Clubhouse Members' Experiences of Being in Recovery in Light of Salutogenesis

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Scientific environment

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Abstract

Background

Mental illness is the leading cause of years lived with disability and a wide range of socioeconomic problems globally and in Norway. Addressing the challenges caused by mental illness, the Clubhouse programme offers lifelong membership as a voluntary participant in a working community for people with a history of mental illness.

Despite its long history, there are several knowledge gaps regarding the Clubhouse programme. According to the literature, a comprehensive theoretical framework is lacking. There is little evidence of the active ingredients of the recovery process in the Clubhouse programme. Likewise, there is little knowledge on how individuals with mental illness experience being a member, and recovery in the Clubhouse programme, in a Norwegian context.

Aims:

Thus, the main aim of this PhD project was to explore and develop a theoretical and empirical understanding of the usefulness of the Clubhouse programme. Based on three research questions: "1. How can the Clubhouse programme be understood in the light of salutogenesis?", "2. What is it like to be a Clubhouse member?" and "3. What do members experience as helpful for their vocational and social recovery and processes of change within the context of the Clubhouse programme?"

Methods:

To investigate the theory of salutogenesis as a theoretical framework for the Clubhouse programme, a systematic theoretical elaboration of salutogenesis compared to the Clubhouse programme was applied. The second and third empirical studies followed a hermeneutic-phenomenological design. A total of eighteen semi-structured interviews were conducted with members of three Norwegian Clubhouses. Systematic text condensation was used in the analysis of the empirical studies.

Findings:

The first study's findings suggest that the salutogenic orientation is consistent with the philosophy of the Clubhouse programme, and salutogenesis might be a promising theoretical framework for the Clubhouse programme. The programme's structured design might enhance comprehensibility, the Clubhouse community might foster manageability, and positive emotional bonds can strengthen meaningfulness. In addition, the different opportunities and services available within the Clubhouse programme can be understood as GRRs.

The second study identified three main themes: "Finally, I belong somewhere I can be proud of," "I feel more like an ordinary citizen, just different," and "I feel somewhat equal to others." The themes suggested that being a Clubhouse member might contribute to members' recoveries by enhancing their sense of meaningfulness.

The third study identified three main themes: "Balancing unlimited support with meeting challenges", "Learning how to build new skills and roles in the community", and "Getting better through and for work". Participants experienced improved mental and social well-being and work readiness. Incorporating health-promoting challenge into the Clubhouse programme might enhance members' recovery processes.

Conclusion:

The theory of salutogenesis might shed light on the active processes within the Clubhouse programme. Furthermore, the results of this project suggest that overall, being a Clubhouse member is a positive experience, where members go through social and vocational improvement. However, several issues might thwart members' recovery processes, most of which could be addressed by incorporating the salutogenic concept of challenge in the programme practice on several levels, for example, task difficulty and follow-up. Further studies are needed on the applicability of salutogenesis as a theoretical framework and processes of change in the Clubhouse programme from a longitudinal perspective.

List of Publications

Article 1: (published)

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Contents

1. INTRODUCTION

Mental illness is a significant challenge globally, both as a burden on human health and health care systems and due to its considerable socioeconomic impact (OECD, 2012; Patel et al., 2018; World Health Organization, 2013). To address the multifaceted challenges of mental illness, global (See, for example, World Health Organization, 2013) and national (See, for example, Helse- og omsorgsdepartementet, 2017) policies call for community-based psychosocial interventions.

An example of such interventions is the psychosocial Clubhouse programme, developed in the United States, which offers voluntary membership in a working community for people with mental health problems (Fontenehus Norge, 2019). While the number of Clubhouses and state subsidies for the programme is steadily growing in Norway (Fontenehus Norge, 2019), more knowledge is needed about how this program works in Norway, as most research on the Clubhouse programme was conducted in the United States (Tanaka & Davidson, 2015a).

In addition, research indicates (Mowbray et al., 2006; Mutschler et al., 2018) that the complexity of the Clubhouse programme, which addresses various challenges of people with mental illness, for example, social, employment and housing issues, makes it difficult to assess which processes in the programme lead to which outcomes. There are also methodological issues research on the Clubhouse programme shares with inquiries into psychosocial rehabilitation, making it difficult to assess the usefulness of these interventions (Farkas et al., 2007; Rössler, 2006).

It might help to develop a theoretical framework for the Clubhouse programme, as it "might illuminate areas that might not otherwise be visible" of the programme (Taylor, 2004, p. 633) and could help to organise empirical findings of the research on the Clubhouse programme to create a fuller understanding of which interventions lead to which outcomes of the Clubhouse programme (Robbins et al., 1999). As a theory of how health and well-being are developed (Antonovsky, 1979, 1987b), salutogenesis might inform research on the ingredients of the Clubhouse programme that are active in promoting members' recovery journeys.

To address the knowledge gaps mentioned above, this study's main aim was to understand better how Norwegian members experienced social and vocational recovery in the Clubhouse programme context and ascertain whether salutogenesis as a theoretical framework could shed light on their health and well-being improved in their recovery processes.

2. THE MENTAL HEALTH CARE FIELD

This chapter will explore the field in which this project took place. It will look at the scope of the challenges caused by mental illness and introduce the field in which the Clubhouse programme, the context of this project, is situated.

2.1 Mental illness in a global perspective

As a health burden, mental illnesses are the leading cause of years lived with disability, being responsible for 30% of the non-fatal, and by a conservative estimate, at least 10% of the overall disease burden Worldwide (Mnookin, 2016; World Health Organization, 2013).

Characteristically, mental illnesses are also highly pervasive; it is estimated that 80% of people in low- and middle-income countries will experience mental illness in their lifetimes (Mnookin, 2016), and 50% of the total World population (OECD, 2012). The two most common disorders responsible for this high prevalence are depression and anxiety disorders (Mnookin, 2016; World Health Organization, 2008).

Research consistently shows that social disadvantage, such as poverty, childhood adversity, violence, and parents' low education levels, emerges as risk factors for mental illness onset and persistence (Patel et al., 2018; World Health Organization, 2013). Furthermore, mental illnesses have a considerable socioeconomic impact (Mnookin, 2016; OECD, 2012; Patel et al., 2018), extending beyond the costs generated by mental health care expenses, absence from work or disability. Less apparent causes are reduced work productivity and labour participation, decreased tax income, the occurrence of physical comorbidities and premature death (Mnookin, 2016; OECD, 2012). These problems are exacerbated by that mental illnesses are typically early-onset diseases, which means that most cases occur before the age of twenty-four and show an enduring and recurring course (OECD, 2012).

People with mental illness face discrimination, stigmatization, and violation of their human rights (OECD, 2012; Patel et al., 2018; World Health Organization, 2013),

which are some of the reasons behind treatment challenges. For instance, most people with mental illness or substance use disorders do not seek treatment due to stigma, poverty, and poor access (Patel et al., 2018; World Health Organization, 2013). Treatment avoidance is as high as 80% in India and China combined, and of those who seek help, only 20% in low-income countries and 1 in 27 in high-income countries receive minimally adequate care (Patel et al., 2018, p. 1559), owing to lack of financial resources, policies, and care systems. Furthermore, while deinstitutionalization and recovery-orientation are considered the current standards in mental health care, the overwhelming majority of the global population has no access to recovery-oriented community mental health services. Instead, this majority receive interventions in institutionalized settings which lack the necessary comprehensive approach in mental health care (Patel et al., 2018; World Health Organization, 2013).

In a Norwegian context, challenges and figures related to mental illness are like those globally. Mental illnesses stand for 15% of the health burden in Norway (Helsedirektoratet, 2016). In their lifetimes, 30 to 50% of Norwegians will experience a mental illness. Similarly to the Worldwide trend, depression and anxiety disorders are the leading causes of mental illness; respectively, 20 and 25% of the Norwegian population will experience these in their lifetimes. From an annual perspective, 10% of the Norwegian population suffer from depression, and another 15% have anxiety disorders (Helse- og omsorgsdepartementet, 2017). Regarding the socioeconomic impact of mental illness in Norway, mental illness stands for 28 % of the economic loss caused by illness, owing to sick leave, disability, and premature death (Helsedirektoratet, 2016).

From the perspective of mental health care systems, Norway is dedicated, similarly to the Worldwide efforts, to promote community-based mental health care (World Health Organization, 2013). In the last decades, a two-tier system was introduced, consisting of a specialized and hospital treatment-based care run by the state and more widely accessible local government-run primary care providing ambulant psychiatric care and psychosocial services (Helse- og omsorgsdepartementet, 2017, 2020; Helsedirektoratet, 2014; Ruud & Hauff, 2002). The latter receives a growing focus

(Ruud & Hauff, 2002), owing to its lower costs and proximity to its target groups (Helse- og omsorgsdepartementet, 2020). Typically, local governments involve civil organizations in primary mental health care provision, due to several reasons, such as to strengthen consumers/patients influence on service planning and delivery (Helse- og omsorgsdepartementet, 2017), promote innovation (Helse- og omsorgsdepartementet, 2020), increase capacity, breadth and diversity of services (Arbeids- og sosialdepartementet, 2021; Helsedirektoratet, 2014, 2015). Furthermore, Norwegian health- and social policies recognize the importance of civil organizations in involving and activating people with mental illness in their own care (Arbeids- og sosialdepartementet, 2021; Helsedirektoratet, 2014), serving as a "vaccine against loneliness" (Helse- og omsorgsdepartementet, 2017, p. 15).

2.2 Mental health care outside an institutional context

The transition to community-based service provision (Arbeidsdepartementet & Helse- og omsorgsdepartementet, 2013; Helse- og omsorgsdepartementet, 2017; World Health Organization, 2013) has brought forward new methods of intervention, extending beyond medical care. Thus, psychosocial rehabilitation became an essential method in the mental health field, emphasizing a positive, health-promoting philosophy focusing on the possibilities instead of the illness of a person in fighting the multifaceted challenges caused by mental illness (Anthony & Liberman, 1986; Helsedirektoratet, 2014; World Health Organization, 1980, 2013). The following sections will provide an overview of how this paradigm shift came about and led to the development and implementation of the Clubhouse programme.

2.2.1 The emergence of community-based interventions

The structural change from institutional to community-based mental health care can be understood by following the historical development of the mental health care field and the accompanying socio-political and philosophical changes.

At the beginning of the 20th century, mental health care was conducted within institutional settings, following a biomedical model of care, with the aim of curing a

disease (Dixon & Goldman, 2004; Drake et al., 2003; Murphy, 2014). However, despite their curative goal, these institutions were largely ineffective as patients were rarely discharged from there (Drake et al., 2003; Murphy, 2014). One of the reasons behind the fall of this type of care was the evidence that patients in these institutions suffered social and functional deterioration rather than improvement (Dixon & Goldman, 2004; Murphy, 2014). Exacerbating this downfall, the invention of new, effective psychopharmaceuticals in the early to mid-20th century finally led to deinstitutionalization, delegating patient care to alternative settings (Corrigan et al., 2008; Drake et al., 2003; Patel et al., 2018).

This process was accompanied by a series of ethical, social, and administrative considerations related to mental health care (Patel et al., 2018, p. 1556). For instance, human rights movements and the psychiatric survivor/consumer movement had a significant effect on changing the design of mental health care. While in the "old" type of institutional care, experts possessing a higher knowledge were in charge of treatment (Engel, 1977; Murphy, 2014), the new, community-based system was built on the participation of those in need of care (Murphy, 2014; Patel et al., 2018).

Parallelly, the reductionist approach of the biomedical programme towards diagnosis and treatment, consigning a specific set of symptoms to a particular diagnosis needing a specific treatment, without respect to the individual's lived experience, has diminished in importance (Murphy, 2014). As a result, community mental health care, a flexible, case- and culture-sensitive approach, have been developed, championing recovery-based psychosocial rehabilitation approaches (Drake et al., 2003).

2.2.2 The evolution of psychosocial rehabilitation

Rehabilitation, in general, is ecological or concerns a person-environment fit, in the sense that it focuses on improving role performance or improved abilities of the person in 'real life' (Farkas & Anthony, 2010, p. 115). Thus, psychosocial rehabilitation aims to support the recovery of individuals with psychosocial difficulties by enhancing their functioning in the community in a role valued by society and selected by the individual, with the least possible amount of professional support (Anthony &

Liberman, 1986; Farkas, 2006; Farkas & Anthony, 2010; Farkas et al., 2007; Rössler, 2006).

Psychosocial rehabilitation evolved parallel to community-based mental health care by recognising critical intervention areas and developing intervention techniques (Anthony & Liberman, 1986; Drake et al., 2003). Prominent scholars within in the field (Anthony & Liberman, 1986; Cnaan et al., 1988; Drake et al., 2003) posited that psychosocial rehabilitation, as a complementary intervention to institutional care in the mental health field, arose from a confluence of the independent development of three programmes: Fountain House, social learning, and community outreach programmes. The first one of these is the establishment of Fountain House, the forerunner of the later Clubhouse programme, which emphasized the importance of work participation and socialization in promoting mental health (Cnaan et al., 1988; Drake et al., 2003). Second, it was realized that social learning programmes provided in institutions did not translate well to community living, while social skills training, supported by role-play, practice, feedback and reinforcement, was effective (Drake et al., 2003). Third, establishing community outreach programmes following the realization that clients not necessarily seek help voluntarily (Drake et al., 2003).

All these programmes are committed to supporting individuals in fulfilling their visions of a meaningful life by supporting them to increase their competencies to assume their desired roles in life (Farkas, 2006; Farkas & Anthony, 2010). Thus, they focus on individual interventions, such as social relationships, work, leisure, family life and studies, as well as environmental interventions, such as social network development, reducing stigma, consumer advocacy or developing a mental health policy, in which rehabilitation can be successful (Farkas, 2006; Farkas & Anthony, 2010; Rössler, 2006).

Furthermore, psychosocial rehabilitation focuses on mitigating the consequences of mental illness, rather than treating the illness itself, even though it acknowledges the importance of symptom management and encourages integration with clinical services and working in multidisciplinary teams (Anthony, 1993; Corrigan et al., 2008; Drake

et al., 2003). Furthermore, psychosocial rehabilitation shares the principle of recovery that while a person might not be "cured" from mental illness, they can still live a satisfying life (Anthony, 1993; Farkas, 2006; Farkas & Anthony, 2010).

Cnaan (1988) argued that the principles of psychosocial rehabilitation could be derived from the practice of the Clubhouse programme. For example, it brought forward the shift from a purely medical approach in mental health care to a more comprehensive focus by realizing that the presence or absence of skills, and not symptoms determine the success of and satisfaction with everyday living for people with mental illness (Anthony, 1993; Cnaan et al., 1988; Farkas, 2006). The Clubhouse programme, and other psychosocial rehabilitation programmes, are easily accessible, low-threshold programmes, with the only inclusion criteria of having a mental illness (Cnaan et al., 1988). Furthermore, the Clubhouse programme emphasized the significance of work in psychosocial rehabilitation (Anthony & Liberman, 1986; Cnaan et al., 1988; Corrigan et al., 2008). For a more comprehensive understanding, the following section will provide an in-depth overview of the Clubhouse programme.

2.3 The Clubhouse programme: a pioneer among community-based services

The Clubhouse programme was born out of the necessity of supporting people who were medically well enough to be discharged from hospital, yet lacking the skills, resources, and social network to lead a satisfying life in the community (Anderson, 1998; Anthony & Liberman, 1986; Corrigan et al., 2008). The programme not only emerged in response to the necessities of people with mental illness, but the "community that Fountain House had created, was directly responsive to the 'human condition'- to what all people everywhere need" (Propst, 1997, p. 54).

2.3.1 Origins of the Clubhouse programme

While the celebrated arrival of effective pharmaceuticals paved the way to discharging patients from mental health care institutions, alternative services were not yet available for supporting the integration of these individuals back to society (Anderson, 1998;

Corrigan et al., 2008; Doyle et al., 2013; Drake et al., 2003). In 1944, a group of former patients of Rockland Hospital in New York State established a self-help group called We Are Not Alone, or WANA for short, to help each other in establishing themselves in the society and help their peers still in the hospital to prepare for their discharge (Anderson, 1998; Doyle et al., 2013). The name referred not only to the notion that members of the group could rely on each other but also to the idea that others in society might experience similar difficulties to those that caused their own mental health problems (Anderson, 1998; Doyle et al., 2013).

WANA was an ad-hoc group without a firm organizational structure and a permanent meeting place (Anderson, 1998). Members were equal participants, and their activities included club evenings, outreach to patients, fundraising and issuing an information bulletin that was distributed at hospitals (Anderson, 1998). Still, with the successes achieved in their operations, the growth of their membership, the dream of finding a "home of their own", or a clubhouse for their community, was born (Anderson, 1998, p. 22). Consequently, in 1948 WANA purchased a building in New York's Hell Kitchen neighbourhood (Anderson, 1998). The first Clubhouse was thus established, which after the fountain in its backyard received the name of Fountain House (Anderson, 1998). While the informal WANA group was transforming into the more structured organization of Fountain House, its elements are still apparent in the programme until today (Anderson, 1998). For example, such elements are the egalitarian structure of the community, where participants are members and not patients, the belief in the individual's capability of self-help, and an emphasis on peer-support (Anderson, 1998; Doyle et al., 2013).

The employment of John Beard as the director of Fountain House marked the next step in the evolution of the Clubhouse programme (Anderson, 1998; Doyle et al., 2013). Earlier, Beard was working on the development of Activity Group Therapy, a method seeking to restore the social functioning of patients in the psychiatric ward by involving them in everyday group activities (Anderson, 1998; Doyle et al., 2013). Building on this experience, he supplied the Clubhouse programme with two core beliefs. First, that even people with the most severe psychiatric symptoms retained

areas of health enabling participation in regular social processes from interpersonal relationships to societal functions (Anderson, 1998; Beard et al., 1978; Beard et al., 1963; Doyle et al., 2013; Propst et al., 1992). Second, that activity, meaningful work especially, is a core component in promoting the recovery of people with mental illness, giving way not only to obtaining employment to support themselves but also to the experience of mastery and developing social relationships (Anderson, 1998; Beard et al., 1978; Beard et al., 1963; Doyle et al., 2013; Propst, 1997). Even today, trust in the person's ability of productive work and meaningful social participation are essential building blocks of the Clubhouse programme.

Thus, the foundations of the 'Fountain House programme of psychosocial rehabilitation' were built at the junction of several basic principles that build up to two pillars of the programme: community and work (Anderson, 1998; Anthony & Liberman, 1986; Beard et al., 1978; Beard et al., 1963; Corrigan et al., 2008; Doyle et al., 2013; Drake et al., 2003).

Later years saw the success of Fountain House, and consecutively the gradual dissemination of the Fountain House methodology first in the United States and later in the World (Anderson, 1998; Doyle et al., 2013; Propst, 1997). With the expansion, it became evident by the 1980s that a detailed description of what exactly constitutes 'working after the Fountain House Programme' (Propst, 1997; Propst et al., 1992). Thus, Fountain House New York, together with a selected group of well-established Clubhouses, developed a set of standards describing their best practices (Anderson, 1998; Doyle et al., 2013; Propst, 1997; Propst et al., 1992).

Today, there are thirty-seven standards of the programme (Clubhouse International, 2018), serving as a basis for the accreditation of Clubhouses around the World. Today, there are nearly 300 Clubhouses in over thirty countries (Clubhouse International, 2020). Eighteen Clubhouses are operating in Norway (Fontenehus Norge, 2019), and the programme is a recognized actor as a work-oriented intervention in primary mental health care (Helsedirektoratet, 2014).

2.3.2 Key elements of the Clubhouse programme

So, what are the building blocks of the Clubhouse programme according to the standards? As we saw, the Clubhouse programme is the ancestor of psychosocial rehabilitation programmes that helps Clubhouse members' recovery through a community experience as well as meaningful work for the community (Bouvet et al., 2015; McKay et al., 2016; Propst, 1997; Raeburn et al., 2013). The programme is based on a community of adults who experience similar challenges caused by mental illness (Corrigan et al., 2008; Propst, 1997). Participants are members - and not patients or clients - who volunteer to participate in the Clubhouse, the physical centre of their community (Battin et al., 2016; McKay et al., 2016; Raeburn et al., 2013).

Members can experience success, get to know each other through working together and learn different skills while carrying out tasks necessitated by maintaining and developing the community (McKay et al., 2016; Propst, 1997; Raeburn et al., 2013). These activities are delegated to work units responsible for different task areas and are carried out in the framework of the so-called work-ordered day, which mirrors a workday typical in society, eight hours of work from Monday to Friday (Battin et al., 2016; Clubhouse International, 2018; McKay et al., 2016; Raeburn et al., 2013). Notably, members cannot be excluded from any Clubhouse-related work task and must be ensured the opportunity to participate in tasks from cleaning the bathrooms to fundraising for and representing the Clubhouse community and no meetings or decisions are allowed without the members being represented (Anderson, 1998; Clubhouse International, 2018; Doyle et al., 2013).

Notably, the Clubhouse programme has a flat hierarchy where tasks are performed side-by-side by members and paid staff (Doyle et al., 2013; McKay et al., 2016; Raeburn et al., 2013). Clubhouses are intended to be understaffed, so they cannot be run without member participation (Clubhouse International, 2018). Staff are generalists; their job is not to treat or rehabilitate members (Doyle et al., 2013; McKay et al., 2016; Raeburn et al., 2013). In fact, Clubhouses must have their own organizational identity, separate from any treatment or business setting (Clubhouse International, 2018). Thus, the main task of staff is to ensure continuity at the

Clubhouse, since members are volunteers and there could theoretically be times when no one would come to take responsibility for a task, and also to engage members who are withdrawn from the community (Chen, 2016; Clubhouse International, 2018; Dougherty, 1994; Kinn, Langeland, et al., 2018).

In addition, Clubhouses offer community support services (Raeburn et al., 2013), such as "helping with entitlements, housing and advocacy, promoting healthy lifestyles, as well as assistance in accessing quality medical, psychological, pharmacological and substance abuse services in the community" (Clubhouse International, 2018, §27). Support can be requested both from staff and members, and typically there are self-help group meetings, such as employment and education, to support each other in getting a job or further education (Doyle et al., 2013).

Vocational rehabilitation is a core priority in the programme, as it recognizes that by obtaining work, one can not only improve one's financial situation but also have an impact on social integration, experiencing success and building a social network (McKay et al., 2016; Raeburn et al., 2013). The Clubhouse programme provides three types of vocational services offering different levels of support (Clubhouse International, 2018; McKay et al., 2006). First, transitional employment, a form of vocational support specific to the Clubhouse programme, offers the highest level of assistance from the Clubhouse (McKay et al., 2006). It provides part-time work within a general labour market setting, at regular labour market rates for a limited period of generally six to nine months. While the employer is an independent company, it is the Clubhouse that recruits workers from its membership, train the recruited member for the job, and provides substitute workers if necessary (Battin et al., 2016; Doyle et al., 2013; McKay et al., 2016; McKay et al., 2006; Raeburn et al., 2013; Sveinsdottir et al., 2020). Second, supported employment represents a lower level of support and consists of help for members in obtaining and keeping a job in the regular labour market, including a possible mediation between the member and their employer, for example in cases such as changing the work environment to meet the person's particular needs (McKay et al., 2006). Third, independent employment provides the least amount of support; members obtain and hold a job in the competitive labour market yet can count

on continuous social support from their Clubhouse community due to their lifelong membership (McKay et al., 2006).

Besides its focus on meaningful activity and vocational rehabilitation, the programme's other foundation is providing community experience for members and a supportive network that is available to them their whole lives (Battin et al., 2016; Doyle et al., 2013; McKay et al., 2016; Raeburn et al., 2013; Sveinsdottir et al., 2020). People with mental illness are at risk of isolation and often lack a supportive social network (Pernice et al., 2021). Thus, proactive reach out, or regularly contacting and inviting back members who withdraw from participation in the Clubhouse community, is an essential element of the programme (Clubhouse International, 2018). Furthermore, Clubhouses also offer social activities, such as celebrating holidays together in the community and organizing leisure activities (Clubhouse International, 2018; Raeburn et al., 2013).

In summary, the Clubhouse programme is a type of psychosocial rehabilitation intervention aiding members in their recovery processes and promote their mental and physical health. It also provides the context of the empirical inquiry in this PhD project, the arena in which study participants construct their experiences with recovery.

3. THEORETICAL FRAMEWORK

This chapter will explore and define the main theoretical concepts in this project. The first part will investigate the different uses of mental health and mental illness concepts, including the various challenges caused by mental illness. Next, recovery will be presented as a central paradigm in the contemporary mental health field. Finally, the theory of salutogenesis will be introduced.

3.1 Imprecise nomenclature in the mental health field

This project belongs to the realm of mental health, and thus inevitably, mental illness. These synonymous terms, however, are not as unambiguous as their frequent use would suggest. For example, Kröber (2017) notes that in German law, only the expression 'mental illness' has a consequence in terms of culpability, while Hallett (2020) uses the term 'mental disorder' as a legal bearing the United Kingdom. Therefore, it is necessary to clarify the meanings of, and explore the concepts related to, mental health and illness.

Several terms are used in the literature to denote the state of impaired mental health, such as mental disorder, mental ill-health, mental health problems, mental disease and mental illness (Decker, 2007; Engel, 1977; Hallett, 2020; Kröber, 2017; OECD, 2012; Patel et al., 2018; Szasz, 1960; World Health Organization, 2013).

Initially, the mental illness concept was introduced by Kraepelin's nosology of the diseases of the mind to establish psychiatry as a medical discipline in the late 1800s (Decker, 2007). Later, affected by the paradigm shift towards deinstitutionalized care (Reaume, 2002), Szasz, in his aptly titled "The myth of mental illness", denies the existence of 'mental illness' per se and argues that it is used to "disguise and thus render more palatable the bitter pill of moral conflicts in human relations" (Szasz, 1960, p. 118). Finally, Engel (1977) proposed a unifying approach to mental illness, which established a biopsychosocial programme that encompasses medical considerations and personal and societal factors.

The latter approach is consistent with the World Health Organization's comprehensive definition (2013), which conceptualizes mental health "as a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and can make a contribution to his or her community." Thus, mental health is more than a mere lack of illness and is determined by multiple risks and protective factors interacting in a complex and dynamic manner over the life course, so that the mental health of each person is the product of a unique trajectory (Patel et al., 2018, p. 1585). Complementary to this positive definition of mental health, Langeland & Vinje noted (2013, p. 303) how the modern mental health concept is more and more directed to well-being, considering people's broader life situations.

Despite having a sound mental health concept to operate on, the multitude of terms regarding impaired mental health used in the literature might still cause confusion. For example, Kröber (2017, p. 211) argues that the term 'disorder' is not precise enough, as it refers to deviation from something, a qualitative perception of different impaired functions without distinguishing between their sources. Thus, he prefers 'mental illness' to denote the state of impaired mental health (Kröber, 2017). However, Hofmann's (2002, p. 657) definition suggests the opposite, as he defines illness as "negative bodily occurrences as conceived by the person himself", or a subjective experience. Similarly, while Kröber interprets the term 'mental disorder' as ambiguous, the American Psychological Association uses the term consequently in their manuals of diagnosing mental health impairments (Decker, 2007). One would turn even to the World Health Organization in vain to find clarity in the matter of nomenclature, as the World Mental Health Action Plan 2013-2020 (World Health Organization, 2013) interchangeably uses the terms 'mental illness', 'mental disorder' and 'mental disease'.

In addition to these issues, there is also a wide range of terms used to denote the different states of mental health impairment based on severity. For instance, Mykletun et al. (2009, p.15.) highlight that many symptoms of mental illnesses can occur among people without being diagnostically ill. The OECD (2012, p. 11.) terms these

occurrences as ‘psychological distress’, meaning “conditions that do not reach the clinical threshold of a diagnosis within the classification systems (the so-called ‘sub-threshold conditions’)”. In addition, further distinctions are made among illnesses that reach the diagnostic threshold as well, such as serious mental diseases and common mental diseases (OECD, 2012).

Under these circumstances, one must take it upon oneself to provide clarity in one’s work. Thus, this thesis, in line with the World Health Organization’s definition of mental health, has a positive approach to health and understands mental health as a construct that incorporates a subjective satisfaction with life and a positive outlook or mood, and meaningful functioning and human development (Huppert, 2005; Patel et al., 2018). Conversely, any state of impaired mental health, referred to in the literature by the previously discussed synonyms such as ‘mental illness’, ‘mental disorder’, ‘mental disease’ and ‘mental disability’, shall be referred to as ‘mental illness.’

Notably, this choice is not contrary to Langeland & Vinje's conceptualising mental illness, mental suffering, mental disorders, mental problems, and psychosocial problems as mental health challenges (2016, p. 300). They argue that in the context of salutogenesis, such a concept would serve three purposes. First, it follows the terminology of Antonovsky, who used the term challenge instead of stressor, conflict, or problem to imply a possibility of a positive outcome. Second, they posited that the term ‘challenge’ reminds one that there is “always some level of health and resources present that can be recognized, utilized and nurtured” (Langeland & Vinje, 2016, p. 300). Finally, their third argument was that it was consistent with the notion that not all responses of an organism to challenge are pathological.

Instead, in the context of this thesis with a complex theoretical background consisting of several concepts, such as salutogenesis, psychosocial rehabilitation, recovery and the Clubhouse programme, a singular concept of ‘mental health challenges’ might lead to unnecessary obscurity. Psychosocial rehabilitation and the Clubhouse programme are practical because they target concrete outcomes by solving well-defined challenges people with mental illnesses face, using a set of well-defined methods particular to the

field (Farkas, 2006; Rössler, 2006). Consequently, the concept of mental illness in this context should also be responsive to these different outcomes. Thus, instead of applying the term ‘mental health challenges’ to all occurrences related to impaired mental health, the term ‘mental illness’ shall be used when discussing impaired mental health per se, such as symptomatology and incidence. Otherwise, the term ‘challenges caused by mental illness’ shall be used to denote all the different issues occurring because of mental illness, such as vocational and social challenges and other obstacles a person with a mental illness might have to overcome to live a full and satisfying life.

3.2 Today’s leading paradigm in the mental health field: recovery

The recovery paradigm emerged in the wake of three previously mentioned converging factors that gave hope for living a full, satisfying life despite having a mental illness (Anthony, 1993; Davidson, 2003; Davidson et al., 2010; Drake & Whitley, 2014; Onken et al., 2007; Whitley, 2014). The first factor leading to the development of the recovery paradigm was the scientific breakthrough of the invention of effective psychopharmaceuticals that helped with symptom reduction resulting in formerly institutionalized patients returning to society (Anthony, 1993; Davidson, 2003; Drake & Whitley, 2014). Second, ground-breaking research results on the course of schizophrenia disproved the Kraepelinian understanding of schizophrenia as an ever-deteriorating and finally deadly illness (Davidson, 2003). Finally, the third factor was the growing influence of the consumer/survivor movement (Davidson, 2003; Deegan, 2002; Reaume, 2002), bringing to the forefront individual experiences of recovery.

An oft-cited definition of the resulting paradigm comes from Anthony (1993, p. 15) and defines recovery as “a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills and roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by the illness. Recovery involves developing new meaning and purpose in one’s life as one grows beyond the

catastrophic effects of mental illness. Recovery from mental illness involves much more than recovery from the illness itself."

Notably, Anthony (1993) uses the term 'recovery from' mental illness, an approach underpinned by the research evidence that the "majority of people with mental illness do not inevitably deteriorate in functioning over time, but rather experience partial to full recovery" (Davidson & Roe, 2007, p. 462). However, Davidson & Roe (2007, p. 460) emphasizes that there is another approach to recovery, 'being in recovery', building on the lived experience of people with mental illness. Deegan (1988, p. 11) described the latter as a unique process for each individual as "they experience themselves as recovering a new sense of self and of purpose within and beyond the limits of the disability".

Even though mental health recovery is personal, tied to the individual and their own experiences, the social nature of recovery is just as essential (Mezzina et al., 2006; Topor et al., 2011). In Topor's words (2011, p. 97), "many other factors are implicated in recovery narratives, factors that lie outside of or beyond the person's own efforts or control." Such factors include the social environment in which the recovery process occurs (Mezzina et al., 2006; Tjaden et al., 2020; Topor et al., 2011), including having a functional personal network of friends and family and professionals. Furthermore, societal factors, such as the availability of goods and an inclusive society also important determinants of mental health recovery (Mezzina et al., 2006; Topor et al., 2011).

By today, recovery is the leading paradigm in mental health care and policy Worldwide and in Norway (Arbeidsdepartementet & Helse- og omsorgsdepartementet, 2013; Borg et al., 2011; Davidson, 2016; Helse- og omsorgsdepartementet, 2017; World Health Organization, 2013; World Health Organization, 2015). As a policy, recovery represents "both internal conditions experienced by persons who describe themselves as being in recovery - hope, healing, empowerment and connection - and external conditions that facilitate recovery - implementation of human rights, a positive culture of healing, and recovery-oriented services" (World Health

Organization, 2013, p. 39). Finally, as a paradigm, it unifies the techniques and interventions that might facilitate the recovery process, for example, user involvement in mental health care (Davidson et al., 2007), acknowledging individual aspirations, capabilities and well-being in psychosocial rehabilitation (Anthony & Mizock, 2014; Farkas & Anthony, 2010; Marin et al., 2005; Slade & Schrank, 2017) and fighting the stigma related to mental illness in society (Corrigan & Watson, 2002; Davidson, 2016).

3.2.1 The challenges of the application of the recovery paradigm in research and practice

Arguably, the process of recovery differs from person to person, illness to illness, and has a non-linear course (Anthony, 1993; Davidson, 2003; Davidson et al., 2020; Deegan, 1988; Farkas & Anthony, 2010; Le Boutillier et al., 2011; Lloyd et al., 2008). Thus, it is difficult to draw up a general course that would undoubtedly lead to the positive development of the recovery process (Anthony & Mizock, 2014; Farkas & Anthony, 2010; Le Boutillier et al., 2011; Leamy et al., 2011; Shanks et al., 2013). Mental health care interventions can neither provide clarity in this matter, as "recovery is what people with disabilities do. Treatment, case management, and rehabilitation are what helpers do to facilitate recovery" (Anthony, 1993, p. 15). In this sense, recovery is a set of principles informing mental health care services (Le Boutillier et al., 2011; Slade et al., 2014).

Several attempts were made at developing a conceptual framework and objective measures for recovery to unify these previously mentioned complexities and find a definitive answer to what is recovery and how it can be achieved (See, for example, Davidson et al., 2020; Davidson et al., 2007; Le Boutillier et al., 2011; Leamy et al., 2011; Shanks et al., 2013; van Weeghel et al., 2019). However, while each of these attempts had merits, support of the scientific community and success in practice, none emerged as generally accepted and implemented (van Weeghel et al., 2019) because they were necessarily vague to incorporate the diversity of individuals' recovery journeys. Therefore, the lack of unambiguity makes it challenging to apply the recovery paradigm as a theoretical framework for research on what might promote a

person's recovery process. However, an established general theory, such as salutogenesis that focuses on how well-being is achieved might provide a more concrete theoretical framework.

3.3 A theory of health and well-being: salutogenesis

Aaron Antonovsky developed Salutogenesis based on his research into how some survivors of the Holocaust managed to lead a full and satisfying life despite their devastating experiences (Antonovsky, 1979). Thus, salutogenesis is a theory of "how people manage stress and stay well", as the subtitle of his second seminal work puts it (Antonovsky, 1987b).

The ontology of salutogenesis suggests an experience of reality as an ever-changing, chaotic environment with which the individual is in continuous interplay (Eriksson, 2017). Arguably, it is parallel to the notion of recovery where the individual is striving to master the disadvantages of the persistent challenges of mental illness (Deegan, 1988, 2002). Furthermore, the epistemology of salutogenesis as a constant learning process (Eriksson, 2017) suggests more similarities between the philosophical background of salutogenesis and recovery as a process of improving one's circumstances and self to live a satisfying life despite having a mental illness (Anthony, 1993).

3.3.1 The basic assumptions of salutogenesis theory

The salutogenic orientation to health can be understood on the foundation of five basic assumptions (Antonovsky, 1979; Griffiths, 2009; Vinje et al., 2016): a continuum model of health, a focus on the person instead of the illness, a focus on the health-promoting factors or opportunities instead of pathogens or risk-factors, considering stress as an opportunity, rather than a ubiquitous evil to fight, and lastly, an active adaptation of coping according to the ever-changing circumstances.

First, faced with the relativity of well-being in his research, Antonovsky broke from the dualistic, biomedical approach to health, according to which anybody who lacked a specific pathogen is defined as healthy. Conversely, the presence of any pathogen

would declare someone ill, irrespectively of their level of functioning (Antonovsky, 1979, 1987b). Instead, he described health as a continuum, between the two poles of ease (complete health) and 'dis-ease' (a complete lack of health), which made it possible to assess nuances of an individual's health status, thus painting a more realistic picture of their well-being and functioning (Antonovsky, 1979).

Second, a further consequence of breaking with the biomedical programme was realising that assessing an individual's health and well-being was far more complex than a mere presence or lack of a pathogen (Antonovsky, 1979). Consequently, the focus had to be shifted from a partial biomedical perspective to a more holistic, biopsychosocial approach where all facets of the well-being of an individual are the centre of attention (Antonovsky, 1979; Vinje et al., 2016).

Third, by assuming a holistic view of an individual's well-being, one can grasp a more comprehensive picture, and healthy aspects become apparent besides the parts affected by illness (Vinje et al., 2016). To promote health and well-being, adopting a focus on these healthy aspects is necessary by emphasizing these strengths instead of the person's illness and inabilities (Antonovsky, 1979; Vinje et al., 2016).

Fourth, the stress concept of salutogenesis has a similar positive approach (Antonovsky, 1979). According to Antonovsky, in a modern World, where stress is omnipresent, it is futile to try to avoid it. Instead, one should make the best of it by coping with stress as best they can and find contentment in the consequent increase in their sense of mastery and achievement (Antonovsky, 1979; Vinje et al., 2016).

Fifth, in the context of continuous coping with omnipresent stressors, an individual is necessarily in a constant process of learning and change (Antonovsky, 1979). Thus, active adaptation is a prerequisite of successful coping and should be an essential ingredient of any health-promoting intervention (Antonovsky, 1979; Langeland et al., 2007).

3.3.2 The Sense of Coherence

After identifying the determinants of health, the question arose as to how one's position on the health continuum can be improved (Langeland & Vinje, 2013), and Antonovsky's answer to this problem was the development of the 'Sense of Coherence' (SOC) (Antonovsky, 1979, 1987a, 1987b; Eriksson, 2017; Langeland & Vinje, 2013; Mittelmark & Bauer, 2016). Antonovsky posited that the stronger one's SOC is, the better position one occupies on the health continuum, and the strength of the SOC is determined by the level of its three core components: comprehensibility, manageability, and meaningfulness (Antonovsky, 1979, 1987b). Based on this, the SOC is defined as:

> The sense of coherence is a global orientation that expresses the extent to which one has a pervasive, enduring, though dynamic feeling of confidence that 1) the stimuli deriving from one's internal and external environments in the course of living are structured, predictable and explicable (or comprehensible); 2) the resources are available to meet the demands posed by these stimuli (or manageable); and 3) these demands are challenges, worthy of investment and engagement" (or meaningful). (Antonovsky, 1987b, p. 19)

Furthermore, Antonovsky (1987b) described meaningfulness as the motivation to deal with a problem, while comprehensibility is there to make sense of it, and manageability draws on internal or external resources to solve a problem. According to Antonovsky (Antonovsky, 1987b, p. 22), meaningfulness was the most important in shaping outcomes. He also argued that an individual does not need the entirety of their life to be comprehensible, manageable, and meaningful; it was enough to be so within their range of interest or in terms of the things and issues meaningful for them (Antonovsky, 1987b). Furthermore, he suggested that while these boundaries of interest could be narrow or wide, four crucial areas of life were necessarily included: one's inner feelings, one's immediate interpersonal relations, one's primary activity and one's existential issues such as an individual's attitude toward death, conflicts and personal shortcomings (Antonovsky, 1987b, p. 23).

3.3.3 Resistance resources

Successful coping requires the individual to draw on resources (Antonovsky, 1979, 1987b). These are the so-called generalized resistance resources (GRRs) (Antonovsky,

1979, 1987b) characterized by Antonovsky as (Antonovsky, 1987b, p. 19) "phenomena that provide one with sets of life experiences characterized by consistency, participation in shaping outcomes and an underload-overload balance". As the experiences in an individual's life influence the level of the dimensions of the SOC, the role of available GRRs to a person are significant in terms of the strength of the SOC (Antonovsky, 1987ab). The major types of GRRs might include (Antonovsky, 1987b; Langeland et al., 2007; Sullivan, 1989) somatic, material, cognitive and emotional, interpersonal-relational, value-related, and sociocultural factors.

However, lacking these resources puts the individual at a disadvantage. Correspondingly to the idea of the health continuum, Antonovsky envisaged a scale between having GRRs and lacking resources to combat the challenges of life, which he termed as generalized resistance deficits (GRDs) (Antonovsky, 1979, 1987b). Consequently, a GRR can be anything that fosters any of the three core components of the SOC, and a GRD is something that inhibits either one or more of them (Antonovsky, 1987b). In addition, a further distinction can be made in terms of the scope of utility of a resource, which creates the group of specific resistance resources, which are resources used in encounters with particular stressors (Mittelmark et al., 2016, p. 72).

In summary, salutogenesis offers a comprehensive model to understand how people actively adapt to a World in which stressors are omnipresent and inevitable; and "disease, illness, and entropy (decline into disorder) are the norm rather than the exception to a rule" (Antonovsky, 1979, p. 25). Central in this model is the individual, free from the value-imposed characterization of being ill or healthy but considered as someone with resources to overcome obstacles (Antonovsky, 1979, 1987b; Mittelmark & Bauer, 2016). Still, by drawing on resources, understanding the challenges one faces and finding this struggle meaningful, one can develop a robust coping mechanism that leads to greater well-being (Mittelmark & Bauer, 2016).

4. LITERATURE REVIEW

The previous chapter has identified and gave a short introduction to the theoretical underpinnings of this project: psychosocial rehabilitation, recovery and salutogenesis. However, the current state of knowledge on these concepts is yet to be understood concerning this project. For example, what is known about the subjective and objective outcomes of the Clubhouse programme and how they are achieved? What do we study when we explore processes of recovery and how recovery outcomes are achieved? Moreover, is there available evidence supporting the idea to contextualize Clubhouse outcomes and recovery by the theory of salutogenesis? The following literature review will attempt to answer these questions.

4.1 Previous research on the Clubhouse programme: outcomes and member experiences

The early body of Research on the Clubhouse programme, primarily quantitative studies, focused on studying the correlation between rehospitalization rates and Clubhouse attendance, considering that the programme was a pioneer of community-based psychosocial rehabilitation services. For instance, participation in the Clubhouse community was reported to reduce rehospitalization rates by all studies (Accordino & Herbert, 2000; Beard et al., 1978; Beard et al., 1963; Bouvet et al., 2020; Chen et al., 2020; Delaney, 1998; Di Masso et al., 2001; Henry et al., 1999; Karp, 2007; Mowbray et al., 2009; Unger et al., 2002; Wilkinson, 1992). Furthermore, more extended participation in the Clubhouse community and receiving reach-out services was shown to ensure a greater reduction in rehospitalization rates (Beard et al., 1978; Henry et al., 1999; Karp, 2007).

Regarding comparing the effects of Clubhouse participation and participating in other programmes, studies showed that Clubhouse participants had lower rehospitalization rates than those of other programmes (Beard et al., 1978; Beard et al., 1963; Delaney, 1998; Karp, 2007). However, other studies (Accordino & Herbert, 2000; Chen et al.,

2020) did not find a difference between the rehospitalization rates of Clubhouse members and users of other programmes participating in their studies.

Another central topic area of Clubhouse research concerns employment, showing somewhat conflicting results. For example, while a French study (Bouvet et al., 2020) showed an improvement of labour market integration by becoming a Clubhouse member, a Norwegian study by Bonsaksen et al. (2016) suggested a generally low level of employment among Clubhouse members.

Moreover, comparative studies concerning employment examined outcomes of the Clubhouse programme compared to Assertive Community Treatment (ACT) programmes (Gold et al., 2016; Johnsen et al., 2004; Macias et al., 2006; Schonebaum & Boyd, 2012; Schonebaum et al., 2006), day-treatment programmes (Beckel, 1998) and outpatient clinic (Tsang et al., 2010). Compared to a day treatment centre and outpatient clinic, Clubhouse members were shown to gain employment more likely (Beckel, 1998; Tsang et al., 2010). However, some studies showed Clubhouse members' employment rates in comparison with ACT users to be lower (Macias et al., 2006; Schonebaum et al., 2006), except for one study (Stein et al., 1999) that found no difference in the employment rates of Clubhouse members and participants of ACT.

Further comparisons between participants of the ACT and Clubhouse programmes showed that Clubhouse members had better results in terms of job retention (Macias et al., 2006; Schonebaum & Boyd, 2012; Schonebaum et al., 2006), earned higher wages (Johnsen et al., 2004; Macias et al., 2006; Schonebaum et al., 2006), had more working hours (Johnsen et al., 2004; Macias et al., 2006) and reported greater global quality of life and service satisfaction (Gold et al., 2016). Furthermore, studies suggested that participation in transitional employment (Johnsen et al., 2004) and the work-ordered day (Schonebaum & Boyd, 2012) enhanced the work outcomes of Clubhouse members.

Clubhouse members reported increased quality of life after becoming Clubhouse members (Bouvet et al., 2020) and were also shown to experience a greater global quality of life than ACT and rehabilitation skills training users (Gold et al., 2016; Jung

& Kim, 2012). However, Stein et al. (1999) reported no difference between ACT users' quality of life scores and Clubhouse members. Furthermore, Boyd & Bentley (2006) showed that compared to users of customer-run drop-in centres, Clubhouse members reported a higher level of subjective quality of life, while users of customer-run drop-in centres scored higher in terms of objective quality of life measures.

Further comparative studies reported that Clubhouse members showed reductions in psychiatric symptoms and a higher level of social functioning and self-determination (Chen et al., 2020), had a higher number of close friends and somebody to count on (Warner et al., 1999), had a higher amount of family contacts, and scored lower on the number of arrests and amount of victimisation (Boyd & Bentley, 2006).

In addition, Yau et al. (2005) found that becoming a Clubhouse member improved an individual's emotional coping abilities, task orientation, social and teamwork skills. However, they argued that these positive changes happened early on and later stagnated. Conversely, others (Chang et al., 2014; Jacobs, 1999; Pernice-Duca & Onaga, 2009; Ritter et al., 2019) suggested that length of membership or higher number of visits to the Clubhouse had a positive correlation with social aspects in members' lives, such as satisfaction with social support and network, reciprocity in relationships and satisfaction with their participation at the Clubhouse. In terms of satisfaction with Clubhouse participation, Hultqvist et al. (2017) found that Clubhouse members valued the possibility of choice, participation in decision-making and receiving peer support. Furthermore, Tanaka et al. (2018) found that members' sense of Clubhouse community belonging contributed positively to their experience of empowerment. In addition, another study (Gumber & Stein, 2018) found that while Clubhouse members' social integration improves significantly within the Clubhouse community, their integration into larger society seemed not as successful, a concern that was raised by qualitative studies as well (Kinn, Tanaka, et al., 2018; Raeburn et al., 2013).

From the early 2000s, a growing body of qualitative literature is available on the Clubhouse programme, of which the majority is concerned with different experiences

of Clubhouse members, and a few investigated family members' and staff's experiences with the programme. Among the latter, Pernice-Duca et al. (2015) examined how family members' experience their relatives being members of a Clubhouse. They found that family interactions were perceived to be improved because the Clubhouse reduced their burden of care.

Regarding staff practices, studies showed that staff helped to build the working community of the Clubhouse by integrating social relationships, unit work and individual's needs (Chen, 2016). Staff was shown to provide support to members' recoveries through forming a therapeutic alliance (Kidd et al., 2017), developing genuine reciprocal relationships, facilitating community building, and ensuring member participation in Clubhouse activities (Chen, 2016; Chen & Oh, 2019; Kinn, Langeland, et al., 2018; Tanaka & Davidson, 2015b). In addition, a good relationship with staff and members has been found to play a crucial role in facilitating a positive community experience because adversity between staff members and perceived condescension from staff towards members was shown to deter members' participation and decreased their satisfaction with the programme (Roth, 2017; Schiff et al., 2008). Conversely, positive interpersonal relationships and the need to reduce social isolation and the safe environment of the Clubhouse was shown to promote participation (Pernice et al., 2021; Schiff et al., 2008). Furthermore, the opportunity to engage in meaningful activities and assuming a meaningful role at the Clubhouse were also reported to increase participation at the Clubhouse (Pernice et al., 2021; Schiff et al., 2008).

Reportedly, members experienced the Clubhouse as an environment that created a sense of community and a place to belong (Carolan et al., 2011), and developed strong emotional connections with the Clubhouse community, which in different studies was described as 'substitute family' (Biegel et al., 2013; Pernice-Duca, 2008), 'home' (Schiff et al., 2008) and 'haven' (Kang & Kim, 2014). Nevertheless, according to Norman (2006), some members experienced their participation in the community as too intense.

Studies show that the relationships in the Clubhouse community are being built within the framework of the work-ordered day (Norman, 2006; Tanaka & Davidson, 2015a) through working together on meaningful tasks (Norman, 2006; Perrins-Margalis et al., 2000) and sharing achievements (Coniglio et al., 2012). Several studies identified further positive community aspects of the Clubhouse programme. These included the opportunity of meeting individuals in similar situations as one's own (Carolan et al., 2011), experiencing social inclusion and belonging, interdependency and intimacy (Coniglio et al., 2012), developing meaningful relationships (Norman, 2006) and rebuilding a social network (Carolan et al., 2011).

Raeburn et al. (2016) argued that Clubhouses support their members' recovery processes in two ways, first by providing consistent and respectful social environment members can belong to, and second, by supporting their sense of autonomy. Similarly, other studies concluded that reciprocal relationships at the Clubhouse, or the giving and receiving support, facilitated recovery because it helped members to experience personhood, and with that a sense of agency, self-worth and belonging to society (Dorio et al., 2002; Kennedy-jones et al., 2005; Mutschler et al., 2018; Pernice-Duca & Onaga, 2009; Tanaka & Davidson, 2015b). Furthermore, participating in the work-ordered day was shown to contribute to reconstructing members' lives, developing their occupational self and skills, and experientially learn what parallels a good life in general (Tanaka & Davidson, 2015a).

A recent meta-synthesis (Kinn, Tanaka, et al., 2018) described members' Clubhouse journey by the four themes of stepping out of limiting realities, anchoring, creating ways of flourishing, and prospects of a life outside the clubhouse. Based on these results, the overarching metaphor "Pushing out the boat" was developed (Kinn, Tanaka, et al., 2018), suggesting that while Clubhouse members experience recovery within the Clubhouse setting, they might have difficulty translating this positive experience to the outside World, a concern shared by other studies as well (Gumber & Stein, 2018; Raeburn et al., 2013).

4.2 The recovery process

The earlier section on recovery gave an inkling of the unclarity of the recovery concept. Indeed, as Davidson pointed out**,** "recovery is a lifelong process that involves an indefinite number of incremental steps in various life domains. As a result, many people view the process of recovery as something that almost defies definition" (Davidson et al., 2005, p. 483). Still, the numerous and highly consonant studies attempting to define recovery might provide insight into what constitutes the recovery process.

For example, several studies found mental health recovery in the sense of "learning to live better in the face of mental illness" (Davidson, 2012, p. 261) complementary to clinical recovery, which has an outcome-focus, and is characterized by symptom reduction, decreases in medication and rehospitalization (Davidson et al., 2005; Jacob et al., 2017; van Weeghel et al., 2019). Furthermore, Whitley & Drake (2010) pointed out that there are several dimensions of recovery beyond the clinical, including existential, functional, physical and social recovery, all of which target the improvement of different areas of a person's life. Other studies have also emphasized the importance of the social (Mezzina et al., 2006; Sells et al., 2006; Topor et al., 2011), spiritual (Davidson, 2012; Leamy et al., 2011; Sells et al., 2006; van Weeghel et al., 2019) and functional (Coffey et al., 2018; Davidson, 2012; Dunn et al., 2010; Ebrahim et al., 2014; Farkas et al., 2007).

While identifying recovery domains is an important topic of recovery research, most studies seem to deal with elements of the recovery process. For example, an impactful systematic review of 87 individual studies carried out by Leamy et al. (2011) found thirteen characteristics of the recovery process (Leamy et al., 2011, p. 448), which were confirmed by later studies (See, for example, Davidson, 2012; Jacob et al., 2017). According to these characteristics, recovery can be defined as an active, non-linear, individual, and unique process and a life-changing experience often described as a journey or struggle (Anthony, 1993; Deegan, 1988). In other words, recovery represents a multidimensional and gradual process with stages or phases defined by a

trial-and-error approach (Anthony, 1993). In addition, a clinical cure does not seem to be a prerequisite for the recovery process, which can indeed occur without professional intervention; however, it is aided by a supportive and healing environment (Anthony, 1993; van Weeghel et al., 2019).

Furthermore, the aforementioned systematic review (Leamy et al., 2011) also identified five processes that constitute the recovery journey, summarized as the CHIME framework. The first process is developing connectedness through peer support, support groups and support from others, relationships and being part of the community. The second process is hope and optimism about the future, characterized by belief in the possibility of recovery, motivation to change, hope-inspiring relationships, positive thinking and valuing success and having dreams and aspirations. Third, identity concerns rebuilding and redefining a positive sense of the different dimensions of one's identity and overcoming stigma. The fourth process deals with finding meaning in life through discovering the meaning of one's experiences with mental illness, spirituality, improving quality of life, identifying and striving for a meaningful life and social roles and goals, and rebuilding one's life. The fifth and final process is empowerment, which incorporates personal responsibility and control over one's life.

According to a recent scoping review (van Weeghel et al., 2019), the CHIME framework is widely endorsed as a framework for the personal recovery process and an insight into the elements promoting recovery. However, it does not deal explicitly with the barriers to the recovery process – we must turn to other studies to reveal these.

As empowerment and self-agency were cited by several studies (See, for example, Davidson et al., 2005; Leamy et al., 2011; Topor et al., 2011) as a crucial element of the recovery process, the lack of citizenship, experiencing social exclusion and lack of decisional power are a roadblock on the recovery journey (Davidson et al., 2005; Jacob et al., 2017). Moreover, another significant barrier is stigma (Pernice et al., 2017; Tew et al., 2011; van Weeghel et al., 2019) because it has a negative effect on

hope by not allowing the individual to step outside of their illness and look at themselves as a whole person with opportunities and resources to achieve a better quality of life. In this sense, stigma is a societal and personal phenomenon, which must be addressed on these multiple levels (Davidson et al., 2005). A further notion connected to self-stigma is recovery expectation that can be defined as a mechanism central to an individual's recovery and includes their beliefs in managing their own functioning, exercising control over events and how in turn, this may affect one's future events (Ebrahim et al., 2014). By a systematic review (Ebrahim et al., 2014), it was found that persons' low recovery expectations are less likely to return to work than those who set higher expectations towards their recovery.

There are further barriers that were identified in the literature; however, these will be discussed in the next section, which will explore the recovery process from the perspective of mental health care in terms of what are the necessary characteristics of recovery-oriented services and how interventions can support or hamper the recovery process.

4.3 Providing support on the recovery journey

As outlined before, recovery seems to be the guiding paradigm of contemporary mental health care (See, for example, World Health Organization, 2013). However, studies indicate that there is yet a gap between concept and practice (Jacob et al., 2017; van Weeghel et al., 2019). Therefore, it is relevant to explore what is considered 'good help' with individuals' recovery processes and understand what might be a hindrance.

In a study of 30 policy documents on recovery-oriented mental health care from six countries, Le Boutillier et al. (2011) identified sixteen themes in four practice domains for that mental health care should aim. According to the first domain, mental health care services should promote citizenship by seeing the person and not only the service user, ensuring the service user's rights, promoting social inclusion, and providing meaningful occupation. In their guidelines for recovery-oriented mental health care, Davidson et al. (2007, p. 30) expressed these themes through the recommendations

"Primacy of Participation" and "Promoting Access and Engagement", while Coffey et al. (2018) emphasized the importance of shared decision making. Second, according to Le Boutillier et al. (2011), an organizational commitment is necessary to carry out recovery-oriented care, including working with a vision of recovery and developing support structures at the workplace, including workforce planning. Furthermore, a vision of care pathways was also identified as necessary in terms of organizational commitment (Leamy et al., 2011), which is in line with the recommendation for ensuring continuity of care (Davidson et al., 2007). The third practice domain should aim to support personally identified recovery goals (Leamy et al., 2011), including the themes of individuality, informed choice, peer support, strengths focus and a holistic approach. These recommendations are congruent with the suggestions that recovery-oriented mental health care should employ strengths-based assessment and offer individualized recovery planning (Coffey et al., 2018; Davidson et al., 2007; Jacob et al., 2017; van Weeghel et al., 2019). The fourth domain concerns the relationship between the individual and the mental health care worker (Leamy et al., 2011), inspiring hope and being based on partnership, in which mental health workers should function as a recovery guide (Davidson et al., 2007).

After developing an overview of what promotes recovery-oriented mental health care, it is prudent to explore what hinders its establishment. A recent review of 26 peer-reviewed studies (Jacob et al., 2017) found that on an organizational level, general problems characterizing traditional mental health care, such as dependency, fear, and being judged as chronically dysfunctional, obstruct recovery. Further factors limiting recovery were staffing shortages, inadequate clinical interventions, and side effects of medications. In addition, the study (Jacob et al., 2017) argued that certain staff attitudes, such as lack of trust in the person, failure to take the situation of the person seriously, poor listening skills, and paternalistic attitudes, that is to say when staff do not allow the person to make decisions and coerce them to do things. Other studies also suggest that the lack of shared decision-making has a negative impact on recovery-oriented mental health care.

Turning to recovery-oriented interventions, while some (See, for example, Jacob et al., 2017; Whitley & Drake, 2010) emphasize the importance of clinical interventions to symptom management and side-effect reduction, most recovery-oriented interventions are of a psychosocial nature. According to Farkas et al. (2007) recovery-oriented, psychosocial rehabilitation services contribute to recovery by focusing on outcomes related to the individuals' role functioning in the real-World community. Therefore, it is an ecological endeavour, where challenges of the person must be addressed parallelly with their environment (Anthony et al., 1999; Davidson et al., 2007; Farkas, 2006; Farkas et al., 2007; Rössler, 2006). Furthermore, in line with the requirements of the empowerment of the individual and shared decision-making, no recovery-oriented intervention can be imposed (Rössler, 2006). Techniques to use and target areas to address in recovery-oriented psychosocial interventions might include promoting role competencies, providing support for role success, increasing empowerment, increasing societal opportunities, and reducing discrimination (Farkas et al., 2007; Whitley & Drake, 2010). The techniques can be applied to existential, functional, physical, and social issues (Farkas & Anthony, 2010; Whitley & Drake, 2010).

The literature identified thirteen attempts (Jaeger et al., 2013; Shanks et al., 2013; Sklar et al., 2013) to assess whether an intervention is recovery-oriented and to what extent it supports the individual's recovery process. However, it was found that all of them have psychometric weaknesses (Shanks et al., 2013; Sklar et al., 2013), and one of them, the Recovery Attitudes Questionnaire, was not recommended for further use due to serious psychometric shortcomings (Jaeger et al., 2013). In addition, these instruments cover different dimensions of recovery, as except for the Questionnaire About the Process of Recovery, they only partially cover the areas outlined by the most comprehensive programme, the CHIME framework (Shanks et al., 2013).

In summary, it is apparent that while there is much concurrence in the literature regarding what constitutes recovery, recovery-oriented services, and recovery-promoting methods, the situation is far from resolved because there is a lack of consensus in terms of recovery theory and practice.

4.4 Recovery in a salutogenic perspective

In salutogenic terms, recovery is a constructive process in which the individual focuses on their own situation in a flexible, adaptive, and future-oriented way and has social, mental and somatic aspects (Griffiths, 2009). This approach to recovery emphasizes the importance of the individual in their own recovery process, thus supports the empowerment of individuals with mental health issues to facilitate their own self-generated recovery (Griffiths, 2009). Furthermore, a salutogenesis-based approach to recovery requires proactive coping and not just passive adjustment, and recovery-oriented interventions must be personally tailored (Griffiths, 2009; Magrin et al., 2006).

Enhancement of an individual's SOC was shown to be beneficial in terms of the individual's rehabilitation process and recovery (Lillefjell et al., 2017) because a strong SOC helps one mobilize resources and to cope with stressors and manage tension successfully (Mittelmark & Bauer, 2016, p. 7). In addition, a strong SOC positively correlates with changes in overall subjective quality of life, general health, global well-being and global psychosocial functioning and negatively correlates to psychopathology (Griffiths, 2009). A recovery process that is based on the strengthening of the SOC would involve three factors: the creation of a new personal vision of oneself through acceptance and adjustment to changes, and that it involves self-discovery, self-renewal and transformation, and rebuilding a meaningful and valued life (Griffiths, 2009; Langeland et al., 2007).

A qualitative study by Langeland et al. (2016), interviewing participants of a salutogenic talk-therapy group, identified four main themes that might shed light on phenomena associated with recovery in the context of salutogenesis. First, the theme of a 'Richer life' expressed how belonging to the group added to participants' everyday life experiences. Second, the 'Well-functioning group' theme included the positive interplay between the group as a community, the group leader, and the participants. Third, the theme of 'Who am I?' referred to participants' re-identification with themselves as their self-awareness and self-acceptance improved, dared to be

open and show affection, took more responsibility for their recovery, and experienced reciprocal effects of their growth inside and outside the group. Fourth, the last theme of 'A community of like-minded individuals' concerned how the positive relationships in the group promoted humour and self-irony, provided relief for family and friends and enhanced focus on positive thoughts and practical solutions (Langeland et al., 2016).

Langeland & Vinje (2016) argued that salutogenic, or health-focused versus pathogenic, or illness-focused approach is necessary for mental health work based on a partnership between the person and the professional, as people are experts on themselves and their unique situations and experiences, including their pain, suffering, and concerns. A salutogenic orientation of interventions would focus on the achievement of successful coping (Mjøsund, 2021). Furthermore, in salutogenic terms, recovery support may work at three levels: strengthening individuals, strengthening communities, and reducing structural barriers to mental health (Langeland & Vinje, 2016) and take advantage of salutogenic stress, or a challenge of appropriate balance between one's resources and stressors, encouraging growth through coping (Magrin et al., 2006).

A recovery-oriented intervention must strengthen the individual's SOC (Landsverk & Kane, 1998). The development of any dimension of the SOC will positively affect all others, as components of the SOC have a reciprocal relationship (Langeland & Vinje, 2016). Comprehensibility can be strengthened by improving the cognitive abilities and understanding the reality of individuals; manageability can be enhanced through providing holistic care and support that matches the needs of an individual. It is important to note that the latter requires an effective needs and care assessment of the individual. Furthermore, meaningfulness can be facilitated through offering activities with a sufficient level of challenge, purpose, and by the provision of a variety of social activities (Griffiths, 2009; Landsverk & Kane, 1998; Lillefjell et al., 2017) and by helping the individual invest in the four crucial areas of meaningfulness: form a view of life, identify supportive networks, achieve mental stability and involving them in meaningful everyday activities (Langeland & Vinje, 2013, 2016; Langeland et al.,

2007). A high level of comprehensibility promotes the capacity to judge reality (Antonovsky, 1979, p. 127). In summary, a SOC-guided recovery process is a process of constructing foundations in-built with flexibility and capability for change using the guidance of a future-orientated plan that provides motivation and direction (Griffiths, 2009, p. 73).

Many existing therapies attempt to enable recovery by seeking to strengthen coping skills or general resistance resources, which would also positively affect the strength of the SOC due to the strong and reciprocal connection between the SOC and GRRs (Griffiths, 2009). GRR-related factors to address in recovery support are, for example, recognition of the existence of a problem, awareness of and confidence in the person's potential, and availability of external resources to aid recovery (Griffiths, 2009; Langeland & Vinje, 2013, 2016; Langeland et al., 2007). As a key GRR, (re)building the individual's social network, lost due to the challenges of mental illness such as a loss of self-confidence, losing trust in others, fear of embarrassment, should be a priority of salutogenesis-based and recovery-oriented interventions (Griffiths, 2009).

The intervention programme for coping of Magrin et al. (2006) builds on the basic tenet that an individual grows by realizing the gap in their identity between what one is and what one might/would/should be. Thus, they built a two-step intervention, starting with a critical discovery of one's identity, and the second step focuses on narrowing the gap between the current and desired identities (Magrin et al., 2006).

4.5 Knowledge gaps in the literature

Exploring recovery processes in the Clubhouse presupposes a sound understanding of the term. Mental health recovery was conceptualized as a quest for increased physical, mental and social well-being (Farkas et al., 2007; Slade & Schrank, 2017), and salutogenesis explores how well-being develops (Antonovsky, 1979, 1987b). Consequently, the strength of an individual's sense of comprehensibility, manageability, and meaningfulness, or SOC, might shed light on individuals' recovery journeys; therefore, work as a unifying theoretical framework for recovery.

Furthermore, most of what we know about recovery comes from subjective personal narratives and quantitative instruments assessing outcomes, areas of what constitutes recovery and stages of recovery (Sklar et al., 2013). Parallelly, research is scant regarding the active ingredients of the recovery process (van Weeghel et al., 2019). Furthermore, it is not clear how these ingredients relate to each other and through which processes they contribute to positive change, a knowledge gap that is common in a Clubhouse research context as well (Mowbray et al., 2006).

There are further knowledge gaps identified in research on the Clubhouse programme. For example, studies note that many of the available studies are too old, making it unclear whether their conclusions hold to this day (Battin et al., 2016; McKay et al., 2016). Another major criticism is that most of the studies were conducted in the United States (Battin et al., 2016; McKay et al., 2016; Tanaka & Davidson, 2015a). Indeed, only a handful of the studies reviewed here were carried out in other countries, making it difficult to draw conclusions that might be valid across cultures, countries and health and social systems. In addition, it is not sure which are the active ingredients in the Clubhouse programme and the processes through which it achieves its outcomes (Mowbray et al., 2006; Mutschler et al., 2018). Furthermore, while dimensions of recovery were studied in the Clubhouse context (See, for example, Hancock et al., 2013; Pernice-Duca & Onaga, 2009; Staples & Stein, 2008), a study with a comprehensive approach could not be identified, and there was a lack of research explicitly targeting Clubhouse members' experiences with recovery.

The SOC theory might be helpful to address this lack in knowledge, as it was found relevant to mental health rehabilitation (Griffiths, 2009; Langeland & Vinje, 2013, 2016; Langeland et al., 2007), and has a clear definition of how health and well-being are developed: if a person has strong comprehensibility, manageability and meaningfulness, one has a strong SOC, and thus an experience of health and well-being (Antonovsky, 1987b).

Furthermore, exploring the individual recovery journeys of Clubhouse members in light of salutogenesis might help with gaining a better understanding of which

elements of the Clubhouse programme are active in the recovery process. Furthermore, such inquiry can also help identify which programme ingredients affect which factors of the recovery/well-being construct. Such investigation would also provide concrete examples of how the SOC and its components are realised in a mental health rehabilitation setting, an issue identified as a knowledge gap in previous research (Griffiths, 2009).

5. AIM OF THE PROJECT AND RESEARCH QUESTIONS

Based on the knowledge gaps mentioned above, the main aim of this PhD project is to explore and develop a theoretical and empirical understanding of the usefulness of the Clubhouse programme based on the lived experiences of Clubhouse members within a Norwegian context. Furthermore, to explore Clubhouse members´ social and vocational recovery processes and explore whether salutogenesis can provide a basis for assessing the programme's impact on the individuals' recovery processes.

Thus, the project explored three research questions. These are:

1. How can the Clubhouse programme be understood in the light of salutogenesis? (Results were published in article 1.)
2. What is it like to be a Clubhouse member? (Results were published in article 2.)
3. What do members experience as helpful for their vocational and social recovery and change processes within the context of the Clubhouse programme? (Results were published in article 3.)

6. METHODOLOGY

6.1 Research design

This project had a social constructivist design throughout. Social constructivism is defined as the conviction that phenomena are produced by intentional human activity affected by social interaction and do not exist as inevitable (Kukla, 2000; Young & Collin, 2004). As a result, this project claims a relativistic - interpretive ontology and epistemology (Malterud, 2016).

A social constructivist ontology in general views the World not as factual, but interpretive and contextual (Kukla, 2000; Ponterotto, 2005; Young & Collin, 2004) and argues that reality can only be understood "in terms of the meanings people bring to them" (Denzin & Lincoln, 2011, p. 3). In particular terms, this project's reality is constructed by adopting the idea that recovery from mental illness is possible, and people can live a full and satisfying life even in the presence of mental illness (Anthony, 1993; Antonovsky, 1979; Farkas, 2006). This notion was adapted because it provided a common ontological standpoint of the several concepts this thesis revolves around, such as recovery, salutogenesis and the Clubhouse programme.

As a consequence of its social constructivist design, this project claims epistemological relativism, in which no knowledge can be certain, but can only be perceived relative to other things, such as society and culture, for example (Kukla, 2000; Young & Collin, 2004). Thus, the lenses through which knowledge can be obtained and interpreted in this project were determined by its central concepts. The notion that the recovery journey is unique to each to each person (Anthony, 1993), and the conviction of salutogenesis that every individual should be considered in the context of their own situation (Eriksson, 2017), prompted an approach in which knowledge construction happened through compiling individual narratives. In addition, as being in recovery is a process without a definite endpoint (Davidson & Roe, 2007), and salutogenesis has a similar view on life as constant coping with ubiquitous stressors to promote health (Antonovsky, 1979; Eriksson, 2017), this

project views knowledge construction as a constant, positive learning process (Eriksson, 2017).

In line with the 'lived experience'-nature of the empirical studies, a hermeneutic-phenomenological approach was selected to inform the research process from developing the studies and research questions, interviews, interview guide and the analysis.

Phenomenological philosophy was developed by Edmund Husserl (Husserl, 1999) and focused on understanding the essence of things. Husserl's method of philosophical phenomenology is defined by three key elements (Husserl, 1999): first, it employs description; second, it assumes the attitude of phenomenological reduction and third, it seeks the most invariant meanings of phenomena.

The first element means that phenomenology does not deal with interpretation, construction, or explanation of things, but a pure, unbiased description of phenomena as they appear or as they are experienced by the observer (Husserl, 1999). Furthermore, phenomenological reduction implies two attitudes in the process of understanding (Husserl, 1999). First, breaking with the 'natural attitude' means being aware and aiming for a detailed understanding of even the most mundane phenomena. The other attitude is the 'epoche', identifying and putting aside one's preconceptions on the subject matter, thus avoiding the 'natural attitude', where one is not aware of how one's notions bias the perception. Finally, seeking the most invariant meanings is about finding the most essential, therefore most generalizable form of things, by applying the method of 'free imaginative variation'.

Later, Martin Heidegger, building on Husserl's phenomenology, abandoned the descriptive approach of the method and introduced the concept of "Dasein". Dasein means "to be there," that is, all phenomena are in the context of the surrounding World and at a specific time, and therefore cannot be described in its essential constancy, understood only in the light of the prior experience and knowledge of the person perceiving the phenomenon (Heidegger, 2002).

A constant interpretation of different paradigms and theories, which can be described by the theory of the hermeneutic circle developed by Martin Heidegger (Heidegger, 2002), was central to this project. The hermeneutic circle is a continuous back-and-forth examination of the elements and context of a phenomenon to gain the fullest possible understanding. In addition, the hermeneutic circle can also serve as a means to work out the preconceptions (fore-meanings, fore-thoughts, fore-structures) of the researcher to reach 'Zu den Sachen selbst', or to the 'things themselves' (Heidegger, 2002). Furthermore, Gadamer emphasized the intersubjectivity of knowledge construction, or the interplay between the seeker of knowledge ('I') and the provider of knowledge ('Thou') (Gadamer, 2006).

6.2 Reflexivity

According to Fossey (Fossey et al., 2002, p. 717), "central to good qualitative research is whether the research participants' subjective meanings, actions and social contexts, as understood by them, are illuminated." Therefore, as the researcher is the instrument both for data collection and interpretation in qualitative research (Kvale et al., 2015), it is their responsibility to convey the above-mentioned 'participants' understandings'.

The premises on which the researcher's role in research is to be evaluated can be expressed through the notion of reflexivity. Reflexivity means analytic and continuous attention to the researcher's role and their relationship to the subject matter and its context throughout the whole research process (Dowling, 2007). In this sense, reflexivity is highly congruous with the hermeneutic circle as a means to 'work out preconceptions' (Gadamer, 2006; Heidegger, 2002), or in Gadamer's words, free one from "the tyranny of hidden prejudices" (2006, p. 272).

Denzin and Lincoln (2011, p. 49) cite the metaphor of anthropologist Clyde Kluckhohn: "It would hardly be the fish who discovered the existence of water", referring to the phenomenon that the insiders tend to overlook familiar phenomena that are taken for granted, thus invisible. Therefore, reflexivity as a self-implemented activity concerning continual awareness and reflection regarding the researcher's role,

attributes, and behaviour throughout the research process is essential in qualitative research (Finlay, 2002). Kvale describes it as reflexive objectivity: to reflect over the researcher's own contribution to the knowledge production (Kvale et al., 2015, p. 273).

Rigorous and continuous self-reflection, assisted by the observations of others regarding the researcher's attitudes and conduct, can create a transparent and accountable research environment, where with applying the necessary checks and balances, scientifically sound research can be conducted, and knowledge produced (Denzin & Lincoln, 2011; Dowling, 2007; Finlay, 2002; Fossey et al., 2002).

This project addressed reflexivity by three means. First, through rigorous and continuous self–reflection throughout the project, assisted by the observations of the other members of the research group (supervisors) regarding the researcher's attitudes and conduct. Furthermore, decisions, interpretations, and other significant project milestones were conducted in a group (PhD candidate and supervisors), which aimed to create a transparent and accountable research environment with regular meetings, continuous, critical and recorded communication. Finally, results before publication were presented in the participating Clubhouses, and the constructed meanings were discussed with participants and other Clubhouse members.

6.3 Methods

Empirical qualitative research methods are the techniques used throughout the steps of the research process: sampling, data collection, data processing, data analysis, and data communication (Carter & Little, 2007; Fossey et al., 2002). Following is a description of techniques applied in the studies in this project.

6.3.1 Theoretical analysis in the first study

The theoretical study was a systematic examination of the theory of salutogenesis and the Clubhouse programme in their fundamental form. The core question of the study was whether the foundational elements of the Clubhouse programme could be

interpreted through a salutogenic lense to develop salutogenesis as a theoretical platform for the programme.

In terms of the fundamental form of salutogenesis, the seminal works of Aaron Antonovsky, the creator of the theory, were considered to provide the essential description of the theory: ‘Health, stress and coping (1979)’ and ‘Unravelling the mystery of health: how people manage stress and stay well (1987b). When it came to the Clubhouse programme, the International Standards for Clubhouse Programmes (Clubhouse International, 2018) was considered the essential description.

Supporting literature was used to elaborate on elements that were not satisfactorily defined in these primary texts or needed elaboration to improve reflexivity regarding the research group’s interpretation of specific paragraphs of the International Standards for Clubhouse Programmes or elements of salutogenesis.

As in the rest of the project, during comparing salutogenesis theory and the Clubhouse programme, a hermeneutic-phenomenological approach was applied. First, the research group (PhD candidate and co-authors / supervisors) identified the core concepts constructing the theory of salutogenesis, including their core definitions. The identified concepts were the five basic assumptions of salutogenesis, the SOC and its dimensions, the crucial areas affecting meaningfulness and the resistance resources.

Then, as a second step, one by one, each of these concepts was cross-checked with the standards to identify links between their meanings, to ascertain which Clubhouse programme feature might contribute to which salutogenesis concept. In this part of the work, additional literature was applied, as some of the standards are formulated in general terms with several possible interpretations. Still, according to the hermeneutic tradition, a back-and-forth approach was applied throughout the interpretation and cross-examination process. Furthermore, findings of this step were reflected upon in a group setting with the participation of both the PhD candidate, who did the initial analysis and the co-authors/supervisors.

6.3.2 The second and third, empirical studies

Like the rest of the project, a hermeneutical phenomenology was selected to inform the empirical studies owing to several reasons. First, they were an inquiry into the human experience, where the aim was to gain knowledge on how different people perceive a phenomenon. Second, the research questions were developed to explore personal experiences rather than objective facts. Third, the emerging experiences were interpreted concerning their contexts. To avoid 'taking things for granted', a detail-oriented approach was employed, and reflexivity had a pivotal importance in terms of the role of the researcher throughout the whole project.

Sampling

Of the five accredited Clubhouses operating in Norway at the start of the project, three were invited to participate. Accreditation was important as an assurance that the participating Clubhouses were following the programme to ensure that the experiences reported by the participating individuals in this project could be credited to their Clubhouse membership. The three included Clubhouses were also screened in terms of their geographical placement to enhance the breadth of data: one in a major city and another in a town in Central Norway, and the third one in a city on the west coast of Norway.

Invitation letters were sent to the participating Clubhouses, requesting their members to volunteer as interview participants. The invitation letter included a project description and a statement of participants' rights, such as preserving participants' anonymity, keeping the information given by them confidential and the possibility to withdraw without consequences at any time. The letter also included information on handling research data. As a final recruitment round, the PhD candidate visited the participating Clubhouses personally to meet with prospective informants and answer their questions.

Regarding the informants, criteria beyond being a Clubhouse member were not employed to keep the inclusion criteria to a minimum, to increase recruitment success. However, efforts were made to raise the interest, and thus recruit, a diverse range of

individuals in terms of gender, age, and familiarity with as many areas as possible of Clubhouse operations. Eventually, eighteen Clubhouse members provided agreed to an interview.

Data collection

Data in this project was collected through semi-structured in-depth interviews. In-depth or intensive interviews, which are defined as "a qualitative method, that involves open-ended, relatively unstructured questioning in which the interviewer seeks in-depth information on the interviewee's feelings, experiences, and perceptions" (Lofland & Lofland, 1984, as cited by Chambliss & Schutt, 2006, p. 166). An interview guide was developed in preparation for the interviews (Chambliss & Schutt, 2006; Kvale et al., 2015), comprised of topics on experiences with Clubhouse membership, work participation, and social relationships in the Clubhouse context. The length of the interviews varied between 30 to 80 minutes, with an average length of 50 minutes. In all cases, the whole of the interview guide was completed to ensure consistency, even though some participants chose not to discuss some topics, resulting in shorter interviews. In line with phenomenological tradition, the interviewer PhD candidate assumed an explorative role in gaining knowledge on the phenomena in question: members' experience with the Clubhouse programme and social and vocational recovery. All interviews were audio-recorded.

Data analysis

The interviews were transcribed to prepare the interview material for analysis (Kvale et al., 2015, p. 137) and provide the researcher with the opportunity to saturate themselves with the informants' experiences (Bourdieu et al., 1999, p. 391). In the transcription process, a verbatim approach was applied, and the interviewer's notes taken during the interviews, for example marking a participant's emotional expressions, were used to reduce the loss of information from live, spoken language to written (Bourdieu et al., 1999).

Shortly after transcription was completed, the analysis phase started using Malterud's systematic text condensation (STC), a pragmatic and inductive analytical method for

qualitative research, consisting of four steps (Malterud, 2012). Steps 1–3 were conducted separately for each transcript, in a hermeneutic circle, an iterative, back-and-forth process of interpretation. All steps were conducted in a group consisting of the PhD candidate and supervisors/co-authors to secure validity in the analyses. In step 1, members of the group (individually) obtained an overall impression of the material and listed their ideas on preliminary themes. In step 2, common meaning units across the researchers were identified, classified, and sorted by codes, potentially related to the previously negotiated themes (Malterud, 2012). In step 3, citations from the meaning units were connected and re-written in the first person as a coherent text (condensates); abstractions were avoided. In step 4, the condensates were re-contextualized by re-narrating them from the researcher's point of view, and an analytic text was prepared, presenting the most salient content related to the phenomenon grounded in the empirical data, including quotations from each code group (Malterud, 2012). The findings were validated against the original transcripts, and all members of the research group reviewed and agreed on the final findings (Malterud, 2012). The analytical process was characterized by the back-and-forth approach of the hermeneutic circle within each and across all steps.

6.4 Ethics

The project was submitted to the Regional Committee for Medical and Health Research Ethics (REK; ref. 2017/442 – appendices 3A and 3B). It was exempted from review because the informants in this study participated as civil volunteers and not as beneficiaries of any medical treatment.

The final project plan, information letter and interview guide were submitted to the Norwegian Centre for Research Data (NSD; ref. 52736/3/HIT - appendices 4A and 4B) as well, where the proposed data management processes of the project were approved.

Information acquired through the interviews was treated anonymously as the informants were registered under pseudonyms. We did not collect personal data from

the informants; only general demographics, recorded under their pseudonyms. All data is stored digitally on the secure servers of the Western Norway University of Applied Sciences. Hard copies of the informed consents were digitalized and then destroyed. The digital copies are stored on the secure servers of the Western Norway University of Applied Sciences, separate from other project data, and destroyed at project closure. All digital data is password protected.

The researcher (PhD candidate) and co-researchers have no role or responsibility in the actual Clubhouses participating in the project. However, the PhD candidate has a personal affiliation to a Norwegian Clubhouse, which was therefore excluded from the study as a possible location for data collection.

7. RESULTS

7.1 A summary of the first article: Salutogenesis as a theoretical framework for psychosocial rehabilitation: the case of the Clubhouse programme

The first article is theoretical and explores whether salutogenesis can be a theoretical framework for assessing the Clubhouse programme in particular and psychosocial rehabilitation (PSR) programmes in general. It argued that the difficulties with assessing and researching PSR programmes could be addressed by introducing a theoretical framework as a common platform, such as salutogenesis, a broad and tested theory, sharing several basic tenets with PSR. Therefore, the Clubhouse programme was explored in light of salutogenesis to assess the viability of this idea.

The article found that the Clubhouse programme was consistent with the different aspects of salutogenesis, indicating that salutogenesis might indeed serve as a theoretical platform for the programme. For instance, it proposed a classification of the different services and opportunities provided by the Clubhouse programme as resistance resources that can be relied upon in tackling the challenges posed by mental illness. However, the classification process revealed a lack of clarity regarding what differentiates generalized and specific resistance resources in salutogenic theory, which led to our recommendation of concretizing these concepts. In addition, the investigation revealed areas where salutogenesis might promote improvement in the Clubhouse programme. Such as, while salutogenesis identifies challenge as a health-promoting factor, the Clubhouse programme seemed to be ambiguous about it.

On the one hand, the programme includes opportunities to face and solve challenges and thus improve one's well-being. However, on the other hand, there are measures built into the programme that might have an overprotective effect, leading to possible service dependency. The next issue was the principle of active adaptation to find the best course of intervention for everyone, which is contingent upon situation assessment that was not available in the programme. Another finding raised further

issues with supporting individuals' relationships and reintegration into society beyond employment support despite their positive effect identified by salutogenesis.

7.2 A summary of the second article: "Finally, I belong somewhere I can be proud of" - Experiences of being a Clubhouse member in Norway

The second article aimed to explore the research question: "What is it like to be a Clubhouse member?" The analysis of the interviews with 18 participants revealed three major themes reflecting the subjective experiences of being a Clubhouse member.

The first theme, "Finally, I belong somewhere I can be proud of", covered topics such as sense of belonging as a positive identity-building factor, community, and programme ingredients creating community. "I am more like an ordinary citizen, but different", the second theme reflected on issues concerning society, such as the "social normalization" effect of Clubhouse membership and comparisons between the Clubhouse community and society. Lastly, the third theme, "I feel somewhat equal to others", concerned relationships: relationships with fellow Clubhouse members, Clubhouse staff and members of the broader society outside the Clubhouse.

The results revealed that the Clubhouse community offers support for individuals, recognition, structure of routines, friendships, network, and a sense of increased status in society. In addition, an increase in motivation levels resulting from becoming a Clubhouse member was widely acknowledged. These results mirrored previous international findings.

Furthermore, this article argued that the positive impact of Clubhouse membership could be explained by examining the results in the light of salutogenesis. For example, positive experiences and building a network could increase members' resistance resources. Furthermore, the reported increase in members' motivation levels suggested strengthening of the meaningfulness component of the SOC through the reported positive changes consistent with the four crucial areas impacting meaningfulness.

The last conclusion of the article was that based on the self-confidence members gain at the Clubhouse; they develop a critical view of other mental health services and society and voiced criticisms. Regarding mental health services, for example, participants pointed out the lack of opportunity to impact their care/therapy. Furthermore, concerning society, their primary issue was stigmatization and the lack of suitable solutions to overcome the difficulties caused by mental illness in the labour market. Skriv også inn implikasjoner av funn fra hver av studiene.

7.3 A summary of the third article: Recovery at the Clubhouse: Challenge, responsibility and growing into a role

The study aimed to explore the personal subjective experiences of being in recovery in the Clubhouse context and understanding how participants experienced their social and vocational recovery processes to shed light on participants' preferences with their care. The qualitative study identified three themes concerning the subject matter: "Balancing unlimited support with meeting challenges", "Learning how to build new skills and roles in the community", and "Getting better through and for work".

Findings indicated that recovery in the Clubhouse context is a transformative experience of positive change in identity, social status, and occupation. The Clubhouse community and the extensive member rights within the Clubhouse programme were essential support systems in this transformation. However, staff and the permissiveness of the programme was also reported as possibly hindering development by not being challenging enough for a Clubhouse member to want to move on.

While, in line with the literature and the theory of Salutogenesis, the majority expressed having a regular, meaningful activity to be helpful in terms of recovery, not every participant aspired for employment. However, those aiming to work found participation at the Clubhouse to improve their work readiness and improve specific job skills.

Furthermore, participants reported the necessity of taking responsibility for their own recovery process, self-agency, and self-determination. While those in better health status could successfully apply these skills for their own benefit, it was noted that someone with a poorer mental health status might not succeed. In addition, the willingness and agency of taking one's rehabilitation in one's own hands, suggest a need and willingness of some people with mental illness, mostly those advanced in their recovery processes, to be involved and actively participate in their care and/or therapy. Considering this insight and the occasional occurrence of overprotectiveness, it is suggested for the Clubhouse programme to ensure the seamless inclusion of people of all states of health into the community.

8. DISCUSSION AND CONCLUSION

This project's overall aim was to gain a better understanding of how members experience their social and vocational recovery in the Clubhouse community in a Norwegian context. Furthermore, to develop salutogenesis as a theoretical framework that might shed light on the results of this and other projects. However, by summarizing the results of the three separate studies, the distinct overall topics that emerge are "Transformation of identity as a health-promoting factor for Clubhouse members", "Salutogenic role development in the Clubhouse community", and "Challenge: a missed opportunity in the Clubhouse context?"

8.1 Transformation of identity as a health-promoting factor for Clubhouse members

This project revealed that developing the senses of belonging and self-worth in the Clubhouse community that participants reported in this project can be understood as the core social phenomena expressing the positive transformations of identity (article 2). Parallelly, article 1 of this project suggested that transformation of identity in the context of the Clubhouse programme can be understood as an improvement in the strength of the SOC (article 1).

Notably, positive transformation of identity is a crucial dimension of recovery by all accounts (Antonovsky, 1987a; Deegan, 1988; Langeland & Vinje, 2016; Leamy et al., 2011; Magrin et al., 2006; Tew et al., 2011). Experiences of participants of this project (article 2), as well as previous studies (Deegan, 1988; Langeland & Vinje, 2013, 2016; Langeland et al., 2007; Leamy et al., 2011; Magrin et al., 2006), suggested that this positive transformation contributes to the development of a salutogenic, or health-promoting, sense of 'personhood' as opposed to 'patienthood'. The latter is based on an illness and weaknesses focus, while the former focuses on one's aspirations and strengths that may help the individual achieve their goals, thus promoting well-being.

Transformation to a sense of 'personhood' can be relevant from several perspectives, such as helping to promote empowerment, counteracting self-stigma, and furthering

social inclusion. Regarding empowerment, participants of this project reported that one of the positive factors of the Clubhouse programme was that it had a positive attitude of focusing on and acknowledging a person's strengths (articles 2 and 3). Arguably, such attitude promotes empowerment, which can be further exacerbated by allowing the person the possibility to exercise influence through participating in egalitarian social structures (Griffiths, 2009; Langeland & Vinje, 2016; Leamy et al., 2011; Tew et al., 2011; van Weeghel et al., 2019; Whitley & Drake, 2010).

Furthermore, counteracting self-stigma, what may be understood as "maladaptive self-statements or cognitive schemas that have developed largely as a result of socialization, whereby a person first learns mental illness prejudice and subsequently internalizes it when he or she is labelled" (Corrigan et al., 2008, p. 402) was found to be central to the Clubhouse programme (article 1 and 2). Corrigan et al. (2008) argue that the most effective way of fighting self-stigma is challenging one's negative beliefs of oneself, experiencing to be accepted in the community, and reinforcing positive emotions towards oneself. Therefore, the experience of, as a participant in this project put it "being not alone in being imperfect" (article 2), or not standing out as a lone person with a mental illness in a community, can counteract stigmatization (Langeland et al., 2016; Langeland & Vinje, 2013, 2016; Langeland et al., 2007).

Furthermore, 'personhood' can also promote social inclusion by reducing stigma, an oft-discussed topic in recovery literature (Corrigan & Watson, 2002; Davidson et al., 2005; Langeland & Vinje, 2016; Leamy et al., 2011; Pernice et al., 2017; Tew et al., 2011). On a societal level, fighting stigma requires large scale movements, advocacy, and education (Corrigan et al., 2008), which mostly fall outside the reach of the Clubhouse programme, even though Clubhouses supposed to facilitate good relationships on the local community level (Clubhouse International, 2018). Still, participants in this project reported an experience of increased social inclusion (articles 2 and 3) ostensibly owing to their increased self-esteem and thus becoming capable of defining their place in the World and set goals for themselves (Corrigan et al., 2008; Griffiths, 2009; Langeland & Vinje, 2013, 2016; Langeland et al., 2007; Magrin et al., 2006; Tew et al., 2011).

As to how identity develops, Davis et al. (2019, p. 257) claim that social structures, social situations, and social networks are integral to identity processes. Group cohesion, emotional attachment, and solidarity are critical to identity formation and maintenance, and identities consolidate through a commitment to networks and relationships (Langeland & Vinje, 2016; Vinje et al., 2016); which can be understood as a sense of belonging, a social factor which promotes recovery from several aspects which was one of the most pervasive experiences reported by participants (article 2).

Belonging to a group is an essential tool for strengthening the SOC, as "Shared values, a sense of group identification and clear normative expectations, lead to an ambience of consistency (Antonovsky, 1987a, p. 164)." In this approach, the sense of belonging to the Clubhouse community supports the dimension of comprehensibility, as it provides a dependable environment (article 1).

In addition, participation in the Clubhouse programme was shown to be helpful in terms of the other dimensions of the SOC as well. For instance, participants talked about the supportive relationships of a Clubhouse community (article 2), which arguably strengthen manageability because belonging to a close-knit group helps people to be more resilient towards adverse experiences and empower themselves (Langeland & Vinje, 2016; Vaandrager & Kennedy, 2017).

Furthermore, when people experience loneliness with few interpersonal interactions, an affective and emotional under-stimulation occurs, which is detrimental to a person's sense of meaningfulness (Idan et al., 2016; Landsverk & Kane, 1998). Thus, participants' experience of moving away from their state of loneliness due to becoming a Clubhouse member (article 2) might enhance their sense of meaningfulness.

8.2 Salutogenic role development in the Clubhouse community

Findings of this project underlined the multiple functions of work in Clubhouse members' lives and reflected a dynamic interplay between work as a means for social

role development and developing a worker role resulting from working at the Clubhouse (article 3). Positive role development is an important goal in psychosocial rehabilitation (Anthony, 1993; Farkas & Anthony, 2010). Furthermore, developing a worker role is a significant functional dimension of recovery (Whitley & Drake, 2010) and arguably the most valued objective in the Clubhouse context (Clubhouse International, 2018; Fontenehus Norge, 2019; Kennedy-Jones et al., 2005; Norman, 2006). Work provides meaningful regular occupation, opportunities to experience mastery, promotes independence by allowing to provide for oneself and an essential arena for building relationships (Antonovsky, 1987a; Corrigan et al., 2008; Kinn et al., 2014; Kinn et al., 2011; Langeland & Vinje, 2016). In addition, obtaining work promotes social inclusion, as the worker role is valued in society (Corrigan et al., 2008; Farkas & Anthony, 2010; Farkas et al., 2007).

In general, as a means to define one's place in the World, role clarity is an important building block of comprehensibility. In addition, it also enhances a person's sense of meaningfulness because it is an investment in existential issues, a crucial area of life (Antonovsky, 1987a, 1987b). Moreover, through the successful completion of steps leading towards one's new role as a worker, the person might experience mastery, enhancing their component of manageability, and acquiring new skills on this journey contributes to the development of the person's pool of available GRRs (article 1).

Besides preparing oneself for the labour market by developing a worker role and gaining skills relevant to possible future employment, the results in article 3 clearly show that work is also an important means to recovery. As reported by several studies (Hancock et al., 2013; Pernice-Duca & Onaga, 2009; Tanaka & Davidson, 2015b), participants of this project talked about an uplifting experience of being needed as an able contributor to the community (articles 2 and 3). In addition, according to the findings presented in articles 1 and 3 and by previous studies, doing meaningful work for the Clubhouse also contribute to strengthening members' self-confidence by experiencing mastery and being needed (Norman, 2006; Tanaka & Davidson, 2015a). Furthermore, the work-ordered day, which provides the framework for carrying out tasks, was also reported by this (article 3) and other projects (Magaw, 2003; Norman,

2006; Tanaka & Davidson, 2015a), also help with structuring member's lives, thus contributing to strengthening the sense of comprehensibility (Antonovsky, 1987a).

The work-ordered day was also found to be an arena to build relationships both by this project (articles 2 and 3) and previous research (Norman, 2006; Pernice et al., 2021; Tanaka & Davidson, 2015a). Indeed, already in the early stages of the programme, it was emphasized that "relationships within the Clubhouse are mediated by the work at hand, and as such are real and concrete. By sharing tasks, achieving results, and dealing with failures, members and staff develop friendship, respect, and mutual confidence" (Propst, 1997, p. 56). As a result, participants of this (article 3) and other projects reported that the relationships they developed went beyond their previous experiences of being passive recipients in social interactions, but rather have an equal footing and reciprocal connection in their relationships (Pernice-Duca & Onaga, 2009; Tanaka & Davidson, 2015b).

Some participants in this project who expressed a desire to obtain employment seemed to have a clear plan regarding using the Clubhouse and suggested that own initiative and the ability to make one's own decisions is a prerequisite of recovery in the Clubhouse context (article 3). Arguably, such a proactive attitude might lead to an elevated sense of empowerment and authority, that previous research has identified as a result of Clubhouse participation (Raeburn et al., 2016; Rouse et al., 2017; Tanaka et al., 2018) and might strengthen the sense of manageability (Antonovsky, 1979; 1987b, Langeland & Vinje, 2016).

In addition, being able to make one's own choices and finding joy in one's work can enhance the sense of meaningfulness (Antonovsky, 1987a), which was clearly the case with participants in this project who found contentment in being able to contribute to their beloved community by means they voluntarily chose (article 3). Indeed, the present project (article 3) and previous research suggested the decision-making power Clubhouse members had over their lives, the higher their measured Quality of Life scores were (Boyd & Bentley, 2006), and self-determination enhanced their recovery process (Raeburn et al., 2015).

Notably, members' experience with the Clubhouse community is sensitive to their relationship with staff (article 2) because perceived patronizing behaviour from staff and disturbing the egalitarian structure of the community can lead to feelings of dissatisfaction and being thwarted. Interestingly, Antonovsky (1987a) highlights factors promoting meaningfulness, that appropriate hierarchy, in which roles are allocated based on functional performance, is a prerequisite for solidarity and cohesion of the work group. Notably, this can clarify why imbalanced hierarchy between staff and members and perceived paternalism from staff disrupts the community based on working side-by-side as equals, as shown in this and previous projects (See, for example, Roth, 2017; Pernice et al., 2021).

8.3 Challenge: a missed opportunity in the Clubhouse context?

Salutogenic stress is a crucial issue in terms of personal growth and is closely related to the notion of underload-overload balance of stimuli (Antonovsky, 1987a; 1987b; Idan et al., 2016), meaning that to lead to positive outcomes or growth, a challenge can neither be too difficult nor too easy (Langeland & Vinje, 2016; Magrin et al., 2006). In the state of underload, one's meaningfulness is affected, as the person will not be motivated to deal with the stimuli they encounter. However, in the case of the state of overload, it is too difficult to deal with the issue; thus, one's sense of manageability erodes (Antonovsky, 1987a; 1987b; Idan et al. 2016). However, health-promoting or salutogenic stress offers an appropriate amount of challenge and can be understood as the 'salt of life' (Magrin et al., 2006) because it can provide one with an experience of mastery by being able to rise to it (Langeland & Vinje, 2016; Magrin et al., 2006; Vinje et al., 2016).

Participants in this project (article 3) reported several relatable issues to the concept of underload-overload of stimuli. One of these was participants' concerns (article 3) for slowing their recovery process by "becoming too comfortable" in the Clubhouse community owing to the unlimited lifelong membership and the comfort of the

Clubhouse community, echoed by previous research as well (Kinn, Tanaka, et al., 2018; Raeburn et al., 2013).

Furthermore, participants in this (article 3) and other projects (See, for example, Norman, 2006; Pernice et al., 2021; Tanaka & Davidson, 2015a) underlined the importance that tasks should be available in a variety of areas, as jobs which they found boring, without an opportunity to grow or unnecessary, had a demotivating effect on them, sometimes even kept them away from the Clubhouse in periods. Such unchallenging tasks would clearly tilt the balance towards underload, which can also be exacerbated by the occasionally patronizing and overprotective behaviour of staff, a notion echoed in all of the articles of this project and the previous literature (See, for example, Kinn, Tanaka, et al., 2018; Schiff et al., 2008).

Notably, Clubhouse members with a reduced capacity due to their poor mental health status might not be able to be proactive and exercise high levels of independent action, might therefore experience overload, weakening their sense of meaningfulness and manageability, thus hindering their process of recovery (Antonovsky, 1987a; Corrigan et al., 2008; Kinn et al., 2014; Kinn et al., 2011; Langeland & Vinje, 2016). Therefore, as participants emphasized (article 3), the available tasks should cater to members' fluctuating mental health status and the needs of individuals who have a reduced work capacity (articles 2 and 3).

8.4 Methodological considerations and study limitations

This project could not have been carried out otherwise than in a qualitative design, as it aimed to understand human experience by asking explorative questions about phenomena as they occur in context (Carter & Little, 2007). Accordingly, the research questions were developed such that they aimed to explore subjective personal experiences and perceptions rather than objective facts.

Owing to its design, the scientific quality of this project can be evaluated by assessing it in terms of the dimensions of credibility, transferability, and reflexivity (Cope, 2014; Seale, 1999). Reflexivity, as an aspect crucial to a hermeneutic-phenomenological

study, was discussed earlier in this thesis. The next dimension to consider is credibility, which “refers to the truth of the data or the participant views and the interpretation and representation of them by the researcher” (Cope, 2014, p. 89). In other words, credibility aims to determine whether the findings of a study are well presented and meaningful, and the procedures used during the study followed scientific rigour (Malterud, 2001). In terms of credibility in this project, all decisive actions during the research process, such as project development, data collection methodology, data analysis and publication, were conducted in a research group setting to ensure that several different perspectives were considered. Relevant ethical permissions were obtained and followed in conducting the study. Furthermore, all data collection and analysis procedures were recorded and available for further study, including the original data source.

Next, transferability deals with whether a study is valid and/or relevant in a broader context or whether it can be applied to other settings and groups (Cope, 2014; Seale, 1999). This project bears the subjective nature of social constructivist qualitative studies. However, with its focus on people's personal experiences with mental illness with a service they attain voluntarily, it can be understood as a form of service-user experience investigation, thus informing other studies of a similar nature. Furthermore, informants provided reports on their experiences with mental health, social status, networks and employment status, among other things, which may serve as comparable information to other studies exploring the experiences of people with mental illness. Moreover, this study complements existing information in research on the Clubhouse programme, especially in terms of the much called for non-US studies. Still, in line with its qualitative nature, findings of these studies are only applicable fully in their contexts and settings, and other researchers might have reached different conclusions, despite efforts taken in this project to ensure transparency of procedure (Fossey et al., 2002).

Finally, turning to the limitations of this research project, it must be recognized that all informants were active members who voluntarily participate in their Clubhouse communities. Therefore, it is safe to assume that they would have an overall positive

attitude towards the Clubhouse programme, which were reflected in the results. In addition, although the theoretical analysis generated promising results, many of which were echoed in previous research, they cannot be considered general truths, and further empirical elaboration of them is encouraged.

8.5 Recommendations for practice

The deliberate application of salutogenic challenge in the Clubhouse programme is recommended to further members' recovery, as no such provisions were found in the Clubhouse Standards (article 1). It is arguably difficult to introduce such an element into a programme based on voluntary participation and self-determination; still, there are possible solutions, some of them already having traces in the standards.

For example, while §18 of the Standards (Clubhouse International, 2018) prescribe that Clubhouses must have "meaningful work to sustain a full and engaging work-ordered day", informants from all participating Clubhouses reported a lack of stimulating tasks thwarting their process of recovery. Therefore, an explicit commitment to provide a variety of stimulating enough yet accessible tasks is recommended based on a routine assessment of the available Clubhouse activities.

In addition, the standards include providing support in multiple areas for members. However, a systematic, individual recovery planning opportunity is missing. In line with the principles of the Clubhouse programme, such an opportunity should ostensibly be voluntary. In addition, it should support the individual member to achieve their selected recovery goals and provide a routine follow-up and assessment of progress.

8.6 Recommendations for further research

The high consistency between the results of this and previous projects suggests that the Clubhouse programme might work similarly across nations and cultures. Notably, this is only a suggestion and should be further tested, possibly with the involvement of several more countries.

Furthermore, exploring Clubhouse members' recovery processes in light of salutogenesis in this project showed promising initial results but need further investigation. For example, considering the different Clubhouse interventions and opportunities as GRRs and exploring which one of these contribute to which one of the dimensions of the SOC can lead to a better understanding of how the Clubhouse programme and other psychosocial rehabilitation interventions achieve their outcomes.

Finally, there is a relatively small amount of literature concerning salutogenesis associated with mental health care, even though, based on this project, it could lead to relevant results. Therefore, further research on the issue of the relationship between salutogenesis and mental health care is recommended.

8.7 Conclusion

In summary, the Clubhouse programme promotes members' recovery processes. Through social opportunities and work activities, the Clubhouse programme helps to strengthen members' SOC by supporting them in rebuilding their self-confidence, providing a safe and predictable environment, offering support, and giving opportunities to broaden their skillset. In addition, the interventions within the Clubhouse programme might provide members with GRRs.

Therefore, the findings of this project suggest that salutogenesis might help make sense of the mechanisms behind recovery at the Clubhouse: in identifying them based on the available member narratives and examining their relationship to the different dimensions of the SOC concept.

In addition to increasing knowledge on the experiences of Clubhouse members in a Norwegian context, the most significant contribution of this project is the recognition that the idea of appropriate challenge as a guiding principle is missing from the literature describing recovery-oriented and psychosocial rehabilitation services, including the Clubhouse programme. Salutogenesis literature clearly shows that tackling appropriate challenges strengthen people's sense of meaningfulness, thus provide motivation for further growth. Therefore, a greater focus on the challenge

concept within the Clubhouse programme, as well as in recovery-oriented and psychosocial rehabilitation practice and research, would also give an opportunity to notice and identify barriers for a person's recovery and modify the course intervention accordingly.

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APPENDIX 1A: ORIGINAL INFORMATION LETTER

Forespørsel om deltakelse i forskningsprosjektet:
Erfaringer som klubbhusmedlem: kvalitative studier i en norsk kontekst

Det er forsket en del på fontenehus-/klubbhusmodellen internasjonalt, men det trengs mer kunnskap om hvordan medlemmer erfarer klubbhusfellesskapet, særlig i en norsk kontekst. Det overordnede målet med dette PhD- prosjekt ved Høgskulen på Vestlandet er å bidra til økt forståelse av hvordan norske medlemmer erfarer nytten av å delta i klubbhusaktiviteter og samarbeide med andre i et klubbhusfellesskap.

Vi vil invitere opptil 20 medlemmer fra flere norske klubbhus til å delta i denne studien. For å belyse forskningsspørsmålene fra flest mulige sider, er det ønskelig at både menn og kvinner i ulike aldre deltar, og at det er variasjon når det gjelder varighet av medlemskapet (minimum seks måneders) i akkrediterte norske klubbhus.

Vi ønsker å forespørre deg om å delta i et intervju. Spørsmålene vil ta utgangspunkt i en intervjuguide, og det er stipendiat Orsi Fekte som skal gjennomføre alle intervjuene. Hvert intervju vil vare cirka 60 – 90 minutter. Det er ønskelig at intervjusituasjonen finner sted i et av klubbhusets skjermede lokaler. Formålet med intervjuet er å utforske hvordan du som informant opplever; (1) å være medlem, og hvordan klubbhus felleskapet kan ha bidratt til; (2) egne tilfriskningsprosesser når det gjelder å delta sosialt og muligheter for arbeidsdeltakelse, og 3) personlig utvikling. Intervjuene skal tas opp på lydbånd, og intervjueren vil eventuelt gjøre notater underveis. I tillegg til intervjuene skal det samles inn følgende opplysninger for hver enkel informant: (1) fornavn, (2) kjønn, (3) alder, (4) varighet av medlemskap og (5) eventuell kontaktinformasjon (telefonnummer eller/og epostadresse). Du trenger ikke forberede deg til intervjuet –det er dine personlige erfaringer som klubbhus medlem som vil være i fokus.

Alle opplysninger vil bli behandlet konfidensielt. Det er kun PhD-kandidaten og veilederen skal ha tilgang til opplysninger / opptak i forbindelse med studien. Deltakernes navneliste og kontaktinformasjon skal lagres adskilt fra øvrige data for å ivareta konfidensialitet og vil slettes ved prosjektslutt.

Etter analyseperioden av prosjektet kan deltakerne kontaktes for å validere tolkningene / resultatene av analysen. Prosjektet skal etter planen avsluttes den 31.08.2020. Datamaterialet skal anonymiseres ved prosjektslutt og lagres digitalt ved serverne av Høgskulen på Vestlandet.

Det er frivillig å delta i studien, og du kan når som helst trekke ditt samtykke uten å oppgi noen grunn. Dersom du trekker deg, vil alle opplysninger om deg bli slettet.

Dersom du ønsker å delta eller har spørsmål til studien, ta kontakt med:

Orsi Fekete

Doktorgradsstipendiat ved Høgskulen på Vestlandet

Telefon: 92 52 90 78

E-post: orsolya.reka.fekete@hvl.no

Eller daglig lederen på ditt fontenehus.

Studien har fått unntak fra REK godkjenning og den er godkjent av NSD.

Samtykke til deltakelse i studien

Jeg har mottatt informasjon om studien, og er villig til å delta i prosjektet «Erfaringer som klubbhusmedlem: kvalitative studier i en norsk kontekst»

(Signert av prosjektdeltaker, dato)

APPENDIX 1B: ENGLISH TRANSLATION OF THE ORIGINAL INFORMATION LETTER

Request to participate in the project "What is it like to be a Clubhouse member: qualitative studies in a Norwegian context."

There has been some research on the fountain house / Clubhouse model internationally, but more knowledge is needed about how members experience the clubhouse community, especially in a Norwegian context. The overall goal of this PhD project at Høgskulen på Vestlandet is to contribute to a better understanding of how Norwegian Clubhouse members experience the benefits of participating in Clubhouse activities and collaborating with others in a clubhouse community.

Up to 20 members from several Norwegian Clubhouses will be invited to participate in this study. In order to shed light on the research questions from as many sides as possible, it is desirable that both men and women of different ages participate and that there is variation in terms of duration of membership (minimum six months) in accredited Norwegian clubhouses.

We would like to ask you to participate in an interview. The questions will be based on an interview guide, and it is research fellow Orsi Fekte who will conduct all the interviews. Each interview will last approximately 60 - 90 minutes. The interview situation should take place in one of the Clubhouse's sheltered premises. The purpose of the interview is to explore how you, as an informant, experience; (1) being a member, and how the Clubhouse community may have contributed to; (2) own recovery processes in terms of social participation and opportunities for work participation, and 3) personal development. The interviews will be audio-recorded, and the interviewer will possibly make notes along the way. In addition to the interviews, the following information must be collected for each informant: (1) first name, (2) gender, (3) age, (4) duration of membership and (5) any contact information (telephone number and/or email address). You do not need to prepare for the interview - it is your personal experiences as a Clubhouse member, that will be in focus.

All information will be treated confidentially. Only the PhD candidate and the supervisor will have access to information in connection with the study. The participants' names and contact information will be stored separately from other data to ensure confidentiality and will be deleted at the end of the project.

After the analysis period of the project, the participants can be contacted to validate the interpretations/results of the analysis. The project is scheduled to end on 31.08.2020. The interview material will be anonymised at the end of the project and stored digitally at the servers of Høgskulen på Vestlandet.

Participation in the study is voluntary, and you can withdraw your consent at any time without giving any reason. If you withdraw, all information about you will be deleted.

If you want to participate or have questions about the study, please contact:

Orsi Fekete
Doctoral fellow at Høgskulen på Vestlandet
Phone: 92 52 90 78
Email: orsolya.reka.fekete@hvl.no

Or the director of your Clubhouse.

The study has been granted an exemption from REK approval, and it has been approved by NSD.

Consent to participate in the study:

I have received information about the study, and I am willing to participate in the project "What is it like to be a Clubhouse member: qualitative studies in a Norwegian context."

(Signed by project participant, date)

APPENDIX 2A: INTERVIEW GUIDE IN NORWEGIAN

Navn: Alder: Lengde av medlemskap:

1. Kan du fortelle meg litt om bakgrunnen for at du ble fontenehusmedlem?

2. Kan du beskrive så detaljert som mulig hvordan det var å komme hit i begynnelsen?

3. Har fontenehus-medlemskapet forandret måten du oppfatter deg selv på? Kan du utdype dette / kan du si noe mer om dette?

4. Hvordan er det å delta i ulike aktiviteter sammen med andre på fontenehuset?

5. Hva slags erfaring har du med å jobbe «side om side» på fontenehuset?

6. Hva opplever du som hjelpsomt når det gjelder å komme seg ved fontenehuset?

7. Kan du fortelle meg om hvordan er det å delta på den arbeidsorienterte dagen?

8. Hvilke aktiviteter på fontenehuset mener du kunne være nyttig for å gå ut i arbeidslivet?

9. Er det noe som du opplever som ikke så bra ved fontenehuset?

10. Har du noe mål som du har fokus på i bedringsprosessen din?

11. Hva slags hjelp har du fått på fontenehuset til å nå disse målene?

12. Hvordan har ditt liv endret seg siden du begynte på fontenehuset?

13. Hva slags betydning har det for deg å delta i fontenehus-fellesskapet?

Mulige oppfølgings- og spesifiserende spørsmål inkluderer, men ikke er begrenset til:

- Kan du fortelle meg litt mer om ….?

- Kan du tenke om en konkret situasjon når …?
- Har du flere eksempler på …?
- Kan du utdype mer om ….?

Mulige fortolkende spørsmål i disse tilfeller innebærer, men ikke er begrenset til:

- Er det riktig å si at ….?
- Du mener altså at ….?

Mulige strukturerende spørsmål til å vende tilbake til intervjuets originale retning og/eller videreføre intervjuet til ett nytt emne:

- Jeg vil nå gjerne få ta opp et nytt emne ….
- Vi skal vende oss tilbake til ….

APPENDIX 2B: ENGLISH TRANSLATION OF THE INTERVIEW GUIDE

Name: Age: Length of membership:

1. Can you tell me a little about the reason why you became a Clubhouse member?

2. Can you describe in as much detail as possible what it was like to come here in the beginning?

3. Has the Clubhouse membership changed the way you perceive yourself? Can you elaborate on this / can you say something more about this?

4. What is it like to participate in various activities with others at the Clubhouse?

5. What kind of experience do you have with working "side by side" in the Clubhouse?

6. What do you find helpful when it comes to recovery at the Clubhouse?

7. Can you tell me about what it is like to participate in the work-ordered day?

8. What activities at the Clubhouse do you think could help enter working life?

9. Is there anything that you experience that is not so good at the Clubhouse?

10. Do you have any goals that you focus on in your improvement process?

11. What kind of help have you received at the Clubhouse to reach these goals?

12. How has your life changed since you started at the Clubhouse?

13. What does it mean for you to participate in the fountain house community?

Possible follow-up and specifying questions include, but are not limited to:

- Can you tell me a little more about….?

- Can you think of a specific situation when…?

- Do you have more examples of…?

- Can you elaborate more on….?

Possible interpretive questions include, but are not limited to:

- Is it correct to say that….?

- So you mean that….?

Possible structuring questions to return to the original direction of the interview and/or continue the interview to a new topic:

- I would now like to take up a new topic….

- We will return to….

APPENDIX 3A: EXEMPTION FROM REK CONSENT LETTER, ORIGINAL

REK
REGIONALE KOMITEER FOR MEDISINSK OG HELSEFAGLIG FORSKNINGSETIKK

Region:	Saksbehandler:	Telefon:	Vår dato:	Vår referanse:
REK sør-øst	Tove Irene Klokk	22845522	05.04.2017	2017/442/REK sør-øst A
			Deres dato:	Deres referanse:
			14.02.2017	

Vår referanse må oppgis ved alle henvendelser

Orsolya Réka Fekete
Avdeling for Helse- og Sosialfag

2017/442 Erfaringer som klubbhusmedlem: kvalitative studier i en norsk kontekst

Forskningsansvarlig: Høgskulen på Vestlandet
Prosjektleder: Orsolya Réka Fekete

Vi viser til søknad om forhåndsgodkjenning av ovennevnte forskningsprosjekt. Søknaden ble behandlet av Regional komité for medisinsk og helsefaglig forskningsetikk (REK sør-øst) i møtet 23.03.2017. Vurderingen er gjort med hjemmel i helseforskningsloven § 10, jf. forskningsetikkloven § 4.

Prosjektomtale (revidert av REK)

Formålet med prosjektet er å øke forståelsen av hvilken nytte norske klubbhusmedlemmer opplever av å være medlem ved klubbhus/fontenehus, og hvordan klubbhusfelleskapet har bidratt til tilfriskningsprosessen.

Klubbhus (fontenehus)-modellen er et psykososialt rehabiliteringstiltak for personer med psykiske helseproblemer. Klubbhusene drives etter en internasjonal modell, med 350 klubbhus i verden og 10 i Norge. Flere studier av modellen har blitt gjennomført internasjonalt, men det trengs mer kunnskap fra medlemmenes perspektiv, særlig i en norsk kontekst. Dette prosjektet skal bidra til økt forståelse av hvordan norske klubbhus-medlemmer erfarer nytten av klubbhusmodellen ved 1) å være medlem; og hvordan klubbhusfelleskapet har bidratt til 2) tilfriskningsprosesser når det gjelder å delta sosialt og komme seg i arbeid, og 3) til personlig utvikling. En hermeneutisk fenomenologisk tilnærming vil bli anvendt. Studien kan bidra til økt kunnskap om hvordan den daglige praksisen i et klubbhus kan være nyttig for å fremme medlemmers muligheter for økt deltagelse i samfunns- og arbeidsliv.

20 frivillige personer, fra to norske klubbhus, som har vært medlem av norske fontenehus i minst 6 måneder skal rekrutteres til prosjektet. Disse skal da delta i halvstrukturerte dybdeintervju.

Vurdering

Slik komiteen forstår prosjektet, har det som formål å undersøke medlemmers egne erfaringer med det å være medlem av klubbhus (fontenehus) i Norge, og hvordan et slikt medlemskap har bidratt i tilfriskningsprosessen. Det skal ikke samles inn biologisk materiale eller helseopplysninger.

Etter en helhetsvurdering har komiteen av disse grunner kommet til at prosjektet ikke faller inn under helseforskningslovens virkeområde, da det ikke anses som medisinsk og helsefaglig forskning.

Hva som er medisinsk og helsefaglig forskning fremgår av helseforskningsloven § 4 a. Medisinsk og

Besøksadresse:
Gullhaugveien 1-3, 0484 Oslo

Telefon: 22845511
E-post: post@helseforskning.etikkom.no
Web: http://helseforskning.etikkom.no/

helsefaglig forskning er der definert slik: «virksomhet som utføres med vitenskapelig metodikk for å skaffe til veie ny kunnskap om helse og sykdom».

Prosjekter som faller utenfor helseforskningslovens virkeområde kan gjennomføres uten godkjenning av REK. Det er institusjonens ansvar å sørge for at prosjektet gjennomføres på en forsvarlig måte med hensyn til for eksempel regler for taushetsplikt og personvern.

Vedtak

Prosjektet faller utenfor helseforskningslovens virkeområde, jf. § 2, og kan derfor gjennomføres uten godkjenning av REK.

Klageadgang

Komiteens vedtak kan påklages til Den nasjonale forskningsetiske komité for medisin og helsefag, jf. helseforskningsloven § 10, 3 ledd og forvaltningsloven § 28. En eventuell klage sendes til REK Sørøst A. Klagefristen er tre uker fra mottak av dette brevet, jf. forvaltningsloven § 29.

Med vennlig hilsen

Knut Engedal
Professor dr. med.
Leder

Tove Irene Klokk
Rådgiver

Kopi til: orsolya.reka.fekete@hvl.no, Høgskolen i Bergen ved øverste administrative ledelse: post@hib.no

APPENDIX 3B: ENGLISH TRANSLATION OF THE EXEMPTION FROM REK CONSENT LETTER

2017/442 What is it like to be a Clubhouse member: qualitative studies in a Norwegian context

Responsible for research: Høgskulen på Vestlandet

Project leader: Orsolya Réka Fekete

We refer to the application for prior approval of the above research project. The application was processed by the Regional committee for medical and health research ethics (REK south-east) on the meeting on 23.03.2017. The assessment was made on the basis of the Health Research Act § 10, cf. the Research Ethics Act § 4.

Project review (revised by REK)

The purpose of the project is to increase the understanding of what benefit Norwegian clubhouse members experience from being a member of the clubhouse / fountain house, and how the clubhouse community has contributed to the recovery process.

The clubhouse (fountain house) model is a psychosocial rehabilitation measure for people with mental health problems. The clubhouses are run according to an international model, with 350 clubhouses in the World and 10 in Norway. Several studies of the model have been conducted internationally, but more knowledge is needed from members' perspective, especially in a Norwegian context.

This project will contribute to a better understanding of how Norwegian clubhouse members experience the benefits of the clubhouse model by 1) being a member; and how the clubhouse community has contributed to 2) recovery processes when it comes to participating socially and recovering work, and 3) for personal development.

A hermeneutic phenomenological approach will be used. The study can contribute to increased knowledge about how the daily practice in a clubhouse can be useful to

promote members' opportunities for increased participation in society and working life.

20 volunteers, from two Norwegian clubhouses, who have been members of Norwegian fountain houses for at least 6 months to be recruited to the project. These will then participate in semi-structured in-depth interviews.

Assessment

The way the committee understands the project, its purpose is to examine members' own experiences with being a member of a clubhouse (fountain house) in Norway, and how such a membership has contributed to the recovery process. Biological material or health information shall not be collected.

After an overall assessment, the committee has for these reasons come to the conclusion that the project does not fall under the scope of the Health Research Act, as it is not considered medical and health research. What is medical and health professional research is stated in the Health Research Act § 4 a. Medical and health research is defined as follows: “activities that are carried out with scientific methodology to obtain to bring new knowledge about health and disease.”

Projects that fall outside the scope of the Health Research Act can be carried out without approval of REK. It is the institution's responsibility to ensure that the project is carried out in a responsible manner with regard to to, for example, rules for confidentiality and privacy.

Decision

The project falls outside the scope of the Health Research Act, cf. section 2, and can therefore be carried out without approval of REK.

Right of appeal

The committee's decision can be appealed to the National Research Ethics Committee for Medicine and Health Sciences, cf. the Health Research Act § 10, 3 paragraphs and the Public Administration Act § 28. A possible complaint is sent to REK Sørøst.

The deadline for complaints is three weeks from receipt of this letter, cf. the Public Administration Act § 29.

With best regards

Knut Engedal

Professor Dr. med.

Leader

Tove Irene Klokk

Adviser

APPENDIX 4A: ORIGINAL LETTER OF THE NORWEGIAN CENTER FOR RESEARCH DATA REGARDING DATA MANAGEMENT IN THE PROJECT

Orsolya Reka Fekete
Institutt for sosialfag og vernepleie Høgskolen i Bergen
Postboks 7030
5020 BERGEN

Vår dato: 06.04.2017 Vår ref: 52736 / 3 / HIT Deres dato: Deres ref:

TILBAKEMELDING PÅ MELDING OM BEHANDLING AV PERSONOPPLYSNINGER

Vi viser til melding om behandling av personopplysninger, mottatt 02.02.2017. All nødvendig informasjon om prosjektet forelå i sin helhet 05.04.2017. Meldingen gjelder prosjektet:

52736	*Erfaringer som klubbhusmedlem: kvalitative studier i en norsk kontekst*
Behandlingsansvarlig	*Høgskulen på Vestlandet, ved institusjonens øverste leder*
Daglig ansvarlig	*Orsolya Reka Fekete*

Personvernombudet har vurdert prosjektet, og finner at behandlingen av personopplysninger vil være regulert av § 7-27 i personopplysningsforskriften. Personvernombudet tilrår at prosjektet gjennomføres.

Personvernombudets tilråding forutsetter at prosjektet gjennomføres i tråd med opplysningene gitt i meldeskjemaet, korrespondanse med ombudet, ombudets kommentarer samt personopplysningsloven og helseregisterloven med forskrifter. Behandlingen av personopplysninger kan settes i gang.

Det gjøres oppmerksom på at det skal gis ny melding dersom behandlingen endres i forhold til de opplysninger som ligger til grunn for personvernombudets vurdering. Endringsmeldinger gis via et eget skjema, http://www.nsd.uib.no/personvernombud/meld_prosjekt/meld_endringer.html. Det skal også gis melding etter tre år dersom prosjektet fortsatt pågår. Meldinger skal skje skriftlig til ombudet.

Personvernombudet har lagt ut opplysninger om prosjektet i en offentlig database, http://pvo.nsd.no/prosjekt.

Personvernombudet vil ved prosjektets avslutning, 31.08.2020, rette en henvendelse angående status for behandlingen av personopplysninger.

Vennlig hilsen

Kjersti Haugstvedt

Hildur Thorarensen

Kontaktperson: Hildur Thorarensen tlf: 55 58 26 54
Vedlegg: Prosjektvurdering

Dokumentet er elektronisk produsert og godkjent ved NSDs rutiner for elektronisk godkjenning.

Personvernombudet for forskning

Prosjektvurdering - Kommentar

Prosjektnr: 52736

Prosjektet er vurdert av REK sør-øst (ref. 2017/442), som har vurdert det til å falle utenfor helseforskningslovens virkeområde.

FORMÅL
Formålet er beskrevet slik: Det overordnede målet med dette PhD- prosjekt er å bidra til økt forståelse av hvordan norske klubbhus-medlemmer erfarer nytten av klubbhusmodellen: Å utforske hvordan personer med psykiske helseproblemer opplever; 1) å være medlem, og hvordan klubbhus felleskapet har bidratt til; (2) hjelpsomme tilfriskningsprosesser når det gjelder å delta sosialt og komme seg i arbeid, og 3) til personlig utvikling..

INFORMASJON OG SAMTYKKE
Utvalget informeres skriftlig og muntlig om prosjektet og samtykker til deltakelse. Informasjonsskrivet er godt utformet, men setninge "Studien er meldt til REK" bør endres til at studien er meldt til personvernombudet for forskning ved NSD.

SENSITIVE OPPLYSNINGER
Det behandles sensitive personopplysninger om helseforhold.

INFORMASJONSSIKKERHET
Personvernombudet legger til grunn at forsker etterfølger Høgskulen på Vestlandet sine interne rutiner for datasikkerhet.

PROSJEKTSLUTT OG ANONYMISERING
Forventet prosjektslutt er 31.08.2020. Ifølge prosjektmeldingen skal innsamlede opplysninger da anonymiseres. Anonymisering innebærer å bearbeide datamaterialet slik at ingen enkeltpersoner kan gjenkjennes. Det gjøres ved å:
- slette direkte personopplysninger (som navn/koblingsnøkkel)
- slette/omskrive indirekte personopplysninger (identifiserende sammenstilling av bakgrunnsopplysninger som f.eks. bosted/arbeidssted, alder og kjønn)
- slette digitale lydopptak

APPENDIX 4B: ENGLISH TRANSLATION OF THE LETTER OF THE NORWEGIAN CENTER FOR RESEARCH DATA REGARDING DATA MANAGEMENT IN THE PROJECT

Orsolya Reka Fekete

Department of Health and Social Sciences, Bergen University College

PO Box 7030

5020 BERGEN

Our date: 06.04.2017 Our ref: 52736/3 / HIT

RESPONSE TO NOTIFICATION OF MANAGEMENT OF PERSONAL DATA

We refer to your notification of management of personal data, received 02.02.2017. All necessary information about the project was available in its entirety 05.04.2017. This response applies to the project:

52736 What is it like to be a Clubhouse member: qualitative studies in a Norwegian context

Responsible for overall data management: Western Norway University of Applied Sciences, highest leader

Responsible for project data management: Orsolya Reka Fekete

The Privacy Ombudsman has assessed the project and finds that the processing of personal data will be regulated by § 7-27 in the Personal Data Regulations. The privacy ombudsman recommends that the project is carried out.

The Privacy Ombudsman's recommendation presupposes that the project is carried out in accordance with the information provided in the notification form, correspondence with the ombudsman, the ombudsman's comments and the Personal Data Act and the Health Register Act with regulations. The processing of personal data can be started.

Please note that a new notification must be given if data management is changed in relation to the information on which the privacy ombudsman's assessment is based. Change notifications are submitted via its own form, at http://www.nsd.uib.no/personvernombud/meld_prosjekt/meld_endringer.html.

Notice should also be given after three years if the project is still ongoing. Notifications must be made in writing to the ombudsman.

The Privacy Ombudsman has posted information about the project in a public database, http://pvo.nsd.no/prosjekt.

At the end of the project, 31.08.2020, the Privacy Ombudsman will make an inquiry regarding status of the processing of personal data.

Sincerely

Kjersti Haugstvedt Hildur Thorarensen

Attachment: Project assessment

_____

Project assessment - Comment

Project no: 52736

The project has been assessed by REK south-east (ref. 2017/442), which has considered it to fall outside scope of the Health Research Act.

PURPOSE

The purpose is described as follows: The overall goal of this PhD project is to contribute to a greater understanding of how Norwegian clubhouse members experience the benefits of the clubhouse model: To explore how people with mental health problems; 1) experience to be a member, and how the clubhouse community has contributed to; (2) recovery processes when it comes to social and labor market participation, and 3) to personal development.

INFORMATION AND CONSENT

The committee is informed in writing and orally about the project and agrees to participate. The information letter is well designed, but the sentences "The study has been reported to REK" should be changed to that “the study has been reported to the privacy ombudsman for research at NSD”.

SENSITIVE INFORMATION

Sensitive personal information about health conditions is processed.

INFORMATION SECURITY

The Privacy Ombudsman assumes that the researcher follows Høgskulen på Vestlandet's internal routines for data security.

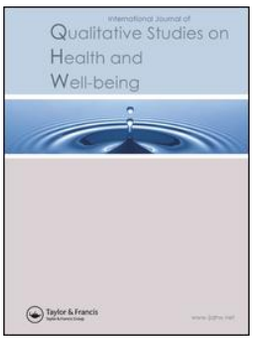
END OF PROJECT AND ANONYMZATION

Expected end of project is 31.08.2020. According to the project report, the information collected will then be anonymised. Anonymisation involves processing the data material so that no individuals can be recognized. It's done by:

- delete direct personal information (such as name / link key)

- delete / rewrite indirect personal information (identifying compilation of background information such as place of residence / place of work, age and sex)

- delete digital audio recordings



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Salutogenesis as a theoretical framework for psychosocial rehabilitation: the case of the Clubhouse model

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ABSTRACT

Purpose: This study explored whether the holistic theory of salutogenesis may be a suitable theoretical framework for the Clubhouse model of psychosocial rehabilitation, a pioneer among psychosocial rehabilitation programmes.

Methods: A systematic examination of elements of the Clubhouse model, as prescribed by the Clubhouse standards, was performed within the context of the theory of salutogenesis including its basic salutogenic orientation and the main concepts of sense of coherence and resistance resources.

Results: We found that several standards and practices within the Clubhouse model can be understood as applications of salutogenesis. We have hypothesized that the Clubhouse model promotes peoples' sense of coherence and mental health. However, our investigation also showed that, to enhance the recovery of Clubhouse members, more explicitly incorporating some salutogenic principles, such as "appropriate challenges" and "active adaptation as the ideal in treatment", may benefit Clubhouse practice.

Conclusions: The Clubhouse model of psychosocial rehabilitation is very consistent with the salutogenic orientation and main salutogenic concepts. The present study suggests that salutogenesis may be a suitable theoretical framework for the Clubhouse model and possibly in the psychosocial rehabilitation field in general.

ARTICLE HISTORY
Accepted 25 March 2020

KEYWORDS
Clubhouse model; mental health promotion; mental illness; psychosocial rehabilitation; salutogenesis

Introduction

The past two decades have seen major changes in the mental health-care field. For example, the World Health Organization (2013) introduced a new definition of mental illness, which acknowledged that it is a complex psychosocial issue beyond being a medical condition. In addition, recovery orientation has emerged as the mainstream policy in mental health care around the world (Anthony & Mizock, 2014; Davidson et al., 2007; Jacobson & Curtis, 2000; Pilgrim, 2008; Ramon et al., 2007; World Health Organization, 2013) as well as in Norway (Ministry of Labour & Ministry of Health and Care Services., 2013; Norwegian Directorate of Social Services and Health, 2005). Community-based psychosocial rehabilitation (PSR) services have become increasingly important in mental health care (Farkas, 2006).

PSR is a multifaceted field that aims to contribute to the recovery of people with persistent mental illness by "enhancing their role functioning in a role valued by society and selected by the individual" (Farkas & Anthony, 2010, p. 116). Even though PSR includes many types of services, it has well-defined principles and a value base (Farkas, 2006; Farkas & Anthony, 2010; Rössler, 2006). These include empowerment, voluntarism, autonomy, partnership, the importance of hope, a focus on strengths and interests versus illness and limitations, and a results orientation. Different PSR services targeting different outcomes generally use similar techniques, such as skills training to improve role performance, providing support to improve role success, and advocacy to increase societal opportunities (Farkas, 2006; Farkas et al., 2007; Rössler, 2006). It is possible to provide a general description of the process of any PSR intervention (Farkas & Anthony, 2010), which comprises three phases: choosing or designating a goal; getting, which means taking steps to reach the goal; and keeping, meaning to maintain the achievement.

Despite the well-defined universal targets, values, principles, and techniques, the evaluation of PSR interventions has been somewhat elusive given the multifaceted nature of PSR (Farkas & Anthony, 2010; Farkas et al., 2007). For instance, within the population of people with mental illness, PSR deals with

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several distinct target groups, all of whom require different approaches and sets of techniques (Farkas et al., 2007). Moreover, different interventions target different outcomes, even though some of them provide comprehensive services (Rössler, 2006). Because PSR services operate in different locations and in different cultures, the picture becomes even more complex and has resulted in small sample sizes for research. Consequently, randomized controlled trial studies and other comparative analyses are difficult to conduct, meaning that research and evaluation have focused predominantly on individual interventions. Therefore, establishing a complete picture of PSR services is difficult, but necessary, for example, by developing comprehensive, complementary, and well-functioning PSR services without overlap to spare resources in a particular area.

As a groundbreaking programme in the late 1940s, the Clubhouse model was a pioneering PSR intervention that contributed greatly to the development of the principles guiding the field (Anthony & Liberman, 1986; Cnaan et al., 1988). Originally developed in New York City, the model is considered to be a well-established recovery- and consumer-oriented intervention (Anthony & Liberman, 1986; Clubhouse International, 2018; Farkas et al., 2007; Stoffel, 2011). The Clubhouse model offers participation in meaningful activities to promote the recovery of people with mental illness by targeting a wide range of outcomes, including but not limited to social, vocational, housing, and citizenship issues (Cnaan et al., 1988; C. McKay et al., 2016). Today, there are some 300 Clubhouses around the world (Clubhouse International, 2017). Ensuring their adherence to the Clubhouse model is a set of 37 standards, the International Standards for Clubhouse Programs, (referred to as "the standards" in this paper) (Clubhouse International, 2018).

The need to understand the active ingredients of the Clubhouse model, or how it achieves its outcomes, has been identified in the Clubhouse literature (Mowbray et al., 2006; Tanaka & Davidson, 2015a, 2015b). Some have suggested that a theory might help this endeavour. For instance, Raeburn et al. (2015) argued that self-determination theory might help to understand better the workings of the Clubhouse model. However, another team (Mutschler et al., 2018) took a more empirical approach by developing a realist theory for the model. The present paper explores a broader and more generic direction by examining whether the theory of salutogenesis might be a suitable theory for the Clubhouse model.

A theoretical framework is a crucial element when researching and evaluating programs (Leavy, 2014). As Langeland et al. (2007, p. 276) have argued, "An intervention is not ready to be evaluated unless the theoretical basis of the intervention has been developed and carried out." In addition, a theoretical framework "can illuminate areas that might not otherwise be visible" regarding a subject matter (Taylor, 2004, p. 633) and can foster association with existing bodies of research (Chambliss & Schutt, 2006).

The theory of salutogenesis provides a generic understanding of how coping, defined as a sense of coherence (SOC), and well-being may be created. The theory is used in several fields, such as nursing and mental health care (Eriksson & Lindström, 2006; Griffiths, 2009; Langeland & Vinje, 2016). Salutogenesis has also been suggested as a suitable framework for public health development (Lindström & Eriksson, 2006), to guide health promotion (A. Antonovsky, 1996; García-Moya & Morgan, 2017), mental health rehabilitation (Griffiths, 2009), and mental health promotion (Langeland & Vinje, 2013). The main purpose of the present study is to explore how salutogenesis might provide also a theoretical framework for the psychosocial Clubhouse rehabilitation model.

Salutogenic theory

Contrary to the biomedical model, which considers a person only in terms of their illness, salutogenesis offers a positive approach to health that is outlined by five basic assumptions (A. Antonovsky, 1979, 1987). First, health is defined as a continuum based on an understanding that although ill, a person still has healthy attributes to build on and is, therefore, in a state between health breakdown (dis-ease) and full health (ease). Second, it is the 'story of the person' as a whole that matters, in a holistic sense, rather than the illness focus of the medical approach. Third, "health-promoting (salutary) factors" or opportunities must be the centre of attention, rather than the pathogens or risk factors. Fourth, tension and strain are potentially health promoting rather than a ubiquitous evil to fight. Fifth, active adaptation is the ideal in treatment instead of assuming a "right treatment based on the right diagnosis" approach. Accordingly, salutogenesis focuses on the person in his/her entirety by interacting with both internal and external environments.

The main concept of the salutogenic model, determining a person's ability to stay well, is the SOC (A. Antonovsky, 1979, 1987). The SOC is defined as a global orientation that expresses the extent to which one can make sense of a challenge and address it successfully if it is deemed worth dealing with. The core components defining the SOC are comprehensibility, manageability, and meaningfulness (A. Antonovsky, 1979, 1987). According to Antonovsky, the third component, meaningfulness, is the most important because it is an emotional–motivational entity and plays a crucial role in shaping the outcome by determining whether something matters enough for the person to deal with. To maintain or increase the level of meaningfulness,

Antonovsky suggested investment in four areas fundamental to life: main activity, inner feelings, social relationships, and existential issues (Langeland & Vinje, 2016, p. 301).

According to salutogenic theory, resistance resources (RRs) are another important determinant of well-being (A. Antonovsky, 1979, 1987). Based on their scope of usefulness, RRs can be divided into two groups: generalized resistance resources (GRRs) with a "wide-ranging utility" and specific resistance resources (SRRs) that have a "situation-specific utility" (Mittelmark et al., 2016, p. 71). A GRR is defined as "any characteristic of the person, the group, or the environment that can facilitate effective tension management" (Vinje et al., 2017, p. 29). A GRR is also considered to be a consistent life experience that has a role in shaping an outcome and poses an appropriate challenge. It can also play a role in facilitating the SOC by promoting the development of any of its core components (Idan et al., 2016).For example, a GRR is an individual's social network that the person can rely on in various situations. An SRR may be an emergency phone number for requesting an ambulance in case of an accident (Mittelmark et al., 2016, p. 71).

The ability to use one's RRs determines whether a challenge is "appropriate." An appropriate challenge is defined as an occurrence that is neither too easy nor too difficult to overcome. In salutogenic terms, a challenge has underload/overload balance (Idan et al., 2016). Although RRs help in the development of the SOC, having the experience of a strong SOC may help to shape a person's experiences (or RRs) in return (A. Antonovsky, 1979, 1987). However, a lack of resources, called resistance deficits (RDs), weakens the SOC. In the continuum model, RDs, which represent the lack of resources to combat the challenges of life, are at the opposite end of the scale from RRs (A. Antonovsky, 1987). Consequently, an RR might be anything that promotes the SOC, whereas an RD represents a lack of resources that can weaken the SOC (A. Antonovsky, 1987).

Figure 1 illustrates the complex reciprocal interaction between well-being, SOC and its core components, and RRs. This figure includes a list of some of the major types of GRRs based on the works of A. Antonovsky (1987), Sullivan (1989), and Langeland et al. (2007).

In terms of the different types of RRs that can promote SOC and well-being, Antonovsky emphasized that social support and self-identity are the most crucial coping resources (Langeland et al., 2007). Langeland and Vinje (2016) elaborated that a well-functioning social network may be a source of several further assets for coping, such as availability of help, guidance, alliance, and reassurance among others. At the same time, being conscious of one's identity is helpful for developing a self-appropriate position within this social network and may contribute to a realistic insight into one's social capabilities. Furthermore, the value-related content of identity, self-esteem, is an important factor in terms of meaningfulness as the motivation for coping by translating to the notion "I am worthy of dealing with this challenge."

The Clubhouse model

The Clubhouse model has developed through a cumulative and pragmatic learning-from-experience approach (Anderson, 1998; Propst, 1997), which has resulted in the formulation of the (current) 37 standards (Clubhouse International, 2018). The standards are organized into eight core domains: membership, relationships, space, work-ordered day, employment, education, functions and funding, and governance and administration (Clubhouse International, 2018).

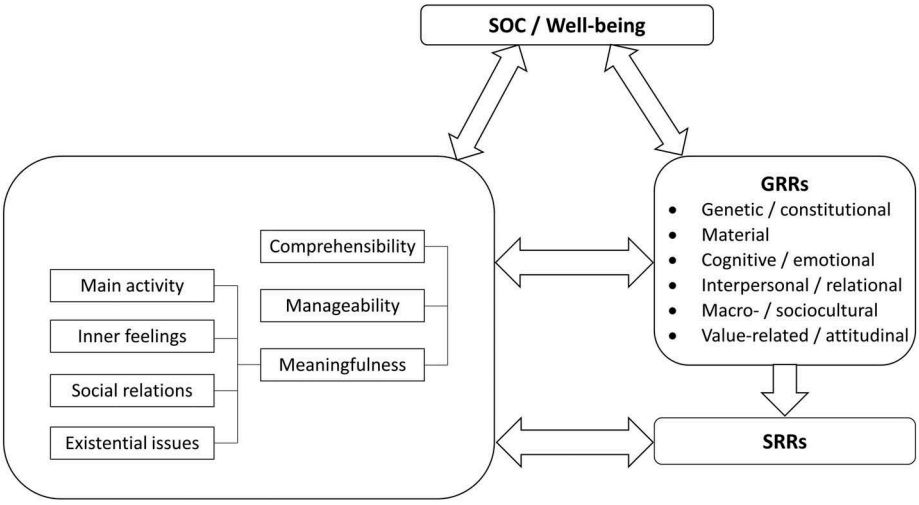

Figure 1. The interplay between well-being, sense of coherence (SOC) and its core components, and the different types of resistance resources (RRs).

Central to the model is that it operates as a Clubhouse; therefore, those who participate are referred to as members instead of users, clients, or patients (Propst, 1997), which results in an egalitarian structure (C. McKay et al., 2016; Tanaka & Davidson, 2015b). Membership has a low threshold and the only criterion is to have a history of mental illness (Clubhouse International, 2018, p. 2). It is also stipulated that membership is voluntary and without any time limit (Clubhouse International, 2018, p. 1), which provides stable, long-term support, which has been shown to have a greater impact on long-term rehabilitation outcomes for people with mental illness than short-term early intervention (Mowbray et al., 2006).

Members' rights are balanced with their responsibilities. The section on relationships in the standards stipulates that members are expected to actively take part in the running of the Clubhouse, "side-by-side" with the generalist staff; Clubhouses are intended to be understaffed so they cannot be run without member participation (Clubhouse International, 2018, p. 9). However, Tanaka and Davidson (2015b) observed that all members are treated as being contributors to the community regardless of their level of participation in everyday tasks. Staff are expected to encourage member participation by working together as equals (Clubhouse International, 2018, pp. 10–11). Studies have shown that both reciprocity in relationships and a positive therapeutic alliance foster recovery from mental illness (Fekete et al., 2020; Kidd et al., 2017; Roth, 2017; Tanaka & Davidson, 2015b). Furthermore, Staples and Stein (2008) describe the Clubhouse model as a unique hybrid of self-help and staff and peer support that provides multiple levels of support to members within the Clubhouse.

The section on space regulates three main areas. First, the Clubhouse must be an individual legal entity (Clubhouse International, 2018, p. 12). Second, the Clubhouse must be separate from any treatment facility or other programs, in addition to providing a place that conveys dignity and professionalism (Clubhouse International, 2018, p. 13). Third, the egalitarian structure in the model is emphasized by providing standards-bound rights to equal access and equal opportunities in using the Clubhouse for both members and staff (Clubhouse International, 2018, p. 14).

Work (employment) is both a tool and a goal within the Clubhouse model (C. E. McKay et al., 2006; Kinn et al., 2018a; C. McKay et al., 2016; Norman, 2006). Work as a tool emerges from the section dealing with the work-ordered day (WOD), which denotes that (a) the WOD parallels typical working hours or the workday, (b) the WOD provides the framework for all Clubhouse-related activities, and (c) all work generated within the Clubhouse must serve the maintenance or development of the Clubhouse facilities and community. Setting work as the main focus may also help to focus on members' strengths, or the things they can contribute to the community, which in return fosters a sense of mastery and achievement for the individual (Tanaka & Davidson, 2015a). Studies have shown that the WOD helps members' sense of autonomy and promotes their social development (Tanaka & Davidson, 2015a), and provides a framework for the "turning points" (i.e., major positive changes) in members' lives (Norman, 2006).

Work as a goal emerges from the section on employment within the standards (Clubhouse International, 2018), which state clearly that the Clubhouse is intended to "enable its members to return to paid work" (Clubhouse International, 2018, p. 21) and to offer a range of services to further this aim such as transitional employment, supported employment, and services for members in independent employment. Transitional employment is a form of employment support provided in the Clubhouse model (C. McKay et al., 2016) and offers employment for members in the open labour market for a limited period of 6–9 months, earning at least the minimum wage. Transitional employment is administered by the Clubhouse but is evaluated and paid by the employer (Clubhouse International, 2018, p. 22).

Although the Clubhouse model emphasizes providing support for members to gain and maintain paid employment, the standards outline further support functions of the Clubhouse in the sections of education and functions. These include transportation, community support services, advisory functions, affordable housing, and promoting and maintaining a healthy lifestyle (Clubhouse International, 2018, pp. 27–28); each of these addresses at least one of the multifaceted problems raised by mental illness (Propst, 1997). Social programs are also offered at Clubhouses (Clubhouse International, 2018, p. 29). Propst (1997) described the social programs as having a dual purpose: (1) they help those who are otherwise occupied during the WOD to keep in touch with the community, and (2) they reinforce the relationships formed by working together during the WOD.

The remaining two domains of space, and governance and funding of the standards prescribe the administrative requirements for each Clubhouse. Interestingly, they require member participation at all levels of Clubhouse representation and decision-making (Clubhouse International, 2018, p. 33 & 37), thereby highlighting the equal nature of the program.

The Clubhouse model as the basis of PSR

Although developed gradually, the Clubhouse standards define a practice that both reflects the principles of PSR and plays an important role in developing these principles (Anthony & Liberman, 1986; Cnaan et al., 1988). Cnaan et al. (1988) derived the general principles of PSR by analysing the Clubhouse model

and the practice of Horizon House, another pioneer in the field. Beyond their main difference, which is that the Clubhouse offers lifelong support whereas Horizon House focuses on helping people return to independent living as soon as possible, Cnaan et al. (1988) identified 13 basic principles of PSR, which have been confirmed by later studies (Anthony et al., 1999; Anthony & Mizock, 2014; Farkas et al., 2007). According to these principles, PSR is based on the understanding that, despite their diagnosis, all people can improve their life by bringing it closer to what is ordinary in the community if they are provided with the necessary skills (Cnaan et al., 1988; Rössler, 2006).

PSR has a social rather than a medical focus by shifting attention from a person's illness to the person's abilities (Farkas, 2006; Rössler, 2006). In addition, PSR recognizes that every individual has different needs, which may require different kinds of support, and that individuals with mental illness are capable of making competent decisions about the interventions they need for their own recovery (Rössler, 2006). Staff should support by being fully committed to the principles of PSR and should form a relationship beyond a professional façade with people using PSR services (Cnaan et al., 1988; Kidd et al., 2017). It is also the individual's decision about whether to join a PSR program, which should be easy because of the few inclusion criteria for PSR services and the requirement of physical accessibility (Anthony & Liberman, 1986; Cnaan et al., 1988). All PSR interventions should concern not just the person's immediate environment but should also aim for necessary changes on a broader, societal level (Rössler, 2006) and be prepared to provide early intervention in cases of relapse (Cnaan et al., 1988). Work is central in PSR because participation in meaningful work and aspiring for gainful employment are restorative and reintegrative given the wide acceptance of the worker role in society (Farkas & Anthony, 2010). However, this work focus shifted slightly in later stages of the development of the field towards programs helping people to cope with symptoms and supporting families in caring for their relatives affected by mental illness (Anthony & Liberman, 1986; Farkas et al., 2007).

The Clubhouse Model in the context of salutogenic theory

A common ground for salutogenesis and the PSR field, including the Clubhouse model, is the principle of being concerned with human beings as a whole and not reducing them to an illness (A. Antonovsky, 1979; Farkas & Anthony, 2010). Salutogenesis, PSR, and the Clubhouse model all acknowledge that the environment is also important in terms of the outcome (A. Antonovsky, 1979, 1987; Cnaan et al., 1988; Farkas, 2006; Farkas & Anthony, 2010; Farkas et al., 2007). Outcome orientation, self-determination, and empowerment are also values shared between salutogenesis, PSR, and the Clubhouse model (A. Antonovsky, 1987; Cnaan et al., 1988; Farkas & Anthony, 2010; Rössler, 2006).

Basic assumptions

Considering the basic assumptions of salutogenesis reveals further similarities with the Clubhouse model. What follows is a systematic examination of how elements of the Clubhouse model can be understood in the context of each assumption.

Health as a continuum

The first basic assumption of salutogenesis is the notion of health as a continuum, which means to "study the location of each person, at any time, on this continuum" (A. Antonovsky, 1987, p. 2). Assessing the status of a person's well-being assumes that all people are healthy to a certain degree despite the presence of illness; consequently, healthy aspects become apparent in addition to those affected by illness (Vinje et al., 2017). Similarly, the Clubhouse model acknowledges the capability of members by entrusting them with the responsibility for the operation of the Clubhouse (Clubhouse International, 2018, p. 11). Tanaka and Davidson (2015b) observed that all members are treated as being contributors to the community independent of their level of participation in everyday tasks. These attitudes are likely to help to move a person or group to a higher level on the continuum.

Story of the person

Antonovsky encouraged a holistic approach to well-being rather than a sole focus on disease; this was not just for compassionate reasons but to be able to see the complex context of a person's health status (A. Antonovsky, 1987). This concept is emphasized in the language used by both the salutogenesis and Clubhouse models. Salutogenesis uses the term "person" to describe the individual in focus (Vinje et al., 2017). Similarly, the Clubhouse terminology uses the term "member" instead of "patient" throughout the complete standards document (Clubhouse International, 2018). This approach seems to be more than a choice of words because, although the term "patient" indicates a person defined by illness, the term "member" infers the positive notion of being a contributing member of a community. This notion focuses attention on the person's environment as an important component of well-being, which is also a major element of the PSR ecological approach (Anthony & Liberman, 1986; Farkas, 2006; Rössler, 2006).

Health-promoting (salutary) factors in focus

Because risk factors are omnipresent, salutogenesis assumes a positive approach to health by shifting

the focus from pathogens to salutary factors (Langeland et al., 2007). In this sense, the aim is not to treat a disease but to build on one's available resources to be able to improve (A. Antonovsky, 1979, 1987). Similarly, the Clubhouse model has a strength-based approach and explicitly separates itself from the illness-focused mental health system (Clubhouse International, 2018, pp. 15–16). This parallels the principle of PSR, which postulates that all people can improve their level of functioning (Cnaan et al., 1988).

Tension and strain as potentially health promoting

The fourth basic assumption of salutogenesis is the consideration of tension and strain as potentially health promoting (Vinje et al., 2017). From the salutogenic perspective in which stressors are omnipresent and tension is general, continuous coping is crucial. However, A. Antonovsky (1979) proposed that salutogenic coping with tension is a positive experience because it has a positive impact on people's well-being by improving the SOC and thus helping them to develop the necessary coping skills. Therefore, tension is viewed as a prerequisite for personal growth to achieve a more constructive and stronger identity (Langeland et al., 2016; Magrin et al., 2006). However, the tension required to cope must pose an appropriate challenge by being neither too easy nor too difficult or, in salutogenic terms, it must have an "underload/overload balance" (Idan et al., 2016). Therefore, appropriate challenges are important (Langeland et al., 2007) and might be defined as "the salt of life" (Magrin et al., 2006).

The major challenge for Clubhouse members is taking responsibility. At the same time, the model's approach to member responsibility seems to be ambiguous. Although members are given challenges in the Clubhouse model, at the same time they are protected from them (Clubhouse International, 2018, pp. 3, 9, 11 & 16). In particular, two standards promote taking responsibility by stipulating that Clubhouses cannot be run without member involvement and members should have shared responsibility in operating the Clubhouse. However, other standards prohibit practices that enforce members' participation by paying or rewarding members for their contribution and by limiting Clubhouse work to those tasks generated by the Clubhouse, which arguably eliminates the competitiveness of regular working life. The PSR literature (Anthony & Liberman, 1986; Rössler, 2006) notes that an important aspect of PSR is reducing stress on the individual. However, in the context of salutogenesis, limited buffering of stressors is needed to provide appropriate, skill-building challenges to increase well-being.

Active adaptation

According to the fifth basic assumption of salutogenic thinking, treatment must reflect that the individual is in a constant process of learning and change because of the need to face and meet challenges. Therefore, active adaptation during treatment is necessary to increase a person's salutogenic capacity (Langeland et al., 2007) instead of assuming a "right treatment based on the right diagnosis" approach. In broad terms, salutogenesis considers any intervention that leads to improvement as treatment.

It is not apparent whether the Clubhouse model shares the principle concerning active adaptation as the ideal in treatment. On the one hand, we consider it to be a personalized treatment that members can decide whether and how they wish to use the Clubhouse (Clubhouse International, 2018, pp. 3 & 20). On the other hand, a condition within the principle of active adaptation is that it is necessary for finding an ideal treatment. It is not clear from the standards whether there is any procedure in place to ensure that members use the Clubhouse in a way that would be ideal for them or whether using the Clubhouse has a positive effect on their life. However, some studies (Macias et al., 1999; Raeburn et al., 2013) report that case management is offered by several Clubhouses, and such a service would likely involve evaluating "treatment" success.

SOC in the Clubhouse model

As the central concept in salutogenic theory, SOC offers the key to coping with stress and helping people maintain an optimal position on the health continuum (A. Antonovsky, 1979). The level of SOC is determined by its three core components: comprehensibility, manageability, and meaningfulness. A higher level of SOC indicates a higher level of well-being (Vinje et al., 2017), and a strong SOC is claimed to be universally beneficial to all people (Landsverk & Kane, 1998). Similarly, the Clubhouse model aims to work towards improving members' well-being (Clubhouse International, 2018).

Comprehensibility

Comprehensibility is the cognitive component of SOC and is described as experiencing stimuli as ordered instead of chaotic, consistent rather than irrational, structured instead of random, and clear rather than ambiguous (Vinje et al., 2017). Correspondingly, the Clubhouse aims to introduce structure—not unlike what usually happens in society—to members' lives by being open on weekdays during business hours (Clubhouse International, 2018, p. 17). In addition, the standards themselves help to promote consistency and clarity by explicitly providing a definition of the model.

Manageability

The second component of SOC, manageability, refers to the ability to manage stimuli if resources are available to meet the demands. Notably, stimuli can be derived from one's internal and external environments (Vinje et al., 2017). According to the preamble to the standards (Clubhouse International, 2018), Clubhouses offer members help in tackling the challenges of life by claiming their goal to be "helping people with mental illness to stay out of hospitals while achieving social, financial, educational and vocational goals." Arguably, offering this help to members might qualify as a factor supporting one's sense of manageability.

Meaningfulness

The last component of SOC, meaningfulness, is the most important SOC factor according to A. Antonovsky (1987) because it is an emotional–motivational entity that determines whether something matters enough for the individual to deal with, and thus plays a crucial role in shaping the outcome of coping. To determine whether the Clubhouse model supports meaningfulness, we studied its crucial areas.

Main activity

We had positive findings about the main activity because Clubhouses offer regular, engaging, and meaningful activities for members (Clubhouse International, 2018, pp. 17–18). In particular, the standards stipulate that Clubhouses must stay open during regular business hours and that work activities must be engaging and meaningful. This also helps members to structure their lives similarly to societal practice, which is consistent with the "normalization" principle of PSR (Cnaan et al., 1988; Farkas, 2006).

Existential issues

Existential issues in salutogenic terms refer to being able to form a view of life in ideological, political, and/or religious terms (Lindstrøm, as cited in Vinje et al., 2017, p. 28). In this sense, having hope and/or a stable belief system might be as important for the individual as building up a logical, solid, and consistent lifeworld. We examined whether the Clubhouse model has standards to establish a rule of law in the Clubhouse community and found several examples. First, the preamble establishes the status of the standards as "a 'bill of rights' for members and a code of ethics for staff, board and administrators." Furthermore, several standards outline members' rights as having full and equal access to all facilities and giving them authority over anything that might personally concern them (Clubhouse International, 2018, pp. 5, 8 & 14). In addition, the standards stipulate members' rights to dignity and respect, and establish an equal hierarchy between members and staff. These elements, together with the stipulation of unlimited membership (Clubhouse International, 2018, p. 1), offer stability and security, which are important existential aspects. However, the Clubhouse standards do not contain any specific measures for life outside the Clubhouse community. Nevertheless, it is reasonable to assume that having access to a supportive community and gaining increased self-confidence would have a positive effect on members' lives outside the Clubhouse. Similarly, the standards do not contain explicit reference to increasing or maintaining hope, an important aspect of the recovery process (see, for example, Anthony & Mizock, 2014) and do not explicitly mention developing a stable belief system. Nonetheless, the conclusion about the support function of belonging to and being able to rely on a community might also be true for these elements.

Inner feelings

Inner feelings can indicate a stable state of mind and an awareness of one's emotions, although it is difficult to separate these general categories from particular emotions that are evoked when a person interacts with his or her environment. However, considering individual aspects only, we did not find explicit examples to indicate that the Clubhouse model contributes to the emotional self-awareness or mental stability of members. Nevertheless, it is again a reasonable supposition that elements such as the principles of self-determination, recovering at one's own pace, conveying respect, and providing a supportive community constitute implicit considerations of members' emotions.

Social relationships

Although the standards do not explicitly mention individual members' inner feelings, several ingredients of the model seem to focus on social relationships and building a community, which arguably have a bearing on a person's social life (Clubhouse International, 2018, pp. 1, 6–7, 18 & 32). These standards seem to focus on three main topics: membership and personal security, keeping members in the community, and strengthening the community by fostering relationships.

Resistance resources (RRs) in the Clubhouse model

As noted, RRs can be general (GRR) or specific (SRR) (Mittelmark et al., 2016). We defined a GRR as a consistent life experience of general utility that is instrumental in shaping the outcome of the coping process. We defined SRR as a tool for coping with a particular situation. With regard to the distinction between GRRs and SRRs, we considered general

Clubhouse opportunities to be available universally for everyone as GRRs, and specific support used by individual members as SRRs. We then classified the opportunities described in the standards detailing the available Clubhouse services, such as employment and education support, community support services, transportation and housing services, assistance with a healthy lifestyle, and social programs as GRRs (Clubhouse International, 2018). We considered specific uses of these services by a member in a way that is helpful to their particular problem to be SRRs. For example, the Clubhouse offers help with housing problems, which we took to be a GRR, but explicitly offering housing to members or helping them to benefit from a housing program was considered to be an SRR.

According to the RR–RD continuum model, the type of life experience can serve as the basis for the classification of RRs, as well as their counterparts, the general and specific resistance deficits (RDs). A summary of some of the types of RRs and RDs is presented in Figure 1. Based on this typology, we suggest in Figure 2 a classification of some of the major Clubhouse interventions. Note that there is a dynamic and reciprocal relationship between SOC, RRs, and RDs, and between RRs and RDs themselves (Idan et al., 2016). Although each type of RR or RD would, respectively, strengthen or weaken the SOC, the SOC would also have an effect; that is, a strong SOC would likely help in acquiring and using RRs, whereas a weak SOC would act in the opposite manner. In addition, a similar interplay may also be assumed between the different groups of RRs because the presence of one might promote the use of another or the absence of one might hinder the use of another.

Constitutional resources are a person's physical and biochemical disposition to cope with problems (A. Antonovsky, 1979). Therefore, one goal of Clubhouses—to support their members with a healthy lifestyle (Clubhouse International, 2018, p. 28) by helping to improve their physical health as well as their mental well-being—could be considered a resource. Material resources are the means to sustain life both in a biological and social sense; therefore, any services provided by a Clubhouse such as providing support to improve physical and/or mental well-being can be considered as RRs. For example, such a service could be the Clubhouse itself as a place to provide support or the employment support provided by the Clubhouse. The next group of resources concerns cognitive abilities, such as the intelligence to obtain knowledge and the possession of necessary knowledge, as well as emotional aspects such as a strong, stable sense of self (identity), which are crucial to tackling challenges. The model ingredients relevant here are those that help with the comprehensibility factor of the SOC.

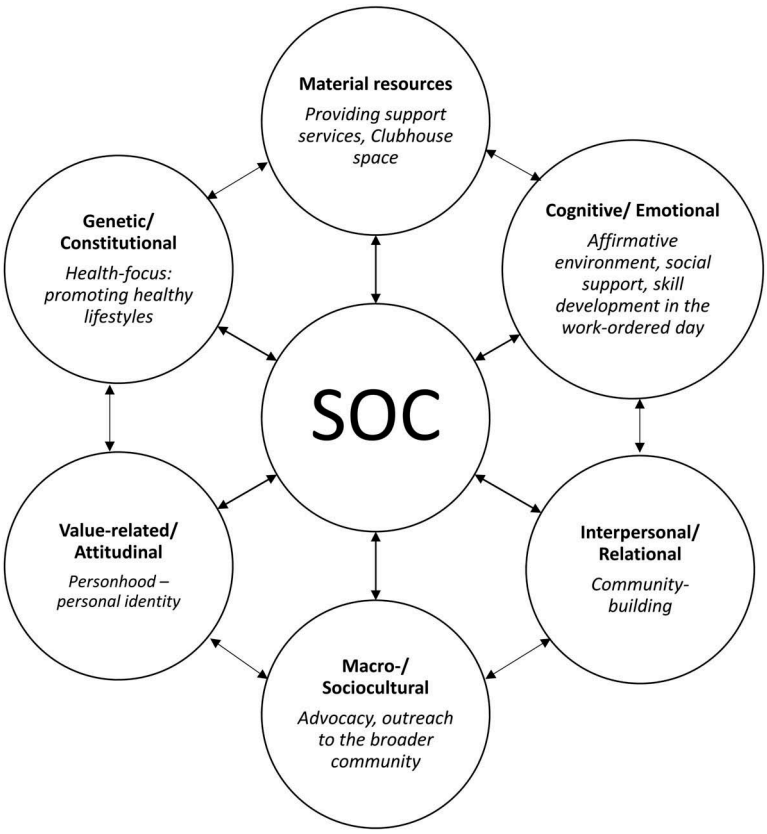

Figure 2. The hypothetical interaction between members' sense of coherence (SOC) and use of different resistance resources (RRs) in the Clubhouse setting.

Another crucial type of RR is having high-quality social relationships and a sense of belonging in the community, both of which seem to be a priority of the model according to the standards. On another level, this translates into the fifth group of macro or socio-cultural factors, such as being part of a stable society that does not require constant adaptation by an individual in response to changing conditions. Finally, a crucial source of coping resources includes attitudes and values, such as a preventive attitude towards problem-solving and a stable belief system in which to operate. In the Clubhouse model, these terms are partly covered by the ingredients that support the existential issues described above and the status as "members" of a Clubhouse.

Discussion

In this article, we analysed the Clubhouse model in the context of the theory of salutogenesis to address claims that a comprehensive theory was lacking to inform research on the Clubhouse model (Mowbray et al., 2006; Mutschler et al., 2018; Raeburn et al., 2015). We have suggested that using salutogenesis as a theoretical framework for the model might also provide a foundation for its application in PSR research because research in these two fields faces similar challenges. For instance, diversity is an important challenge, particularly in terms of interventions, user groups, and goals, which make it difficult to achieve sample sizes large enough to make comparisons (Farkas et al., 2007; Rössler, 2006).

The starting point of this paper was that as a broad, established theory, salutogenesis might provide a unifying platform to address these issues. In addition, by providing insight into how well-being is achieved by strengthening the SOC, we reasoned that the SOC questionnaire (A. Antonovsky, 1987) may provide a useful tool for measuring outcomes. Therefore, we conducted a systematic examination to identify the different elements of the Clubhouse model, with an emphasis on those prescribed by the standards, and how these can be understood in the context of salutogenesis.

We found that Clubhouse practices such as a PSR intervention are highly consistent with salutogenic principles, and we suggest that salutogenesis might be a suitable theoretical framework for the Clubhouse model. However, we also identified areas where salutogenic theory might help improve the Clubhouse model, and vice versa.

For example, assuming that reclaiming the role of an equal participant in society (outside the Clubhouse model) is one of the major aims of a person's PSR and one of the foremost ways salutogenesis might improve Clubhouse practices (Magrin et al., 2006). This means acknowledging and implementing the concept of appropriate challenge as a health-promoting factor. Based on the standards, the current practice is ambiguous in this matter. On the one hand, members are expected to contribute to the operating of a Clubhouse (Clubhouse International, 2018, pp. 9 & 11). On the other hand, the standards offer lifelong membership regardless of an individual's contribution (Clubhouse International, 2018), and empirical studies show that Clubhouse members are likely to choose to remain within the safety of the Clubhouse community rather than cope with the challenge of leaving it. For instance, Raeburn et al. (2013) identified the potential risk of developing "service dependence" for Clubhouse members. The results of a recent meta-synthesis of 11 qualitative studies (Kinn et al., 2018b) drew a similar conclusion. According to this study, the Clubhouse community encourages members in the processes of "pushing their boats out" onto the "open sea" of society and work life, after a supportive and building-up period of being "anchored" in the Clubhouse (Kinn et al., 2018b). However, despite flourishing when participating in Clubhouse activities, some members felt they were not ready to leave the "safe harbor" for fear of the challenges outside the Clubhouse. We suggest that consciously offering greater challenges that members can relate to real-life problems may help their social integration as part of their recovery (Kinn et al., 2018b).

Next, active adaptation as the ideal in treatment is another area for possible development. A person's active adaptation in a treatment means using the appropriate measure to solve a given problem (Griffiths, 2009; Vinje et al., 2017). Therefore, to select an appropriate measure, one must assess the given situation. Notably, although it is possible for people to tailor their use of the Clubhouse to their individual needs, we could not determine from our review of the standards whether a recovery plan is developed for each person, and we conclude that it may not be an integral part of the model. The absence of such a plan suggests that there is no kind of assessment in place, which makes it impossible to change the course of intervention (tailoring), which is a postulate of the active adaptation concept. We suggest that such a systematic approach to member support may result in a more effective intervention.

Salutogenesis emphasizes the importance of personal relationships for strengthening the meaningfulness component and thus the SOC. Although the community is a definite focus of the model, we found that the standards lack elements concerning individual relationships within the community and, therefore, the initiatives directly concerning the members' inner feelings. Moreover, except for helping members to complete tasks and become employed or educated in society, there seem to be no Clubhouse initiatives to help the individual members integrate into society and to improve their well-being

outside the Clubhouse. This was also evident from the empirical studies on individual and social relationships in the Clubhouse model. For instance, although some studies (Carolan et al., 2011; Fekete et al., 2020) found that the Clubhouse model provides opportunities for rebuilding social networks, a sense of belonging, and contact with peers, another study (Pernice-Duca, 2008) claimed that fellow members were least likely to be nominated as a source of support within Clubhouse members' social networks. Similarly, Biegel et al. (2013) argued that, whereas members perceive their Clubhouse as a place to belong and a family substitute, they listed remarkably few individuals from their Clubhouse environment as part of their social networks. Furthermore, a recent Norwegian study did not find a significant correlation between members' loneliness and use of a Clubhouse (Bonsaksen et al., 2019). On the other hand, several studies have shown that Clubhouse members experience a close emotional connection with their Clubhouse environment. (Biegel et al., 2013; Fekete et al., 2020; Pernice-Duca, 2008; Schiff et al., 2008). In addition, other studies suggest that members experience the Clubhouse environment as supportive, affirmative, and accepting (Norman; Schiff et al., 2008). In summary, we suggest that, although there is a development potential in terms of individual relationships within the Clubhouse model, it may be based on the foundations of a strong community reported in empirical studies.

One of our major findings was that the services and opportunities offered by Clubhouses can be understood as RRs, and we differentiated between GRRs and SRRs according to the range of their utility (Mittelmark et al., 2016). In this article, we propose a classification of general Clubhouse services according to the classes of GRRs discussed in the salutogenic literature (A. Antonovsky, 1987; Langeland et al., 2007; Sullivan, 1989). We suggest that the particular solutions a member might use within these general opportunities could be considered as SRRs. Even though this approach seems to be operational and logical in our case, it is arguably ambiguous because, with the same utility-range definition, several other logical models can be outlined. For example, from a macroperspective, mental health care could be a GRR within the universal health-care system. In this sense, the Clubhouse model as an intervention within the mental health services could serve as an SRR. Therefore, we suggest that improvement and concretization of the definition of GRRs and SRRs are necessary. Arguably, the expertise of PSR with factors that facilitate a person's rehabilitation process might be helpful in the further development of the RR concepts.

Lastly, we emphasize the potential benefits of the common positive terminology in the salutogenesis and Clubhouse models as a matter for consideration. Salutogenesis focuses on seeing the person behind the diagnosis and considers tension as an ordinary occurrence in everyday life. The use of the word "person" in salutogenesis and reference to Clubhouse participants as members illustrate the transition from "patienthood to personhood" (Peckoff, 1992) through which the person becomes a contributing community member, which is a positive step from being considered as a "mental health patient." We suggest that, from a societal perspective, promoting this approach may also help to reduce the stigma and prejudice faced by someone who is labelled as a "patient" or "service user," and instead referring to them by neutral terms such as "member" or "person", which makes these people like everyone else in society, who all must learn to cope with tensions and challenges in their lives.

Conclusion and limitations

In the present paper, we have explored the Clubhouse model in the salutogenic context by discussing the different salutogenic factors and RRs contained in the Clubhouse model. In conclusion, this study suggests that salutogenesis seems to be a suitable framework for Clubhouse research and practice, and for PSR as well.

Given the considerable insight of salutogenesis into how well-being is achieved, we suggest that Clubhouses might play a role in promoting a stronger SOC, which is the foremost agent in promoting mental health and well-being. As we proposed in our preliminary classification, Clubhouse interventions aiming to achieve well-being may function as GRRs (or SRRs). Further studies of these interventions and the insight of PSR into factors that assist an individual's rehabilitation process may help in the further development of the RR concepts of salutogenesis.

Admittedly, this paper is only a theoretical elaboration and, therefore, constitutes a string of ideas for answering salient questions about PSR, such as suggestions for future research and practical development, using the Clubhouse model as an example. Consequently, we emphasize that, although we have presented some ideas and findings, further research is needed to determine whether they have empirical merit. The next step is to perform empirical studies of the Clubhouse model from the salutogenic perspective.

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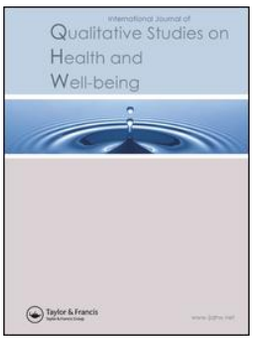

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"Finally, I belong somewhere I can be proud of" – Experiences of being a Clubhouse member in Norway

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ABSTRACT

Purpose: The number of psychosocial Clubhouses is growing rapidly in Norway. However, more knowledge is needed about the subjective experience of Clubhouse members in terms of their recuperation processes and experiences in the Clubhouse context. Therefore, this qualitative study explored what it is like to be a Clubhouse member in Norway, and further discuss it in light of the theory of Salutogenesis on successful pathways to coping and well-being.

Methods: Using a hermeneutic–phenomenological approach, the present study included in-depth, semi-structured individual interviews with 18 Clubhouse members from three accredited Norwegian Clubhouses. Analysis was conducted using systematic text condensation.

Results: Three main themes emerged from the analysis: "Finally, I belong somewhere I can be proud of," "I feel more like an ordinary citizen, just different," and "I feel somewhat equal to others." Overall, the participants experienced improved mental and social well-being owing to their membership of a Clubhouse.

Conclusions: Our findings correspond with previous international research. Owing to the positive effect participation in the Clubhouse seem to have on members' motivation, Salutogenesis might help explain helpful processes within the model. Moreover, the model might be a relevant example for policy and service development in mental health care and the labour market.

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KEYWORDS
Psychosocial rehabilitation; Clubhouse model; mental illness; recovery; Salutogenesis

Current international and national mental health care policies call for health promoting recovery- and user-oriented interventions as well as community-based programmes (Ministry of Labour & Ministry of Health and Care Services, 2013; Norwegian Directorate of Health, 2014; World Health Organization, 2013). Offering psychosocial rehabilitation for people with mental illness in a therapeutic community, the Clubhouse model represents such a programme (McKay, Nugent, Johnsen, Eaton, & Lidz, 2016; Raeburn, Halcomb, Walter, & Cleary, 2013).

The origins of the model can be traced back to the late 1940s, when a self-help group of former mental patients established the first Clubhouse, Fountain House New York (Anderson, 1998). True to its roots in the user movement, the model was built on the principles of empowerment, self-determination, equality, and democracy (Battin, Bouvet, & Hatala, 2016; McKay et al., 2016; Raeburn et al., 2013). Today, the *International Standards for Clubhouse Programmes* regulate the model and describe minimum services to be offered by Clubhouses. In addition, the standards serve as a bill of rights for members and staff and provide a basis for quality control through accreditation (Clubhouse International, 2018). Currently, some 300 Clubhouses operate worldwide (Clubhouse International, 2019), of which 14 are in Norway (Fontenehus Norge, 2019).

The program offers community experience and meaningful activity (Norman, 2006) for people with mental illness (McKay et al., 2016; Raeburn et al., 2013). The nonclinical approach of the Clubhouse model is reflected in its principles and terminology. Thus, people who participate in the community are referred to as members, not users or patients (McKay et al., 2016). Central to the model is its focus on participation in work (Raeburn et al., 2013). Within the framework of the so-called "work-ordered day," members and a skeleton staff run the Clubhouse side by side (Raeburn et al., 2013). In addition, Clubhouse members are offered support services, such as vocational rehabilitation, education support, help with housing and entitlements, and support with healthy lifestyles and social programs (Clubhouse International, 2018; McKay et al., 2016).

Since the 1960s, numerous quantitative and qualitative studies have investigated the Clubhouse model.

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The initial inquiries had a quantitative focus—measuring the model's effectiveness in terms of rehospitalization (Beard, Malamud, & Rossman, 1978; Beard, Pitt, Fisher, & Goertzel, 1963; Delaney, 1998). Later studies have examined outcomes, such as the impact of Clubhouse membership on quality of life (Boyd & Bentley, 2006; Jung & Kim, 2012), education (Unger, Pardee, Anthony, & Rutman, 2002), and employment outcomes (Dorio, Guitar, Solheim, Dvorkin, & Marine, 2002; Schonebaum & Boyd, 2012; Schonebaum, Boyd, & Dudek, 2006). However, according to two recent systematic reviews (Battin et al., 2016; McKay et al., 2016), evidence regarding the effectiveness of the Clubhouse model is limited.

Since the late 1990s, the number of qualitative studies investigating the model has increased, including research focusing on members' experiences of participation in the Clubhouse community. For example, Clubhouse membership has been found to expand individuals' networks, enhance their personal lives (Roth, 2017; Tanaka & Davidson, 2015a), and improve their social skills and sense of belonging. Moreover, some informants called the Clubhouse community their family in several studies (Biegel, Pernice-Duca, Chang, & D'Angelo, 2013; Carolan, Onaga, Pernice-Duca, & Jimenez, 2011; Roth, 2017). In addition, Clubhouse affiliation has been found to increase members' sense of "personhood" and inclusion, and to provide an experience of control over their lives (Tanaka & Davidson, 2015b).

Moreover, qualitative studies have revealed that members find participation in the Clubhouse community to be a stepping-stone to vocational recovery (Roth, 2017; Tanaka & Davidson, 2015a). For example, participation in the work-ordered day has been found to increase members' self-confidence (Norman, 2006; Tanaka & Davidson, 2015a), apparently resulting in increased faith in their ability to (re)enter the labour market (Chen & Oh, 2019). Consistent with these findings, a recent metasynthesis (Kinn, Tanaka, Bellamy, & Davidson, 2018) explored the Clubhouse participation experiences of Clubhouse staff and members and their families. Their results showed that Clubhouses provide a valuable community for the recovery of individuals—a place to "anchor" themselves securely to rebuild their self-confidence, relationships, and perspectives (Kinn et al., 2018, p. 1205).

In addition, several studies have examined aspects of the Clubhouse community such as reciprocity, which was found to create bonds and facilitate a sense of equality (Coniglio, Hancock, & Ellis, 2012; Pernice-Duca & Onaga, 2009; Tanaka & Davidson, 2015b). Conversely, inequality was considered to disrupt the community (Roth, 2017; Tanaka, Craig, & Davidson, 2015; Waegemakers Schiff, Coleman, & Miner, 2008), so the relationship between staff and members was found to be crucial in terms of the perceived quality of the Clubhouse environment.

Previous research has also criticized the model. For example, Raeburn et al. (2013) expressed concern about Clubhouse members developing service dependency. Similarly, it was suggested that the comfort of the community may hinder members' efforts to conduct their lives outside the Clubhouse (Kinn et al., 2018).

The principles of the Clubhouse model seem to correspond with those of Salutogenesis (Antonovsky, 1979, 1987; Griffiths, 2009; Langeland & Vinje, 2017; Vinje, Langeland, & Bull, 2016), which is a theory on "how people manage stress and stay well" (Antonovsky, 1987). Because the theory focuses on the abilities (or health) instead of the weaknesses (or illness) of a person, it seems that Salutogenesis may be a suitable theoretical framework and "comparative context" (Sandelowski, 1993, p. 216) for the present study.

Salutogenesis is a broad, resource-oriented theory concerning the origins of health and well-being (Antonovsky, 1979, 1987; Mittelmark & Bauer, 2017; Vinje et al., 2016). It posits that health is a continuum from health breakdown, which Antonovsky (1979) referred to as "dis-ease", to health which he referred to as "ease". However, dis-ease is not the same as disease, meaning that in real life, people fall somewhere between these two endpoints, and, thus, can be somewhat healthy even alongside serious illness. Nonetheless, to stay and feel healthy, people must manage the challenges of life (Antonovsky, 1979, 1987). Their ability to do so depends on their Sense of Coherence (SOC), which is determined by three factors: comprehensibility, manageability, and meaningfulness (Antonovsky, 1979, 1987).

Resistance resources (RRs) are additional assets that facilitate response to challenges (Idan, O., Eriksson, M., & Al-Yagon, M., 2017). RRs are defined as "any characteristic of the person, the group, or the environment that can facilitate effective tension management" (Vinje et al., 2016, p. 29). However, their counterparts, resistant deficits (RDs), hinder effective coping. There is a dynamic and dependent relationship between SOC and RRs (and conversely, RDs). The availability of RRs facilitates coping, thus strengthening SOC. A strong SOC improves the individual's health on the ease–dis-ease continuum, and better health makes a person more capable of gaining and utilizing RRs (Antonovsky, 1987, p. 28).

While introducing Salutogenesis as a potential theoretical framework for the Clubhouse model addresses a need highlighted in previous literature (Mowbray, Lewandowski, Holter, & Bybee, 2006; Raeburn, Schmied, Hungerford, & Cleary, 2015), other knowledge gaps exist. For example, there seems to be a lack of understanding of how model outcomes are achieved from a transnational and transcultural perspective (Tanaka & Davidson, 2015a, p. 271). Moreover, a better understanding of member experience is also important in terms of the increasingly

principal status of user-involvement and codetermination in mental healthcare (Farkas, Jansen, & Penk, 2007; World Health Organization, 2013). Thus, Clubhouse members might provide key information on how they experience processes that improve their health and well-being in the context of a psychosocial rehabilitation program.

Consequently, this study seeks a better understanding of the subjective experiences of being a Clubhouse member in recovery in Norway by answering the research question, "What is it like to be a Clubhouse member?"

Methods

Study design

This qualitative study was designed according to a hermeneutic–phenomenological approach (Dowling, 2007; Giorgi, 1997; Laverty, 2003). Accordingly, the study had an inductive approach and was based on individual descriptions of the phenomenon in question, in this case the experience of being a Clubhouse member.

Participants and sampling

Participants (n = 18) were recruited from accredited Norwegian Clubhouses. Originally, an invitation letter was sent to the directors of two accredited Norwegian Clubhouses (of five at the start of the study), both of which agreed to participate. They were in Central Norway, one in a major city and the other in a town. Eventually, to reach other possible interview participants, a third Clubhouse located on the west coast of Norway was invited to participate. The researcher (the first author) had no personal affiliation with either of the participating Clubhouses.

The interviews were conducted at the participants' Clubhouses, in a separate room with only the researcher and the participant present. The final sample consisted of 18 Clubhouse members: five women and 13 men between the ages of 27 and 75.

Data collection

Data were collected via individual, semi-structured, in-depth interviews (Kvale, Brinkmann, Anderssen, & Rygge, 2015; Malterud, 2017). The interview guide included open-ended questions such as: "Can you tell me how you became a Clubhouse member?", "What is it like to participate in various activities with others at the Clubhouse?", "What kind of goals do you have in terms of your recovery?", "How does the Clubhouse help in achieving these goals?", "How has your life changed since you joined the Clubhouse?", "Is there anything you do not particularly like about the Clubhouse?" The resulting interviews varied in length between 30 and 80 minutes. All interviews were audio recorded, and the researcher took notes to assist the subsequent analysis.

Data analysis

Audio records were transcribed verbatim, partly by the first author and partly by a contractor. Systematic text condensation was used as the method of analysis (Malterud, 2012). In step 1, all authors individually obtained an overall impression of the material and identified preliminary themes that spontaneously emerged from the material. In step 2, meaning units (parts of the original texts) were identified, classified, and sorted by codes related to the preliminary themes identified in step 1. The content and description of the codes were regularly rechecked to avoid overlap and to make necessary adjustments. In step 3, meaning units were connected and rewritten in the first person as a coherent text (condensate) by the researcher, avoiding abstractions. In step 4, the condensates were re-contextualized by renarrating them from the researchers' point of view and an analytic text was prepared, presenting the most salient content related to the phenomenon of interest to the study, grounded in the empirical data, including illustrative quotations (Malterud, 2012). During the analytical process, steps 2 to 4 were revisited several times as required by the hermeneutic circle of understanding (Laverty, 2003). The final findings were validated against the original transcripts, and all authors reviewed and agreed on the final findings (Malterud, 2012).

Ethics

Data management measures in the study were approved by the Norwegian Centre for Research Data and the project was exempted from review by the Medical Research Ethics Committee. All information acquired was anonymous, as informants were registered under pseudonyms.

As reflexivity has a pivotal role in qualitative research to ensure that the researcher has the least possible effect on results (Dowling, 2006), the first author conducted rigorous and continuous self-reflection throughout the study. This was assisted by the observations of the other authors regarding the researchers' attitudes and conduct. The research group aimed to create a transparent and accountable research environment with regular meetings as well as continuous, critical, and recorded communication.

Results

Three main themes emerged from the analysis of the interview data in terms of participants' experience of self in the Clubhouse setting. These were: 1) "Finally, I belong somewhere I can be proud of", 2) "I am more

like an ordinary citizen, but different", and 3) "I feel somewhat equal to others".

Finally, I belong somewhere I can be proud of

The participants, all established Clubhouse members, described the Clubhouse as a community where they felt accepted and met people with whom they could identify. According to most participants, their common ground was sharing the experience of having a mental illness, often described by the metaphor of "being in the same boat as the others," which made them "feel as if they were not alone in being imperfect." Having similar future goals of recovery emerged as another community-building factor shared by several participants. In addition, every participant mentioned that their Clubhouse membership helped them to fight loneliness by becoming members of a community and developing personal bonds. As one participant expressed:

> If you are interested in more friends, then the Fountain House* is one of the best … Absolutely, it is. Eh, it's been many years since I made new friends. I do get to know new people from time to time on festivals and such things, but, but here it becomes a bit more like intensive (…) And not just like in connection with partying … It is kind of a bit more real and not so superficial as maybe many other of the acquaintances in the last few years. (Thomas)

The experience of belonging to the community seemed to be emotionally charged and positively valued. For instance, some participants, such as Anna, used powerful statements to describe what the Clubhouse meant for them:

> I was very depressed when I first came here. But it has become better, of course. So, I'm doing very well nowadays. I just have a good life. Well, I have a life. I can have the rest of my life the way I have it today. So I have to say that the Clubhouse saved me, that is, saved my life …

Similarly, some participants described the Clubhouse community as a family. A participant went as far as to state that in an event such as a divorce he would be able to cope fine because he had the Clubhouse. Personal relationships between Clubhouse members seemed to vary in intensity from casual friendships to close personal bonds—even marriages in some cases. According to all participants, relationships were developed both inside and outside the Clubhouse. During the work-ordered day, working together or individually for the community seemed to create a social space where members had the opportunity to connect:

> (…) we are social while we do stuff. (…) Well, we do stuff and if somebody needs … or is wondering about something, we just ask the nearest person for help. And so, we joke … I think many of us try to be a little playful, and joke a lot, you see. Of course, we must respect boundaries, but uhm, it makes it feel less tense. We have a very good atmosphere, indeed. (Lucas)

Furthermore, bonding between members seemed to occur outside the Clubhouse, for example by helping each other personally and practically, like moving or helping to clean a fellow member's apartment. In addition, several participants talked about attending social activities together, and they seemed to use the Clubhouse as a convenient base to arrange these. Notably, the customary ways of developing relationships in a corporate domain seemed to have been adapted to Clubhouse environments. Interestingly, all participants reported that their Clubhouse community practiced the Norwegian custom of having a drink with colleagues around payday and organizing Christmas parties as is customary in corporate life, involving both salaried staff and unpaid Clubhouse members.

Besides opportunities for socialization, many participants valued the Clubhouse as a safe and secure community. For instance, some participants mentioned the importance of protection from what they perceived as "outsiders", by not allowing unfamiliar people into the community. Interestingly, this appeared to contradict the experience of most participants, who talked about entering the community freely and being welcome for the first time, when they were strangers to the community. Other participants emphasized that the social environment made them feel safe; they felt accepted and welcomed, even when they did not feel well. Moreover, several participants seemed to appreciate that they could come to the Clubhouse any time or would always have a place to fall back on because they had lifelong membership for which they did not have to worry paying a fee.

I am more like an ordinary citizen, but different

Several participants talked about that their Clubhouse membership helping them to escape inactivity and isolation, which Emma described by the following metaphor:

> (…) Say five years ago … then I was just at home lying on the sofa watching TV and … that is no life. Then it is better to get out of the door and stay here, and … work towards a goal, and making friends, and …

Owing to the regular workday schedule offered by the Clubhouse, several participants underlined that they were able to keep similar hours to those who have regular jobs, which made them feel like they fit better

*Clubhouses in Norway are referred to as fountain house (fontenehus).

into society. In fact, most participants regarded participating in Clubhouse activities as their job. Moreover, several participants described feeling an increase in their social status, from feeling like an outsider to becoming a productive member, such as Anna:

> I don't pretend anymore; I don't have to lie to (people who ask) "What were you doing?" What are you going to answer if you didn't do anything? It's really shameful and embarrassing. But now I say, "I work at the Clubhouse," which I am really proud of, and people can just think what they want about it …

In addition, all participants emphasized that it was not just being active but having a valued activity that was very important to them. Moreover, doing something valued seemed to strengthen their sense of belonging and self-esteem. Several participants talked about factors that influenced the meaningfulness of their work at the Clubhouse, such as making a difference in their own community and even internationally, owing to the Clubhouse network:

> What I seek is to be useful. I feel that what I do has a ripple effect over … And I wouldn't be able to experience it in a NAV (Norwegian social and employment services) program where one does not see the end of what one is doing. In a way, it is good with the Clubhouse that one actually sees a ripple effect of one's activity, both internally and externally. You see, the Clubhouse is international. You can just point to (anywhere on) a world map and there would be a Clubhouse. (Matthias)

In contrast to their efforts to fit in, some participants seemed to appreciate that pretense—a widely accepted and sometimes required behaviour in society—was not present in the Clubhouse community. Many participants mentioned former negative experiences in society of "putting on a mask" or denying having a problem just to be pleasant in a social situation, which they could forgo in the Clubhouse setting. Similarly, some participants talked about feeling pressure in society to fit in almost to the extent of becoming indistinguishable, which they did not feel in the Clubhouse community:

> And I also got to be in … well, the Clubhouse was very good in helping me to dare to think outside the box. So, I don't have to be so square; I must not follow what society thinks … Well, you should not steal and such things, but you don't need to follow the flow that everyone goes along with. You must follow the one that is right for you. (Olivia)

In addition, many participants appreciated that unlike the situation in the outside society, they had the opportunity to tailor each workday to their needs and abilities at the Clubhouse. The notion of "daily form", in other words how a person felt on any given day, recurred in many of the interviews:

> I'm not always able to do something when I'm here, but for example, standing and washing dishes for a couple of hours or something like that actually feels pretty good, even though it might sound awful. Then it feels somehow like I managed to achieve something. (…) Sometimes so … I'm not able to do anything (…) so sometimes I try to avoid work meetings just because it sucks to sit at such a work meeting and then not sign up for anything. (Axel)

All participants seemed to appreciate that their presence at the Clubhouse was not dependent on their "daily form," or rather, on how much they could contribute according to their health status. In fact, most of the participants suggested that it was preferable to come to the Clubhouse even when one was not in a suitable state to work rather than staying at home. However, several participants were critical of the regular labour market, where they perceived that employees were unnecessarily overtaxed, such as Maya:

> (In Norwegian society) Everyone should work so efficiently all the time. And then one relaxes between five and twelve in the evening. But, like in the daytime and Monday to Friday, you are on, then you go to work. (…) But I think other countries may be a bit more like that; yes, in the time between twelve and two we relax, and we go and eat lunch. (…) in contrast to us Norwegians who just chop–chop–chop all the time. Then, when it is the weekend, yes, then suddenly it is allowed to put your feet on the table. But then you are often so tired that you can't put your feet on the table anymore. You just lay like carnage. No, I, I … Maybe our society needs a little push like that; yes, (…) it's okay to take a siesta on a Tuesday, for example.

In contrast, many participants talked about how their work at the Clubhouse was different from the regular labour market. For instance, they emphasized the importance of community effort, meaning that despite members' individualized schedules and workloads, results were still accomplished at the Clubhouse, because everybody contributed according to their abilities. Most participants said that they preferred coming to the Clubhouse every day to have as regular a work schedule as possible yet keeping flexible hours and taking regular breaks during the day to maintain their health. Noticeably, several participants identified work stress, and society's inability to prevent or improve it, as the major hindrance to regular employment.

I feel somewhat equal to others

Participants expressed a preference for Clubhouse practices and staff attitudes that offered dignity and personal value. Several participants seemed to feel that society's image of their role as passive was mirrored in the mental healthcare system. Many participants reported that Clubhouse staff acknowledged the abilities of members by asking for and accepting their help. However, they felt that employees of other

mental health care programs did not include patients/service users in requests for meaningful contribution, because they did not trust their competency. Moreover, one participant described being directly excluded from participation in another program. In fact, most participants generally seemed to find that doing meaningful jobs with others at the Clubhouse was a positive distinction from other programs:

> (It is important) to participate and do things with others—something that makes sense, that is, it is not like … We do not move anything from A to B and then move it back to A, but we, we wash … I clean the toilet for example. I help to make lunch. Everybody does something. (Emil)

Regarding their peers, participants seemed to view their community unanimously as a fellowship of equals, because all of them worked for a common goal. However, participants seemed to have ambiguous attitudes towards cooperation, which Mathias summarized in his interview:

> I'm kind of like that, like an overachiever, I like to get things done on my own. However, it is always nice to do things with others. One writes job applications together or helps (others) with things. (…) But it's not something you want all the time, either. I prefer most to work independently, or to get things done, but in cases like the World Day (i.e., preparations to celebrate World Mental Health Day) and such, there's a lot of collaboration as well. Yet, it's not all that needs to be done side by side either. Sometimes I feel like (a certain task) is a little like overkill for two to do.

The argument for working together seemed to concern sharing workload, increasing efficiency, and receiving and giving help, especially to new members. Furthermore, some participants mentioned that cooperation had helped them with self-regulation and learning to function with others, by letting others' opinions prevail or letting others take on tasks that one might have monopolized or previously felt to be one's own. However, several participants preferred to work alone, doing their own jobs for the common goal. Their reasons for this preference were their difficulty in maintaining focus in company, exhaustion in adapting to another person or vice versa, or finding the other's inability to adapt irritating.

While most participants agreed that their relationship with staff should be equal, and reported no major differences, they mentioned some issues. For instance, some members were more likely to rely on help from staff than from their peers, even if those peers were qualified to help. In addition, many participants seemed to appreciate that staff took responsibility for matters that Clubhouse members would not. For example, a participant reported that members preferred staff to do the tasks that were unpopular or occurred towards the end of the workday. Furthermore, several participants disapproved of fellow members trying to be the "boss" or taking charge in a problematic situation. Consequently, they considered taking control or assuming the role of peacekeeper to be a staff member's role, because they were paid and, thus, obligated to work and take responsibility. Admittedly, this was also considered to affect equality between staff and members:

> I see a challenge in the relationship between staff and members of having as flat a hierarchy as possible. However, we will never, uh, avoid the fact that there is a natural distinction because they are employed. It is very much up to, uh, the staff themselves to, to give the respect that the members need. And to give the space needed for members to use the Clubhouse as they are supposed to be able to. (Lucas)

Most participants agreed that maintaining social balance in the community mainly depended on staff attitudes. For instance, some mentioned that the role of staff members was to involve members in doing tasks and enable them to do so, instead of taking over and completing them themselves. Another possible staff mistake, as Mathias observed, was overprotectiveness:

> I feel that I have more responsibility than staff often think I do (…) I have found many times that when I take responsibility (…) it's often that they (the staff) become a little uneasy (…). I am very committed to (the idea) that the Clubhouse should be equal. (…) Anyway, I am little like that; I feel a responsibility for making sure that the … that the staff don't misuse it. I'm at least a bit like that; feel that I have some responsibility to make sure that … employees do not abuse it. Or if they aren't considerate … Yes, then I become like a watchdog.

Clubhouse members appeared to prefer staff to let them choose whether they accepted responsibility for a certain task. However, when staff intervened without being asked, it was perceived as an action that disturbed the balance of the community. Overall, participants seemed to have different expectations of staff that may put them in the precarious position of balancing several, often conflicting requirements.

Discussion

The aim of this qualitative study was to explore the experiences of Clubhouse members in Norway. According to our findings, Clubhouses offer a community that members can belong to and receive support from to re-establish their dignity, gain recognition, develop their sense of self-worth, and achieve a positive change in their perceptions of their status in society.

Overall, our results indicate that Clubhouse membership helps members to cope with the challenges caused by mental illness in everyday life by providing

access to resources such as social support and meaningful activities. An overall theme is that participants experienced a positive change in their identities that was strengthened by participation in the Clubhouse community. The most prominent aspect of their development appears to be the interplay between social support from the community and the level of motivation of the individual.

In our study, the statement "I was lying on the sofa, watching TV, doing nothing" was repeatedly mentioned by several informants as a precursor or alternative to their participation at the Clubhouse. A strong sense of demotivation seemed to dominate participants' lives, which admittedly changed for the better after they joined the Clubhouse. In line with previous research (Kinn et al., 2018; Norman, 2006; Pardi & Willis, 2018; Roth, 2017), we found that individuals gained several positive life experiences after becoming a member at a Clubhouse, so their range of available RRs have increased.

Furthermore, we suggest that the process of participating in the community increases members' motivation. This may be of great importance for continuing their recovery and avoiding isolation based on the role of meaningfulness in a person's SOC. Antonovsky (1987, p. 22) considered meaningfulness to be the most important element in shaping the outcome of coping as a sense of coherence, because, as a motivational factor, it decides whether a problem is even worth addressing. To maintain or increase the level of meaningfulness, Antonovsky (1987, p. 23) suggested investing in four basic life domains that inevitably have an impact on people's lives, such as major activity, existential issues, immediate interpersonal relations, and inner feelings. Correspondingly, we argue that Clubhouse participation provides members with positive life experiences in these four crucial areas of their lives.

First, the quality of a person's main activity is important, because having something meaningful to do on a regular basis that makes a difference improves self-perception, which in turn has an impact on staying motivated. In other words, positive experiences have a dynamic and mutually reinforcing relationship leading to further positive change. Similar to previous research (see for example, Hancock, Bundy, Honey, Helich, & Tamsett, 2013; Kennedy-Jones, Cooper, & Fossey, 2005; Norman, 2006; Tanaka & Davidson, 2015a), this study revealed that participating in the Clubhouse community provided individuals with regular and meaningful activities. In fact, consistent with our results, Clubhouse members generally report that their work at the Clubhouse made them feel "useful" and promoted their inclusion by allowing them—in the words of our participants—to contribute to "something bigger than themselves," which constitutes an important experience improving self-perception (Antonovsky, 1987; Norman, 2006; Pardi & Willis, 2018; Tanaka & Davidson, 2015a).

Second, the existential aspect of meaningfulness is the ability to cope with one's failures and shortcomings, death, conflicts, and isolation (Antonovsky, 1987, p. 23). Perceiving the Clubhouse setting as a safe and inclusive environment (Kang & Kim, 2014; Kennedy-Jones et al., 2005; Kinn et al., 2018; Tanaka et al., 2015) seems to play a crucial role in coping with these existential challenges by improving the availability of RRs and enabling their use. Consistent with previous findings (Biegel et al., 2013; Carolan et al., 2011; Hancock et al., 2013; Jung & Kim, 2012; Norman, 2006; Roth, 2017; Waegemakers Schiff et al., 2008), our participants experienced acceptance and inclusion in the community and felt reassured that they would receive ongoing and unconditional support from the Clubhouse. However, our results also show that staff members play a decisive role in whether members feel comfortable in the community. Similarly, previous studies indicated that poor relationships with staff, especially related to disruption of egalitarian status within the Clubhouse, is a major reason for members having a negative perception of the community (Roth, 2017; Tanaka et al., 2015), thus their existential stability.

Third, social connectedness is another key element, not just in terms of meaningfulness (Vinje et al., 2016) but in promoting recovery as well (Shanks et al., 2013). Participants in our and other studies (Biegel et al., 2013; Carolan et al., 2011) reported that the sense of belonging to the Clubhouse community was of major importance to them. Interestingly, the shared struggles with mental illness and the common experiences of a defective mental health system emerged as important community building factors between members, which corresponds to the findings of a previous study (Carolan et al., 2011). Apparently, the recurring experience of our participants of not being alone in imperfection or not fitting into a community may lead to the realization that one has a place in society.

Fourth and finally, the most prominent findings regarding the area of inner feelings, or positive and stable emotions (Vinje et al., 2016) include positive feelings towards the community and experiences of increased self-confidence. Previous studies corroborate our findings that the Clubhouse community is of great importance to its members and offers a family-like emotional experience (see for example, Biegel et al., 2013). In addition, it promotes an increased sense of self-worth, optimism, and hope (Biegel et al., 2013; Hancock et al., 2013; Tanaka & Davidson, 2015a).

Overall, Clubhouses arguably promote meaningfulness in salutogenic terms. Moreover, our findings demonstrate that these crucial areas also have

a strong mutual impact. Thus, we suggest that the experience of being a Clubhouse member can be described by a positive transformation of self. This development is due to increased motivation through having meaningful activity and a stable community to belong to. However, more research is needed to test whether Salutogenesis can really explain recovery processes in the Clubhouse model.

Moreover, probably with their increased self-confidence, our participants seemed to develop a critical view of their roles inside and outside the Clubhouse, the mental health care system, and the society, similar to the findings of Kang and Kim (2014). For instance, regarding other programs, our Norwegian participants expressed criticisms that they had been patronized and not involved in their own care. Mental health care providers play a major role in supporting individual recovery (Anthony & Mizock, 2014; Le Boutillier et al., 2011; MacDonald-Wilson, Deegan, Hutchison, Parrotta, & Schuster, 2013; Shanks et al., 2013). Thus, aspects such as promoting autonomy, partnership, codetermination, and inclusion are staples of a recovery-oriented service. While few explicit findings are available on Clubhouse members' perceptions of attending other programs from previous studies (see for example, Pardi & Willis, 2018), our results indicate that the mental health care field in Norway has room to improve its practices according to recovery-oriented policies (Norwegian Directorate of Health, 2014; World Health Organization, 2013) and principles (Anthony & Mizock, 2014; Davidson, Rakfeldt, & Strauss, 2010; Le Boutillier et al., 2011; Shanks et al., 2013). However, more research is needed to elaborate on these findings.

Additionally, all participants in our study reported a wish to find work or a meaningful occupation outside the Clubhouse. These findings are in line with previous research regarding the desire of people with mental illness for work (Bonsaksen et al., 2016; Crowther, Marshall, Bond, & Huxley, 2001; Organisation for Economic Co-operation and Development, 2012). However, several participants noted that their participation in the labour market and, thus, their chances of becoming included in society, were limited. They attributed this to the lack of solutions offered to them to overcome the disadvantages caused by mental illness, such as dealing with stress and society accepting their illness and embracing them for whom they really are as individuals. Concurrently, unemployment and underemployment of people with mental illness constitutes a major source of societal and economic loss (Organisation for Economic Co-operation and Development, 2012). Therefore, we suggest that the Clubhouse model may be a relevant example of the development of policies and solutions to improve the situation of people with mental illness in the labour market, mostly in terms of flexibility.

Finally, the results of this study correspond with those of previous international research in the field (Biegel et al., 2013; Jung & Kim, 2012; Norman, 2006; Pardi & Willis, 2018; Roth, 2017; Tanaka et al., 2015; Tanaka & Davidson, 2015a, 2015b), suggesting that being a Clubhouse member is a similar experience across countries, social systems, and cultures.

Limitations

In line with its qualitative, phenomenological design, the present study did not seek absolute truths, but attempted to reveal the essence of a phenomenon (Laverty, 2003). Owing to the intersubjectivity of this endeavour, other researchers may interpret the available material differently (Dowling, 2007). However, measures were taken to increase rigour throughout the process (Cope, 2014).

Notably, our participants showed an overwhelmingly positive attitude towards the Clubhouse community and attributed great importance to it in their lives. Previous findings reflect similarly positive opinions (Ritter, Nordli, Fekete, & Bonsaksen, 2018; Roth, 2017). However, one must bear in mind that all these studies, including ours, were only able to reach a limited number of members who were active in the Clubhouse community. Consequently, considering the voluntary nature of the model, it is reasonable to think that our participants had a positive bias towards and satisfaction with the model. It is likely that involving the group of former members who quit the Clubhouse would have yielded more diverse and, perhaps, more realistic results.

Disclosure statement

No potential conflict of interest was reported by the authors.

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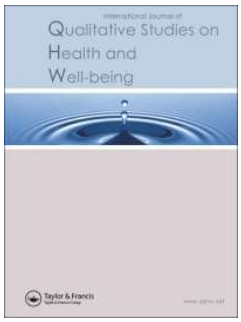

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Recovery at the Clubhouse: challenge, responsibility and growing into a role

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Recovery at the Clubhouse: challenge, responsibility and growing into a role

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ABSTRACT

Purpose: To explore how people with mental illness experience recovery in the Clubhouse context, and which ingredients of the model they find active in promoting recovery.
Methods: Hermeneutic–phenomenological design. Individual, semi-structured interviews with 18 Norwegian Clubhouse members. Systematic text condensation was used in analysis.
Results: Three main themes emerged: "Balancing unlimited support with meeting challenges", with two sub-themes: "Unlimited membership: space for self-agency or hindering development?" and "Becoming a Clubhouse member: concerns and positive experiences". The second main theme was: "Learning how to build new skills and roles in the community". The third main theme was: "Getting better through and for work", with two sub-themes: "Work at the Clubhouse as a means to recovery" and "Preparing for a working life in society". Overall, participants experienced improved mental and social wellbeing and work readiness.
Conclusions: Recovery in the Clubhouse context requires members' personal initiative, thus people having poor mental health might struggle with utilizing the Clubhouse. However, participants reported that lack of challenges within the community thwarted their recovery. Based on Salutogenesis, conscious application of challenge in Clubhouse activities might enhance members' recovery. Furthermore, participants' all-round involvement in their recovery journeys suggests the importance of shared decision-making in recovery-oriented services.

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Clubhouse model; mental illness; psychosocial rehabilitation; recovery; salutogenesis

Introduction

Empirical evidence has been mounting for several decades that mental illness is not a condition that inevitably deteriorates and that it is possible to recover from it (Davidson, 2003; Langeland et al., 2007; Leamy et al., 2011). Consequently, the recovery paradigm has become the guiding principle in global mental health (Anthony & Mizock, 2014; Le Boutillier et al., 2011; Ministry of Labour & Ministry of Health and Care Services/Arbeidsdepartementet & Helse- og omsorgsdepartementet, 2013; Norwegian Directorate for Health and Social Affairs/Sosial- og helsedirektoratet, 2005; World Health Organization [WHO], 2013).

Recovery has been described as a deeply personal, unique and transformative process, during which the person in recovery redefines her- or himself and several aspects of their lives, with the hope of living a satisfying life despite struggling with a mental illness (Anthony, 1993; Deegan, 2002). This is compatible with the theory of salutogenesis and the field of psychosocial rehabilitation (PSR), both of which emphasize that every person, at all times, has a healthy aspect to build upon (Anthony & Liberman, 1986; Antonovsky, 1979, 1987b). Furthermore, the recovery and salutogenesis literature highlights the distinction between "recovery from" mental illness, a biomedical approach with a focus on symptom management and treatment, versus "being in recovery", an approach in which recovery is described as a continuous active adaptation process in order to live a satisfying life in the face of a mental illness (Antonovsky, 1979, 1987b; Davidson, 2003; Davidson & Roe, 2007). According to the theory of salutogenesis, three personal attitudes might enhance the healing of a person in recovery (Langeland et al., 2007). First, it is necessary that the individual develop a more constructive identity other than that of a patient suffering from mental illness. Second, having confidence or being proactive in meeting one's challenges can promote processes of recovery. Third, since health incorporates multiple aspects of well-being, the individual's processes of being in recovery

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must take account of these, including physical, mental, social and spiritual dimensions (Langeland et al., 2007).

Noticeably, the recovery literature also underlines the social nature of recovery, pointing out that the social dimension is inherent in the recovery process (Mezzina et al., 2006; Topor et al., 2020). According to studies, the social surroundings might serve as a source of support and point of cultural reference for the individual, and an environment to exercise the self-agency one develops in their process of recovery (Mezzina et al., 2006; Topor et al., 2011, 2020). Therefore, high quality of social support in one's social environment is crucial as a part of recovery process (Langeland et al., 2016; Topor et al., 2020), and being a member of a Clubhouse might represent such a social environment.

As each person has a unique recovery process, the patient/consumer's involvement in and active adaptation of all aspects of service delivery/treatment are crucial (Antonovsky, 1979, 1987b; Le Boutillier et al., 2011; Davidson et al., 2017). Furthermore, because recovery is a non-linear process, recovery-oriented services should ideally have a flexible and individualized approach (Le Boutillier et al., 2011). Accordingly, recovery-oriented services are intended to provide support for the individual in achieving their personal goals (Le Boutillier et al., 2011; Davidson et al., 2007). Research suggests (Le Boutillier et al., 2011; Davidson, 2016; Davidson et al., 2017; Dixon et al., 2016; Fekete, Langeland et al., 2020; Langeland et al., 2007) that the engagement of the person in recovery in all aspects of care, or in shared decision-making (SDM), has a positive impact on outcomes and increases wellbeing. However, studies indicate that personalized care and SDM are not evident in practice (Davidson, 2016; Dixon et al., 2016; Oute et al., 2018). A possible reason for this is that service providers have difficulty in ascertaining consumer/patient preferences (Woltmann & Whitley, 2010), a factor that has been associated with a higher level of involvement of the consumer in SDM (Fukui et al., 2013).

We suggest that gaining an understanding of how people with mental illness experience their recovery process in the context of an evidence-based and recovery-oriented programme, such as the Clubhouse model (McKay et al., 2016; Raeburn et al., 2013), might help to develop a better insight into consumer/patient preferences. Apparently, there is a wide range of research related to the Clubhouse model, still, we could not identify research exploring members' experiences of vocational and social recovery processes in the Clubhouse community, which is the aim of the present study.

The context: the Clubhouse model

The Clubhouse model is a pioneer among PSR programmes (McKay et al., 2016; Raeburn et al., 2013), with the first Clubhouse, Fountain House having been established in 1948 in New York. Today, 300 Clubhouses operate in 38 countries (Clubhouse International, 2020). The model is regulated by the International Standards for Clubhouse Programmes, which also "serve as a 'bill of rights' for members and a code of ethics for staff, board and administrators" (Clubhouse International, 2018, Preamble) and provide a basis for quality assessment.

The programme offers community experience and useful activity for people with a history of mental illness (Norman, 2006; Raeburn et al., 2013). The principles and terminology of the model reflect its non-clinical nature. Thus, participants in the programme are referred to as member instead of user or patient, and participation is strictly voluntary and free for life (Battin et al., 2016; McKay et al., 2016; Propst, 1997; Raeburn et al., 2013). The programme offers their members community experience and possibilities of participation in useful activity (Norman, 2006; Raeburn et al., 2013). The basic intervention of the model is the work-ordered day (WOD), a workday following customary working hours in society. According to the Clubhouse model, staff and members are intended to collaborate side by side as equals on doing tasks related to operating the Clubhouse, from cleaning bathrooms through to making lunch, writing grants and planning programmes (Battin et al., 2016; McKay et al., 2016; Raeburn et al., 2013). Notably, the staff are not expected to act as service providers or care workers; their main task is to engage members in activities and assist in their inclusion in the Clubhouse community (Clubhouse International, 2018). In addition, Clubhouses offer support services for their members such as employment support, education support and access to housing and entitlements. It is not necessarily the staff who provide these services, but possibly a fellow member or a task group within the Clubhouse community (Biegel et al., 2013; Coniglio et al., 2012).

Previous Clubhouse research

Previous studies on the Clubhouse model have revealed outcomes that are arguably a part of the members' recovery journeys. For example, results from several quantitative studies indicate that participation in the WOD reduced relapse (Beard et al., 1978, 1963; Delaney, 1998), improved psychopathology (Tsang et al., 2010), quality of life (Accordino & Herbert, 2000; Tsang et al., 2010; Unger et al., 2002) and work readiness, and increased employment duration (Bonsaksen et al., 2016; Schonebaum & Boyd, 2012). In addition, a meta-ethnography of 16 qualitative studies of staff's, members' and families' experiences of the Clubhouse model (Kinn, Tanaka et al., 2018) revealed that individuals' recovery journey

within the community can be described according to the themes "stepping out of limiting realities", "anchoring" and "flourishing". Other qualitative studies, such as that of Tanaka and Davidson (2015a), revealed that the WOD improved members' autonomy, a common recovery goal, through developing work skills and providing respite and a sense of accomplishment. Moreover, Mutschler et al. (2018) findings indicate that participating at the Clubhouse helped members to feel better and at peace, to develop a sense of personhood beyond their identity as a patient and to acquire social, work related, and daily life skills.

Other qualitative studies relating to the Clubhouse model concerns the relationships and social networks of Clubhouse members, as these factors are strongly associated with recovery. Indeed, studies (Pernice-Duca & Onaga, 2009; Tanaka & Davidson, 2015b) have found that having reciprocal relationships at the Clubhouse indicates progress in recovery. Further research has claimed that members consider the Clubhouse community as an opportunity to (re) build their social network (Carolan et al., 2011), and have a strong emotional connection with it, considering their Clubhouse community as a "substitute family" (Fekete, Langeland et al., 2020; Pernice-Duca, 2008).

Methods

Study design

A qualitative, hermeneutic-phenomenological design was chosen to help to understand and account for people's experiences on the subject matter and how they construct meaning in their ordinary life world (Dowling, 2007; Gadamer, 2013; Laverty, 2003). Based on this approach, we sought a description of how participants constructed meaning of their experiences regarding the phenomenon of "recovery in the Clubhouse context" and interpret the findings in light of the research questions, by exploring the individual accounts in an inductive and iterative manner (Dowling, 2007; Gadamer, 2013; Kvale et al., 2015; Laverty, 2003). This study is part of the project "What is it like to be a Clubhouse member?"—Qualitative studies in a Norwegian context.

Participants and sampling

The study applied purposeful sampling, where being an established Clubhouse member was the criterion for inclusion. Members from three accredited Clubhouses, two in central Norway and one on the west coast of Norway, agreed to participate. An invitation letter with information about the project was made available to the members. Participants were also informed of their rights, such as the right to anonymity and the right to withdrawal at any time without consequences.

Participants gave their informed consent in writing before the interviews. Altogether 18 Clubhouse members, consisting of five women and thirteen men between the ages of 27 and 75, contributed with interviews, which had an average length of 50 minutes.

Data collection

For the convenience of the participants, the researcher visited their Clubhouses and conducted the interviews locally, in a separate office at each participant's Clubhouse with only the researcher and participant present to ensure privacy and anonymity.

Individual, semi-structured interviews were conducted during the data collection. An interview guide was used to ensure the consistency of the interviews, including questions such as: "Can you describe what it was like to come here in the beginning?", "What do you experience to be helpful to your recovery at the Clubhouse?", "Which activities at the Clubhouse do you find useful for entering the labour market?", "What are your recovery goals and how does the Clubhouse help you in achieving these?" and "How has your life changed since you joined the Clubhouse?" All interviews were audio recorded, and the researcher took notes to assist in the subsequent analysis.

Data analysis

Audio records were transcribed verbatim, partly by the first author and partly by a contractor. The method of analysis was systematic text condensation (Malterud, 2012), a four-step method. Inspired by Giorgi's phenomenological method, STC is a descriptive and explorative method (Malterud, 2012), following a four-step procedure for analysis, which lent itself for the project's hermeneutic-phenomenological design. The first step, which was conducted by all authors, was to identify preliminary themes that emerged spontaneously from the material. Taking these preliminary themes as a starting point in step 2, meaning units were identified in the original text, decontextualized from their original context, sorted by codes and classified, which resulted in the final themes. Subsequently, in step 3, the extracted meaning units were rewritten as a continuous text in the first person for each theme (condensates). Finally, in step 4, the condensates were re-narrated in third-person format and recontextualised in order to "elucidate the research question" (Malterud, 2012, p. 800). As a result, an analytic text was prepared presenting the major ideas within the

material concerning the phenomenon in question and illustrated by excerpts from the original interviews to represent the voices of participants (Malterud, 2012). During the analytical process, the results from steps 2 to 4 were continuously reconsidered in order to ensure the credibility of the data (Cope, 2014). The final findings were validated against the original transcripts and were reviewed and accepted by all of the authors (Malterud, 2012).

Ethics

The researcher had no personal affiliation with any of the participating Clubhouses. Procedures of cooperation were established in order to ensure the quality of the study process. These included regular meetings of the research group and the provision of continuous feedback to the first author, with emphasis on reflexivity (Probst, 2015).

Results

Three main themes emerged from the interviews regarding the participants' experiences of change and the factors promoting it in the Clubhouse environment, and sub-themes were developed under two of the main themes in order to provide clarity of the major topics building these main themes up. The first main theme was "Balancing unlimited support with meeting challenges", with the two sub-themes "Unlimited membership: space for self-agency or hindering development?" and "Becoming a Clubhouse member: concerns and positive experiences". The second main theme was "Learning how to build new skills and roles in the community". Finally, the third main theme was "Getting better through and for work". This main theme was also built up by two sub-themes: "Work at the Clubhouse as a means to recovery" and "Preparing for a working life in society". Table I shows an overview of the main- and subthemes we have developed.

Balancing unlimited support with meeting challenges

Participants' experiences of recovery at the Clubhouse seemed to be a balancing act between security and challenge, self-agency and support, described by the sub-themes below.

Unlimited membership: space for self-agency or hindering development?

Notably, every participant spoke appreciatively about how the free, lifelong membership the Clubhouse offered gave them time to recover. They linked this to positive experiences, such as being offered unlimited time to get better without any pressure and being ensured a stable support system to fall back on. As Lucas said:

> I don't know what it will be like then (when I get a job), but, uhm, I think that in any case the Clubhouse will be here for support if I need (…) if it is not working out very well, so I could, instead of getting sick leave and sitting at home, so I can come here and do … use the Clubhouse. Or I could get help with making the job work if I needed it.

Despite the leeway provided by unlimited membership, most of the participants seemed to agree that one must make the most of this time. For example, some voiced concern about settling into the Clubhouse community so well that one would hesitate to pursue goals outside of it. Mathias was one of those, saying: "But this is … unlimited time, which makes you … makes you relaxed. Uhm, hope not too much, because one would want to go out to work … " Still, most of the participants appreciated the opportunity of having the freedom to determine the pace of their own recovery, deciding their recovery goals and choosing the activities they wanted to partake in.

Commitment to sobriety seemed to be another important decision to make in order to participate at the Clubhouse. Some participants said that it created a more pleasant environment, while other participants said it motivated them to become drug-free. Notably, a participant credited this measure with enhancing the recovery focus in the Clubhouse community:

> Mantra number one in the house is being drug-free when you are here, in any case, no matter what. And I feel that if we, like, let it slide that people can (come when they are under the influence) … it would kind of lower the bar too much, because this is actually a place where people have taken the decision that they want to be healthier. (Thomas)

Many of the participants reported that taking their recovery into their own hands and asking for help seemed to be the most basic form of taking initiative. Participants mentioned a range of issues they might

Table I. Main themes and subthemes.

Main themes	Sub-themes
Balancing unlimited support with meeting challenges	Unlimited membership: space for self-agency or hindering development?
	Becoming a Clubhouse member: concerns and positive experiences
Learning how to build new skills and roles in the community	
Getting better through and for work	Work at the Clubhouse as a means to recovery
	Preparing for a working life in society

ask for help with, such as contacting official entities such as one's GP or the Labour and Social Services Agency or writing CVs and official correspondence. At the same time, many of the participants noted that help was readily available at the Clubhouse:

> Very easy (to get help). You do go to for example … like the way I did, you go to a staff member and say … now I would like to do this, and I need a little help with it … and so you get that help. If that person there cannot help you, so you maybe try to find someone who can help … (Emma)

However, some of the participants described issues connected with receiving help from staff, suggesting that receiving help might also be dependent on one's readiness to take control. For example, according Theodor "those who are more uninhibited get help, and those who are in a way a bit slow, they fall into oblivion."

Still, participants seemed to turn to staff more than their peers to provide them with support. However, some participants emphasized the risk of staff solving members' problems rather than helping them to meet challenges themselves. However, others, such as Oscar, described being able to grow from meeting challenges posed by staff:

> So, after half a year, and then became … Then I thought, then I was still, in a way … Had extremely low self-esteem, so, no, I did not want to do the whiteboard presentation (task allocation at the unit meeting), as I said to a staff member. But then she went: "Well, you can learn. You do this there." "No, no, no." "But yes!" And then she persuaded me to do it then. And then things went pretty well … (Even) if that's not the case (i.e. success), right? So, you have to be really … You should try, okay, cut out complaining and stuff, and focus on resources and stuff. And I really did.

Becoming a Clubhouse member: concerns and positive experiences

Owing to the fact that participants described making conscious choices and taking initiative as key elements in their recovery processes, it seemed to be the general experience that the Clubhouse would best suit people who are prepared enough to make these efforts. For example Anna, described herself as not being ready for the Clubhouse the first time she tried to join:

> I was at the Clubhouse maybe a year ago. I was there three times with my therapist, who recommended it (the Clubhouse) to me. But then I only came here those three times, because I was … I think I didn't know why … not totally why I should be here, so I wasn't ready. Then a year passed, and I became super ill, and so … well, in the hospital they are really aware of the Clubhouse. They knew that this here is really good, so they tried to get me in here. So I came here, and so I met again one of the staff members who works here, I knew some of the people here a little, right, and so I felt that this is my only chance to … to get a … get an … everyday, which … well with routines.

Opposite of Anna's experiences, other participants who had a positive community experience, mentioned becoming members at their first encounter with the Clubhouse, such as Emil, who said " … it (the Clubhouse) was at once very inclusive. I felt myself … I was very welcome, but not just in the beginning. (…) I was shocked that everybody said hi." Participants like Emil reported to find a suitable opportunity in the Clubhouse; both as place to socialize, and as an alternative to other mental health services, which they had not provided them with suitable results.

However, a few participants said that they had found the introduction phase confusing and insecure and, as a result, they considered quitting in the early stages of their membership. As Lucas said:

> I was frustrated then, because I didn't quite know what to do, and, and no one saw it either, so … I was about to stop coming here. (…) And it was a little complicated, it was … People thought I needed help all the time. That I didn't understand what to do. But … Yes, I talked to a staff member and then, uhm, she thought I was a good fit for accounting. And that … So, after that, I got some training, uhm, in the routines there and … Yeah, ever since then I've been dealing with the accounting.

Others described taking a careful approach to settling into the Clubhouse because of anxiety arising from previous experiences of exclusion and stigmatization in other services.

In addition, some participants suggested a level of difficulties with including everyone equally into the Clubhouse community. These participants talked about feelings of discomfort facing peers whose behaviour was dominated by their mental illness. These members with apparent symptoms were perceived to not fit in the community because they were not ready to offer support for others, thus contribute to the community effort or were perceived as draining the energy of others. Axel described it as such "I miss a normal workplace sometimes. Where you might not have to deal with sick people (…) It can be tiring."

Learning how to build new skills and roles in the community

All of the participants said that one of the means of improving their everyday coping and wellbeing was participation and social interaction in the Clubhouse community. They reported that the Clubhouse environment was warm and welcoming, which provided them with a safe space for social interaction. However, settling into the community was described as a difficult process of learning the system of meetings, tasks and getting familiar with the status quo between members and staff.

Getting used to the Clubhouse seemed to bring with it the task of defining relationships. For example, some participants described developing relationships in which they could open up by discussing their challenges and asking for or listening to other members' opinions about them. However, some of the participants also said they had to establish boundaries so as not to exhaust themselves by socializing with those whom they were not particularly drawn to. Still, many of the participants saw the interactions with their peers as an important part of their personal growth process. Several participants, such as Emma, described positive changes in their social capacities as a result of social interactions at the Clubhouse:

> So I … I actually learnt quite quickly when I started collaborating with others that I could be quite harsh, but … and when I thought when I was home and was only for myself, sort of, but … then you got that feedback … not so straight maybe, but you realised that here I have to do something.

Another important topic in the community seemed to be discussing one's mental health challenges with both fellow members and staff, which is demonstrative of a feeling of security. Notably, the shared experience of mental illness seemed to be a unifying issue for members, and it gave them an opportunity to provide a kind of nurturance to each other that the staff could not give. Maya described this as follows:

> It is also cool to be able to mean something for someone in that situation. To be able to be with the tours and be able to support them and say, "You'll get over this, this is just a bump" and like "I've been there myself", and, well … And to only be able to say that sentence, that you yourself have been hospitalised, uhm, that, it established a kind of trust that, uhm, maybe those who are staff members cannot …

Many participants also credited their symptomatic improvement to their Clubhouse membership. In fact, some participants said that they purposefully used the Clubhouse as therapy, such a form of exposure therapy for social anxiety. Yet another participant, Thomas, chose the Clubhouse over another form of treatment:

> I had been ill for a long time, eh, and I thought, "What will it take for me to recover even faster? What will it take for me to have a much faster recovery process?" (…) So my therapist said: "I cannot do anything more for you, either medically or conversationally, but get yourself into group therapy." But much of what I was able to imagine or that was promised to happen in group therapy, has, has … is actually happening here at the Clubhouse. (…) Uhm, so I feel like this has worked as a treatment for me.

Every participant commented on different aspects of the positive social influence of belonging to a Clubhouse. As one of them put it, the Clubhouse was a place where one could "exercise their social muscle." Indeed, several participants said that the Clubhouse was an arena for honing their social skills, especially after a long bout of isolation.

> Uhm, there is a lot of opportunity to socialise here, anyway. To talk to people and make friendships and maintain them. Uhm, so I don't get stage fright. If you have spent too much time alone then it is scary to go out. So, you break that (pattern) in a way. (Axel)

Moreover, many of the participants underscored the importance of having a community that was open and available to them no matter the circumstances. For instance, one participant noted that this was the first place in her life where she felt accepted, and several participants reported having built up a sizable part, if not all, of their social network through the Clubhouse.

Getting better through and for work

Work was a central topic of the interviews, emerging in two subthemes: the meaningful work one did at the Clubhouse as a means to propel the recovery process, and obtaining and keeping work in the labour market as a recovery goal.

Work at the Clubhouse as a means to recovery

In terms of work as a means, several participants said that it was important for them to be able to do meaningful tasks for the Clubhouse community because it helped them not to ruminate over their problems and health issues. Accordingly, many participants reported feeling healthier by working at the Clubhouse, merely by shifting their focus from their illness to something positive. One of the participants, Maya, described it by saying "you must fill your day with something meaningful. (…) It doesn't have to be much, just something concrete that you can focus on instead of your problems."

Furthermore, some of the participants commented on several aspects of the positive influence of work participation at the Clubhouse. For instance, one participant expressed a hope of reducing the amount of medication he takes thanks to his more structured daily life, and others talked about how the workday schedule made them feel more ordinary in relation to society at large, and two others reported having a more satisfying private life as a result of the structure that the Clubhouse had instilled in their lives.

> Uhm, (what's important is) a meaningful everyday life. A job to go to, and I consider this to be my job today. And then it's about having good friends. Have some free time. Go to a party sometimes, with no kids and, right. And then … And be with my kids, do nice things … So, so (I don't receive) any support from the Clubhouse directly to be a good mother, but (…). Well, since I have a work-ordered day, then, it probably means that I manage to be a better mother … (Maya)

Most of the participants mentioned having the option for self-improvement at the Clubhouse, such as discovering one's work capacity, experiencing one's own potential, taking pride in one's work achievements, realizing new talents and interests and working on developing specific skills. In addition, one of these participants described the Clubhouse as a place for experiencing success, and as such, as an opportunity to build self-confidence and self-esteem.

Interestingly, there seemed to be marked preferences when it came to the type of work participants favoured, which appeared to extend also to the TEPs (transitional employment placements) and choice of work unit. The two poles of these preferences were clerical and kitchen work. While office work was praised as being mentally challenging and more complex and the clerical unit as being a calmer space, these were also criticized as being boring and as not showing obvious results. At the same time, kitchen work was credited as being active and producing obvious results, and hence for instant gratification, even though it was criticized as not being mentally challenging enough.

> Well, all is not money, because the time we spend here on earth, it is measured, it is small. We do not know if we will ever get any more, at least as it is in my chosen, my view of life, so it is important to use it to please yourself, to please others and to enjoy your everyday life. And what better way than to cook? You know, to please others. I don't feel like I could please others by sitting in an office, to be completely honest. (Thomas)

Preparing for a working life in society

Several participants said that they had become Clubhouse members to get help with getting back into the labour market. Interestingly however, none of them expressed a desire to continue in their previous professions. In fact, those who discussed this issue said that they had made their choices explicitly to avoid jobs similar to their former ones, which many of them thought had caused their recurring relapses. Moreover, one participant said he wanted to avoid the environment of his previous job, where drugs were prominent.

In addition to the participants who contemplated new career paths, several others said that participation in the Clubhouse community made them realize that they could have a career despite having a serious mental illness and use their participation in the work-ordered day as a stepping-stone towards competitive employment. They reported that the work they did for the Clubhouse community provided them with a feeling of usefulness and a sense of accomplishment, which in turn gave them hope regarding their return to the labour market. In addition, some of the participants, such as Olivia, reported receiving support to try skills they did not know they had:

> (They asked me at the Clubhouse) "What do you want to work with? What are you dreaming of?" And … I've always dreamt of becoming an accountant. But I never dared. Because I felt I was too stupid, I wasn't … I wasn't good enough to be one. (…) But then a staff member said to me, "But why can't you? You just go to evening school, you also go to college, and you go where you have to go, and then you're done." It was … It was that simple.

Accordingly, several participants said that being active at the Clubhouse would smooth their transition back to work from long-term sick leave or unemployment. In addition, some of these participants reported that, ideally, they would like to get a job after being a Clubhouse member for some time, even if it was "just" a part-time job, a transitional employment placement (TEP) or studies.

Notably, while several participants said that TEPs were a good opportunity, being a springboard to the labour market, a few of them noted that it was too hard to get a TEP, and most of the available TEPs were unidimensional, as explained by Thomas:

> We have something called transitional employment here at the Clubhouse, and it is 100 percent office work. Or uhm, I'll say it like that, office work one can do even without completing high school. I think we should take it a step up, because there are quite a few resources here that are smart as hell, but who, uhm, don't like … (…) Have some that are a bit more complicated (…). And I also wish they could get more transitional employment places simply with restaurants there. Or canteens or whatever.

Beyond support in obtaining employment, several participants described many ways in which they found their Clubhouse participation useful for the labour market. Among these were the meetings at the Clubhouse, which are considered to be helpful for practising job skills such as professional communication and public speaking. In addition, Emil discussed further opportunities for learning to act and communicate professionally at the Clubhouse:

> It (the Clubhouse) is for finding out how one works. What is it like to go into a canteen with lots of strangers, for example? What is it like to come to work and find a closet or room … ? Where should one put one's bag? What, what … If one hasn't had an office. So, all that, one would be able to try out. (…) Well, it is about getting to know themselves, to be confident in themselves.

However, not all participants expressed a desire to obtain regular, paid employment in the labour market in the future. Many reasons were given, such as feeling that one's illness was too disabling, having been granted a disability pension and having one's finances in order. Yet others declared themselves too old to go back to work, "having done enough for society

already", even though only a fragment of this group was over the working age (67 years in Norway).

Discussion

A message from the participants interviewed in this study was the importance of developing a new and stronger identity, after experiencing the debilitating effects of mental illness, a notion also recognized in the literature as crucial part of being in recovery (Anthony & Mizock, 2014; Davidson et al., 2017; Deegan, 2002; Dixon et al., 2016; Norman, 2006; Solomon & Gioia, 2016). Furthermore, personal choices regarding the development of a new identity and roles are considered crucial for enhancing the recovery process, as indicated in our results as well as in previous studies on recovery (Davidson et al., 2017; Stanhope et al., 2013; Topor et al., 2020) and salutogenesis (Antonovsky, 1979, 1987a; Fekete, Kinn et al., 2020; Langeland et al., 2007).

As in previous research, our findings indicate that there is a positive link between Clubhouse members' social networks and processes of recovery, and that the Clubhouse community is shaped by dynamic interplay between members and staff (Biegel et al., 2013; Carolan et al., 2011; Fekete, Langeland et al., 2020), where staff were described as key providers of support. As shared experience plays an important role in integrating isolated people into the community, as shown in salutogenic research (Vaandrager & Kennedy, 2017, p. 166), our results similarly showed that peer relationships were based on common experiences with ental illness.

Furthermore, research indicates that the social network of a person in recovery, including their family, care providers and peers, have a crucial impact on their recovery outcomes (Davidson & Roe, 2007; Davidson et al., 2017). For instance, a person's social network has been identified as a key resistance resource that may help the individual cope with life challenges, thus improving their health and wellbeing (Antonovsky, 1979, 1987a; Langeland et al., 2016; Topor et al., 2011, 2020), and the quality of social support has been set out as a cornerstone of the health-promoting theory of salutogenesis (Fekete, Kinn et al., 2020; Langeland et al., 2016; Langeland & Vinje, 2016).

In terms of social support, the sense of acceptance and feeling of security at the Clubhouse community, provided a safe arena for (re)building personal identities, thus promoted recovery according to previous studies (Biegel et al., 2013; Fekete, Langeland et al., 2020; Kinn, Tanaka et al., 2018; Pernice-Duca, 2008; Tanaka & Davidson, 2015b). However, when this feeling of security was not balanced with challenges to be met, it had a negative effect on the recovery processes, an issue raised both in the present study and in previous research (Kinn, Tanaka et al., 2018; Raeburn et al., 2013). This also resonates with a previous study (Fekete, Kinn et al., 2020) that points out that overcoming challenges and solving problems give an experience of mastery and capability, could give an opportunity for enhancing positive development within the Clubhouse model as described by salutogenic theory (Langeland et al., 2016; Langeland & Vinje, 2016; Langeland et al., 2007)

Our results echo previous research that participating in meaningful activity at the Clubhouse made an important contribution to health and wellbeing (Fekete, Langeland et al., 2020; Norman, 2006; Perrins-Margalis et al., 2000; Tanaka & Davidson, 2015a; Waegemakers Schiff et al., 2008). As noted in the salutogenesis literature, work can serve both as an end and as means, to instil routines and everyday structure in a person's life and as a source of personal growth (Langeland & Vinje, 2016). Correspondingly, the theory of salutogenesis suggests that regular meaningful occupation of any kind, such as paid or unpaid work, voluntary community activity or studies, can also be beneficial to the recovery process, as it enrichens the meaningfulness factor, the motivational element in the sense of coherence (Fekete, Kinn et al., 2020).

Obtaining regular employment is underlined as an important goal in both international and national health care and social policies (Harnois & Gabriel, 2002; International Labour Organisation, 2017; Ministry of Labour/Arbeidsdepartementet, 2013), because it promotes individuals with an opportunity to sustain themselves, gain a sense of achievement by contributing to society and experiencing self-realization. Similarly, the Clubhouse model has a prominent focus on promoting work participation for its members (Clubhouse International, 2018), thus have a preference for developing a worker role as a central goal (Kennedy-Jones et al., 2005; Norman, 2006; Tanaka & Davidson, 2015a). In line with these aims, the majority of participants had plans regarding future employment. However, not all of the participants were willing to return to the labour market. Exploring clubhouse members' personal reasons behind this decision, both in Norway and internationally, could reveal factors that may have an effect on these people's vocational recovery journey.

Conclusions

Our results indicate that vocational and social recovery in the Clubhouse context is a transformative experience: a step towards a better life and evolving into a personally preferred role in particular. Self-determination and the ability to make life choices were valued components of this process and were contingent upon the possibility of choice offered by unlimited Clubhouse membership.

While consistent with international policies the Clubhouse model focuses on possibilities enabling

individuals to participate in work, our results indicate that developing a worker role was not necessarily the main goal of study participants, but rather achieve development in social aspects of their lives. Nevertheless, in line with the principles of recovery and the theory of salutogenesis, participation in meaningful work-related activities for the Clubhouse community was reported as enhancing recovery. This finding indicates that participation in meaningful activities and socializing in the community constitute all together important elements of a recovery-oriented programme.

Another recovery-promoting ingredient that emerged from this study was the provision of a wide playing field for the person in recovery, such as the unlimited membership offered by the Clubhouse model. However, self-agency and taking responsibility seemed to be key to making the best use of such an opportunity, which individuals with a poorer mental health status might not be able to achieve. Consequently, we suggest that Clubhouse communities, as well as similar PSR programmes, focus on enabling people at all stages of their recovery journeys to seamlessly join the programme, settle in and find appropriate roles. However, our study indicates that such processes should be balanced with offering greater challenge for those who need it: providing individuals opportunities to take responsibility and become empowered. These findings may be important in terms of shared decision-making in recovery-oriented services, suggesting that those persons who are able to are, given the opportunity, likely to take an interest in and actively participate in designing and conducting their own therapies/interventions.

Limitations

While our findings are the result of a rigorous and ethical methodology, owing to the nature of qualitative research they are not intended to be representative. Rather, the aim was to enhance our knowledge on the basis of the experience and views of these participants. While we employed procedures to enhance reflexivity by carrying out the analysis and discussing the findings in a group setting, our results are not absolute (Fossey et al., 2002). Further research might uncover nuances in our findings or provide additional data. Furthermore, one must bear in mind that, due to the method of recruitment in this study, it is likely that the Clubhouse members who volunteered to participate were among those who more actively utilized the Clubhouse and who were thus probably more active in the realization of their recovery goals.

Disclosure statement

No potential conflict of interest was reported by the author(s).

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