aware of the exposed situation of the children but did not intervene either. At best, they could offer a provisional refuge when the child ran away from their home:

> "Where I grew up, the first ten years of my life, we lived far away from the neighbours. So, nobody noticed what was happening. It became better when we moved to a new house. The neighbours were closer, and it was easy to run to the neighbours to call the police and things like that."

The experience of abandonment, loneliness, and invisibility created feelings of despair and hopelessness and an urge to find one's own solutions to survive.

Before recovery: Drug use and mental health problems as solutions

Drug use and mental health problems started early, when the child was still living in their parents' home:

> "I think I started on drugs this young because I was really depressed, scared, and sad. I was out a lot and had lot of shame and things like that."

Participants pointed to a direct connection between the conditions in which they were raised and their mental health problems and use of drugs. But drug use and mental health problems were not initially considered as problems, but rather as solutions.

> "So, you try to survive. You find survival strategies, like I did. But maybe it was the wrong way to do it, because I started on drugs to handle all this. We do it in different ways."

> "Before I understood my diagnosis, I didn't know who I was. How I reacted. I was not aware of these things. I acted without thinking, see? So, there was a lot of shame. It was easier to continue with drugs than handle those things."

One of the participants described drugs as his best friend, helping him against the shame connected to the everyday violence in his home.

> "I got ownership of the drugs. The drugs had been my best friend since I was quite little. When I started on drugs, it was the right thing to do. Because I could avoid all the bad feelings and that shame and all the shit I was exposed to."

Alcohol had the capacity to relieve feelings of insufficiency and fragility. It became a tool that made revenge possible as well as a form of self-dignity.

> "So, I thought alcohol was good for me. Because when I drank, all my bad experiences faded away. I became tougher. I dared to fight back, and I dared to defend myself and fight back against those who beat me."

Drug addiction also became a way to be included in a social network. Breaking with loneliness resulted not only in interaction with other drug users, but also sharing common experiences of violence with them—a first experience of 'peer-support'.

> "We were a bunch of friends who all lived under the same conditions. We found each other. I don't know how it happened. It was in a way like it should be, that we found each other."

Using drugs and other expressions of pain, usually interpreted as symptoms of mental illness, were described as means of coping with an impossible situation. However, the problem with these solutions was that they worked well, at least initially. 'Symptoms' were a way to avoid being directly confronted with the old everydayness of violence and loneliness.

With time, the life as a person with drug and mental health problems became a problem. Periods of institutional care and/or prison replaced each other, parallel with a decay of the body and increasing mental health distress.

Even if the original violent situations did not exist anymore, people still used their initial threat responses, which had now become their main problems:

> "I was not willing to put away the drugs. I just have to be honest. I just started, and it became kind of OK. But it isn't OK when you are about to kill yourself. It is not OK."

At a certain point, the person realized that the solution had become worse than the original experiences and situations it was meant to remedy.

> "I understood that I had been in and out of psychiatry for more than ten years, and nothing had happened. I came to a turning point. It was about living or dying. I couldn't bear to be in that situation anymore. So, I reached

> that point, and at the same time I wanted a better life. I didn't know how then. But I knew that I would not go back there again. I needed a change. It was when it started."
>
> "You realize you are getting better when you actually want to live."

Informants went through a life-changing phase either in prison or as a result of an insight about the destructivity of their life. Turning points occurred more or less when the person was at some kind of nadir in their life. They might have been there before; but for some reason, insight and thoughts about leaving a life-threatening way of life were transformed into action. Sometimes the transformation was helped by the presence of somebody else in this situation, but it could also be caused by personal despair.

The necessity of change: New choices, new directions

The necessity of change appears as a matter of life and death. The alternative to the now life-threatening strategy is unclear. In some cases, changes start just as a refusal, a decision that it is not possible to carry on. In many stories, the turning point is a clear act of will of the person. Seemingly out of nowhere comes a decision. 'I wanted' and 'I decided' are reoccurring expressions explaining turning points. We witness a simple, primitive, and even brutal return of the person (drug addict, mental health services user) as an agent in their own life, even if it is in the form of a 'No', without any plan or project on how to live on. It seems that the old question behind the now failed coping strategy is asked again, but now in a new context.

> "The biggest effort is to work with yourself. There is nobody else who is able to dig me out of the ditch. You must do it yourself. It starts and ends with yourself. What do I want in life? What do I have in mind? What do I like?"

The recovery journey seems to mirror the period before the recovery occurred. For some, a turning point can be described as not only breaking with drug addiction, but also with oneself as a part of the drug addiction world, social relations, and habits, and back to loneliness and invisibility.

> "It's the relationship. It's the drug community you have. Because immediately when I stopped intoxicating myself, I was really lonesome. It was boring. And that loneliness a lot of people are struggling with today."

The person goes back to the original loneliness drugs once helped with.

> "I felt better the day I decided to stop using drugs. […]. Due to the circumstances, it was difficult to go away, but then I got the chance to change because my girlfriend was arrested. I was at a crossroad. I had the opportunity to choose the right thing. And if I hadn't, it would all have turned out wrong. I cut all my friends. I made a fresh start and after one year I was

> clean. I made it. It's one of the greatest things I have ever done. No help. No doctor. I did it all myself."

In these cases, the person excludes them self from the world where they once found a community.

> "I was bullied by my friends, and I had a mother who drank. She was more or less a psychopath. I think it is incredible that I have recovered as much as I have. It was a period when I intoxicated myself too, but it was just alcohol. In the end, I sorted it out. If you want to have a life, you have to stop doing these things. You should not be like your mother and all your brothers and sisters who are all alcoholics. So, it was just one alternative […]. But then it was not fun to go out anymore, because I was not drinking. I must agree with one of the others: "You just have to stop meeting them." So, because of that I have been on my own a lot."

Initially, the person escaped from violence and social isolation to the community of drug addicts, and now goes through the reverse process of escaping this community back to loneliness and back to them self as an insecure agent in their life.

> "To stay off drugs is difficult. You have to change everything you did before. The way you talk. The way you behave. The way you think. The way you treat yourself. Diet and hygiene."

Being in recovery: The importance of being seen and heard—through actions and words

To be seen and heard are some of the most common expressions when people talk about their recovery experiences. This was also true for our participants. In one of the focus group interviews, the following exchange of experience took place:

> "I think it is important for those working [in mental health services] to listen to people. But they are not good at that. To be seen and listened to."

Even if these expressions are regularly used and accepted, they are seldom explored. What does it mean to be seen or heard? What must one do to get another person to experience being seen and/or heard? Especially one who has not previously experienced being seen and heard.

One recurrent aspect is that you experience not being reduced to your diagnosis or problems:

> "Here at this meeting place, people are not understood as ill. But when you are hospitalized, they see the ill person. I feel they are looking down on me. Why is it like that? Here, it is not like that."

To be seen means that others do not only focus on you as a problem, but also see something else. According to our participants' experience, to be seen and heard has little to do with eyes and ears. Instead, this is mediated through actions and words.

> "I have been imprisoned many, many times. I have been in prison for years. What was needed for me was a hug from the prison chaplain. It was that hug that made me realize: 'Wow, this is something I have needed.' Pure love from sort of a random man in the prison! He wanted the best for me. In a prison!"

In many cases, participants contrasted their experiences of being invisible with situations where they felt seen and heard. One participant described his experience of not being heard and seen:

> "When I feel I am not treated with love, I feel they have not taken me seriously. They don't see me, and quite simply it goes in one ear and out the other."

Later, the same person talked about a helpful professional he later met:

> "I got a therapist who saw something good in me. He was a cognitive therapist, which was beneficial for me. He was human. He didn't wear a white uniform. He was like you and me. We talked. It was fantastic."

To be seen is mediated through actions, attention, silences, and questions as ways to explore together what one has said. The other's will to know and understand more about me is a key to being seen and heard.

> "He looked into my eyes. He looked at my mouth. He never interrupted me, allowed me to finish. He was sitting there, listening. And when I stopped, he asked some questions. He was present simply by being there. He himself had had a rough childhood. He told me that, and immediately we built a relationship. At once, I felt safe together with him. If I had a bad day, I could sit in his office, crying and weeping and rant and rave."

To be seen includes the possibility to see the other, for example, a professional mental health worker beyond their formal competence and professional role. There might also be an ingredient of reciprocity that removes the traditional divisions between sick and healthy, normal and deviant. Words and actions complement each other even if this means that the professional takes a stand for the person against their own organization.

> "What has helped me in the last few years is that I have got a very good doctor who takes me seriously. She listens to me, supports me, and trusts me. […]. She helped me to become strong enough to oppose the system, get rid of my diagnosis, and quit the medicine."

Thus, it can be easy to observe some actions and understand how and why they might influence central aspects of one's life, but actions also can be small 'micro-affirmations' that might go unseen by a clinical gaze.

> "I was not sure if I would enjoy myself here, but I feel the place is helping me. It does. It does something for me. I am happy for the people here. Just to see a smile, see the sparkling eyes showing they are happy to see me. The small seeds—they are not small, they are big."

One of the participants describes the paradoxical aspect of these actions:

> "They are small, but they can be big in their consequences. They mediate others' pleasure in your presence, of you just being there, just being the one you would like to be and appear as in the other's eyes."

Being in recovery: Going beyond early destructive experiences

Some participants described very clearly their present life, being in recovery, as a complete contrast to the context they had grown up in and to the life they lived until recently. Some focused on changed materialities:

> "Five years ago, nothing in my life was in order. I didn't have a driver's licence, had no car, I didn't own a flat. Five years ago, I had no charity work. And now I have a car, I have a driver's licence, I own my own flat, I keep my life in order, and I do charity work in an organization for drug users where I am happy."

If materialities are important to fully understand recovery processes, so too are they in relation to new relational and emotional contexts. Like in their childhood, the participants had found others to share experiences with, but now in a completely different context:

> "My experience is that this is a place where I can be myself and they see me in a good way. I have never used drugs, but I am struggling with my mental health. Life goes up and down. This meeting place is a wonderful place, you never walk alone but together with the staff. That's great. I had no confidence in my mother because she didn't see these things. But I started to go to this place and saw myself as who I am."

Changed material and relational conditions make changes possible in peoples' sense of self, discovering and co-creating themselves as they did not know it was possible, but as they wished they could be: someone who is valuable in them self and able to give value to others.

The new social-material context was contrasted to the living conditions where it all began. Family is for some a metaphor used about the new context where they were able to be themselves.

> “We are family.”
>
> “If people are not coming, we will miss them.”

This new family is in total opposition to their former experiences of family life.

> “No, this is not a rough family. This is a loving family. I don’t feel I’ve got my life back, I feel I have got a life I never had. Like that. My life was bad since birth. But now I have a life like it is meant to be. I feel at home.”

Having come home to a loving family closes the circle. This appears as a community you can feel happy coming to and where people not only miss you when you are not there, but even express it. This family was not a step back to the beginning, but a step forward in a new life.

In this context, recovery is not recovering from an “illness.” Recovery is going beyond early destructive experiences and preliminary working responses to these threats.

Discussion

Our results confirm aspects of earlier studies about service users’ experience-based descriptions of the causes of their distress. Wang et al. write about “. . . the intersection of trauma, serious mental illness and post-traumatic growth.”[28] The first theme of Nixon et al. is called “Pre-psychosis childhood traumatic experiences” but covers one third of a page out of the article’s eight results pages.[27] Thus, the results also add important aspects to the present knowledge.

The description of the recovery journey seems to be a reversal of the journey down to hell that precedes it. It begins with violence and goes on to invisibility and loneliness. The first turning point consists of the development of drug addiction and/or madness as well-functioning solutions, threat responses, management, or coping strategies for these destructive living conditions. They mediate a connection to a community, a relief from the life-threatening distress and visibility in relation to different authorities. However, the solution tends to become worse than the original problem in the long run. With time, they become new entrapments and designated as symptoms of illnesses.

A profound change, the second turning point, is described as a re-appropriation of one’s will over the world of drugs and madness, even if it is an uncertain road to travel. In some cases, it starts with a return to loneliness and social exclusion. This period of withdrawal is interrupted by a special occasion, meeting someone unexpectedly, often in an improbable place. In this interaction, invisibility is broken and communion occurs. In other cases, the recovery journey begins with this encounter, without a period of loneliness, but it involves leaving the now destructive community for a positive one.

Situated encounters

Many of our participants stressed their recovery journeys were personal, embodied, relational, situated, and social processes. To take this complexity into account is a challenge in research. Recovery cannot occur against the will of the person, and this will might be the fruit of situations of life and death when the mind/body is perceived to be on the verge of destruction. The efforts of the person are supported by an assemblage consisting of places to withdraw to and places where encounters with others are made possible.[35, 36] These interactions occur in both spontaneous and organized contexts and are characterized by reciprocity, which reinforces the hope for a possible different life and sense of self. Recovery also involves avoiding negatively charged places, situations, and people. However, it is important to note that most of the places mentioned in our stories were "created places," formed either by municipalities or independent service user organizations but with funding from public stakeholders. There was no central planning behind the recovery journeys, just chance and coincidences, and it was paved with socially organized possibilities and hinders. Prisons could be places where important social encounters occurred.[37] Community mental health centres could be places where one was treated as invisible, but also as a fellow human being.[38, 39] Service-user-organized places in the city could be places of fellowship and integration.

Recovery is a story about a backward journey, connecting contrary aspects from periods of despair and of recovery (how one is in relation to others, i.e., invisible or considered). Thus, it makes possible an understanding of recovery as repairing the negation of childhood's core needs. In this sense, it also gives important clues about how recovery-oriented services could be oriented, and how professional and non-professional relations and situations can contribute to recovery. The often-mentioned fear that a close relationship between service users and professionals is dangerous in creating a dependency is problematized as one could also see dependency as a step in a process toward independency in the sense of a capacity to choose who one wants to be dependent on. This fear risks negating people's development potential.

Well-known but lacking

In reading the accounts presented in our findings section, one might be astonished by the lack of recovery literature/research about the experience-based descriptions of the background to the problems people have recovered from.[27, 28]

The existence of a connection between socio-psychological factors during people's childhood and their later fate is not a new hypothesis. Freud heard the stories of his female patients about different forms of abuse but did not dare to accept their stories and insights. Instead, he theorized a child creator of their life and its suffering based on their own unconscious fears, desires, and wishes for recognition and not on real abusive situations.[40]

Later, attachment theory opened the door to reality and highlighted how, when there is a lack of basic parental skills, children may become insecure beings, struggling in life, and

developing coping strategies that could be labelled as unhealthy and even pathological.[41] From research in the trauma field, the correlation between childhood trauma experiences and negative physical and mental health conditions later in life has become recognized, such as through the Adverse Childhood Experiences (ACE) study.[42] Knowledge from this field shows how traumatized persons who have experienced their integrity being violated are shaken to their core, leaving imprints both mentally, existentially, and genetically.[43, 44]

These theories are grounded in child observations in specific situations, in-depth interviews, and on a large questionnaire study where adults' memories of early experiences were statistically correlated to problems later in life. The specific contribution of recovery stories might be that the concerned persons themselves point out the connection between childhood experiences and their drug and/or mental health problems.

Recently, the emerging Power-Treat-Meaning framework has included childhood trauma in social contexts and defines trauma not only as specific situations but also as a consequence of enduring living conditions associated with poverty, racism, and gender oppression.[14] This framework is partly based on adults' experiences of oppression early in life and problems defined as mental illness later in life, such as hearing voices.[45] Recovery stories fit into this framework and add descriptions of ways going beyond entrapment in old and inadequate threat responses.

Black-boxed experts

Asked about their recovery process, many participants, as in this study, strive to contextualize and make sense of their journey by framing it in their life history.[2] People with their own experience of drug and/or mental health problems are sometimes considered as experts in possession of EBK about recovery.[46, 47] However, being considered as the expert is seldom the case when it comes to the start of the story. However, if we maintain that they possess knowledge that should be taken advantage of, the collective silence in recovery research about the dark face of the story should be scrutinized.

A reason for this silence might be the researchers' efforts to hide what does not fit into a positive recovery story. According to Latour, "black-boxing" is to make something invisible that does not fit into your theories. It is a way of hiding facts so they will no longer exist. Actor-network theory describes how complex systems have been simplified (black-boxed), and only by opening the black boxes is it possible to see the complex picture.[48]

According to Ricoeur, when a researcher is reading a transcribed text from an interview, the text will live its own life.[49] The story no longer belongs only to the narrator, but to the researcher as well. When the researcher configures a recovery story, they transform "the events into a story." This configurational act consists of 'grasping together' the detailed actions or what we might call the recovery story's incidents. "It draws from this manifold of events the unity of one temporal whole."[49] Ultimately, family organizations are powerful actors in the psy field and are sometimes considered as parts of the service users' movement. This might put pressure on researchers not to blame parents and friends who

might be more comfortable with biological explanations for drug and/or mental health problems than explanations, such as different types of violence during the person's childhood that they may have witnessed and even participated in.

Conclusions

Recovery research stresses the importance of experience-based knowledges and has focused on the recovery processes to inform recovery-oriented services and structure knowledge about the contribution of different actors to this process. Simultaneously, the same recovery research has bypassed the experience-based knowledges transmitted by users in their narratives about the reasons for their problems.

The persons we interviewed made a connection between their experiences of isolation and violence during their upbringing and their later difficulties. The narratives we collected resulted in different contributions to our knowledge:

I. The problems (drug and/or mental health) were described mostly as a way to cope (threat responses) with the person's initial problems. They led to experiences of connection, belonging, and not being alone in their terrible situation.
II. As coping fulfilled these functions, it became an established way to handle difficulties. When the person got older and the threats they were submitted to changed and they also gained access to other resources to handle them, the old coping remained part of their repertoire to handle life challenges. Thus, the former ways to cope became problems in themselves.
III. Breaking with those threat responses was described as an act of will. The decision to stop using old ways of coping often resulted in a break with one's social life (relationships, home, etc.) and also a progressive discovery of places/persons offering connections built upon acceptance, places to belong, being, and becoming (home, congregations, social meeting places, etc.). These places and the persons associated to them meant the opportunity to experience mutuality and to perceive one's self as someone who had something to offer to others.

Thus, there is a necessity to pay attention to and integrate persons' experience-based knowledges, not only about recovery processes, but also about the reasons for mental health and/or drug problems in future recovery research. In this work, it is important to keep a critical stance to the production of the narratives involved in the construction of these knowledges.

Finally, these knowledges should be used in developing preventive approaches to drug and/or mental health problems, but also in care context to avoid the risk of focusing on what might not only be the person's central problem, but also their way to handle other threatening problems.

Methodological Considerations

Instead of focused interviews about recovery processes, we ended with more life-history-like narratives, as the interviewees put their recovery in this type of context. Life histories have been scrutinized by Bourdieu in regard to the risk of creating a biographical illusion.[50] In trying to apply some order to the chaos of life events, one can easily build cause-and-effect chains where earlier situations are seen as the cause of later problems or recovery processes. Analyzing the collected stories, one should be aware of this risk and also of the presence of master narratives of how mental health and/or addiction problems occur.[23] We think that our efforts to collect detailed thick stories might be one way to anchor the experiences in the person's practice and EBK.[51]

These risks should not hinder us from considering taking care of this knowledge as an important and often missing basis for the elaboration of recovery narratives.

Thus, the story we have presented can be seen as the result of a more or less co-creative process, including the production, collection, and analysis of a multitude of contradictory and complementary narratives in the different and common cultures that researchers and (ex-) service users gravitate in. And so they are. But experience-based stories are not solely stories. We maintain that they have a connection to the practice-related experiences people are involved in.[52] Our story about their stories is thus a story based on many peoples' experiences that they told us about. Neither experiencing violence during childhood nor recovery journeys' character of a backward journey can apply to all the EBK of all the persons who have gone through, or are still involved in, a recovery process. Still, it might reflect (but also produce) *a* reality.

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