COACTION

REVIEW ARTICLE

"Hitting the wall": Lived experiences of mental health crises

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Abstract
Background: As Norway moves toward the provision of home-based crisis response, knowledge is needed about understandings of mental health crisis and effective ways of addressing crises within the home.
Objective: To elicit and learn from service users' experiences about the subjective meanings of crisis and what kind of help will be most effective in resolving mental health crises.
Theoretical: A phenomenological-hermeneutic cooperative inquiry method was used to elicit and analyse focus group responses from mental health service users who had experienced crises.
Results: Findings clustered into three themes: (1) Crisis as multifaceted and varied experiences; (2) losing the skills and structure of everyday life; and (3) complexities involved in family support.
Conclusion: Several aspects of crises require an expansion of the biomedical model of acute intervention to include consideration of the personal and familial meaning of the crisis, attention to the home context, and activities of daily living that are disrupted by the crisis, and ways for the person and the family to share in and learn from resolution of the crisis.

Key words: *Acute mental health care, service users, experience-based knowledge, mental health crisis*

When I feel things go downhill I take the dog with me for a long walk. And I mean a long walk – till I get really warm. Afterwards when I get home I put on Hot in the City by Billy Idol.

This is how a woman with many years' experiences with mental health crisis described her ways of dealing with these situations. When she got some warning signals of mental distress, she had learned that intensive walking with her dog and playing load music with her favorite singer helped.

In recent years, there has been a rapid growth in the involvement of service users in service transformation, in mental health research and in the debate of what constitutes evidence (Rose, Thornicroft & Slade, 2006). The value of lived experience for the mental health knowledge base as well as quality improvement of services has been gradually more appreciated, although involving tensions (Borg, Karlsson & Kim, 2009). Community mental health

care, practiced in an independent or a team mode, demands health professionals to approach service users in the everyday context rather than in the institutional context, thus making user involvement a key orientation in practice. Crisis resolution home treatment (CR/HT) teams is one of the recent service models of community care with a major focus of providing appropriate services for acute crisis events in peoples' homes. The new service contexts calls for a transformation of existing practice models as well as developing a relevant knowledgebase drawing on service users' as well as practitioners' experiences. This was the background for the research project the present paper draws upon. The concrete aim of this article is to explore service users' subjective experiences of mental health crisis from first person perspective. Two research questions were asked: (1) What does it mean to have mental health crisis? and (2) What does it mean for

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the person to involve family members in the crisis situation? We describe this study and our findings below.

Background

In line with the World Health Organization policy, and reflecting developments in mental health services internationally, decentralization has been the developmental trend during the last decades in the western countries with the target to minimize hospitalization and maximize care and support within the person's everyday life context (Borg & Davidson, 2008; European Commission, 2005; Killaspy, 2006; Mezzina, 2005; SAMHSA, 2009). A significant recent development is the crisis resolution home treatment teams with the objective of providing available and accessible community-based crisis services and an alternative to in-patient acute admissions (Fulford & Farhall, 2001; Glover, Arts & Babu, 2006; Sjølie & Karlsson, 2010; Winness, Borg & Kim, 2010). In Norway, there has been an ambitious implementation plan for this new service. The Norwegian Health and Social Directorate targeted the creation of CR/HT teams in all 78 community mental health centers in Norway by 2008 (Norwegian Ministry of Finance, 2005). This directive is based on international research evidence that suggests CR/HT is preferable to and a more effective form of service provision compared with acute institutional care (Norwegian Directorate for Health and Social Affairs, 2006). The literature provides some insights into the effectiveness of CR/HT teams both at macro and individual levels. Established CR/HT teams in England have been shown to significantly reduce hospitalization. Glover and colleagues (2006) report that teams providing a full 24 h 7 days a week service reduce hospital admission on average by 32%, while teams without "full cover" also reduce admission on average by 10% in comparison with areas without these services. A recent literature review by Sjølie and Karlsson (2010) also reveals reduction of hospital admission. This review (Sjølie & Karlsson, 2010) reports that the knowledge regarding CR/HT primarily focuses on three areas: structural issues such as standards, organization, and development; process issues in terms of clinical interventions; and outcome in relation to cost-effectiveness and admission rates. There is paucity of studies on clinical intervention methods in home treatment as well as a limited attention on outcomes at the micro level.

Studies focusing on more person-centered outcomes report benefits including user satisfaction and family engagement (Glover et al., 2006). For example, Karlsson and Hultberg (2007) note that the service users of a CR/HT team felt a greater sense of control and an appreciation for having choices and opportunities for participation. A newly published literature review on the service users' experiences with crisis resolution and home treatment (Winness et al., 2010) identifies three domains as being particularly important in responding to crises: the availability and accessibility of crisis support in the home context, being understood and met by the clinicians as a "normal" human being, and the value of dealing with the crisis within the context of the person's everyday life.

Persons suffering acute mental distress represent a heterogeneous group, with differences experienced both across individuals and over time. Factors such as lack of access to services and support, homelessness, poverty, unemployment, discrimination, and other health problems may be as much a part of the situation as strictly defined psychiatric symptoms (Borg et al., 2009; SAMHSA, 2009; Tew, 2005). Service users' experiences of what constitutes effective help in an acute crisis remind us of the limitations of narrow biomedical models in understanding mental distress and the need for more socially oriented knowledge (Hultberg & Karlsson, 2007; Wilson & Beresford, 2002; Winness et al., 2010). Tew (2005), for example, calls for a plurality of overlapping perspectives that reflect the complexity and diversity of experiences based on factors such as gender, culture, economic status, age, family, and social relationships, and personal biography. Although medicine may offer help through psychopharmacology, medications alone by no means represent a sufficient response to mental distress. Understanding crises solely as biological events does not offer a comprehensive enough understanding of the phenomenon to enable practitioners to assist people effectively in dealing with the personal experiences and/or social difficulties that have contributed to their mental distress (SAMHSA, 2009; Wallcraft, 2005; Wilson & Beresford, 2002).

The research perspective and methodology

Having subjective experiences and meaning as our focus of attention, this study was carried out within the framework of a hermeneutic phenomenological cooperative inquiry approach (Borg, Karlsson, & Kim, 2010; Finley, 2011; Hummelvoll, 2008; Reason, 1994). The study was inspired by Finley (2011, pp. 15–16) describing "doing phenomenology" as a focus on lived experience and meaning; the use of rigorous, rich, resonant descriptions; a concern with existential issues; and a potentially transformative relational approach. The meaning of any phenomenon is generated and created through

dialogs in social relations as words and stories are shared in a common and inter-subjective discourse. The research into the experiences and meanings of mental health crisis and of involving family members in the crisis situation began with these perspectives as the foundational ideas.

Study context

Data for this paper were derived from a larger project entitled "Crisis Resolution and Home Treatment in Community Mental Health Care" that has been described elsewhere (e.g., Sjølie & Karlsson, 2010; Winness et al., 2010). This study emphasized the importance of understanding mental health crises from various perspectives through involving a variety of stakeholders in the research process. Consistent with the emphasis on experience-based input described above, we included in the research process a number of key stakeholders, such as service users, family members, and clinicians, in a variety of roles. One role has been to serve on a competence group consisting of two family members and three former service users. Inspired by the concept of participatory research (Beresford, 2003; Cornwall & Jewkes, 1995; Davidson, Stayner, Lambert, Smith & Sledge, 2001), this group has not only described and reflected on their own experiences but also has been involved in developing interview content and inclusion criteria, in conducting data analysis, and in ongoing planning and discussions throughout the entire study.

The substudy to be reported below focused specifically on the experiences of service users and was carried out using a qualitative design involving focus groups. A person with lived experience with mental distress and as a service user (author three) participated as a moderator together with the first two authors utilizing the cooperative inquiry approach. The fourth author participated in writing the discussion and overall review of the paper.

Cooperative inquiry

Cooperative inquiry involves not only integrating theory and research into the practice of participants but also developing new knowledge through the inquiry process itself (Cornwall & Jewkes, 1995; Davidson et al., 2001; Hummelvoll, 2008). Researchers and participants in the role as co-researchers work collaboratively in identifying problems, deciding on themes for inquiry, selecting a research design, and designing projects for clinical implementation (Beresford, 2003). In a cooperative inquiry, practice innovation runs parallel to the research process. It is essential that the researchers

take an active part in the ongoing, innovation process, and do not become isolated as outsiders who passively observe events as they occur (Hummelvoll, 2008).

In the present study, multistage focus group meetings were used to engage service users actively in both the research process and knowledge production. The multistage focus group is characterized by exploring a certain theme or phenomenon through several meetings, and is described by Hummelvoll (2008) as inquiring into knowledge dialogs and subjective meanings emerging from experiential material. In this way, it is possible both to articulate the participants' experience-based knowledge and to elevate this knowledge to a higher level of abstraction.

Data collection

Three focus group meetings were held during a period of 6 months in 2009. These groups involved semistructured discussions related to participants' personal experiences of mental health crises and were based on the two research questions described above. The meanings of crisis and of family involvement were carefully explored through the social relations of the group setting and stories were shared in this intersubjective discourse. The meetings were audio-taped and transcribed verbatim. Summarized notes of the transcripts for each meeting were shared with the participants (the persons with lived experiences) at the beginning of the subsequent meeting for feedback and to provide a context for open dialogs (Hummelvoll, 2008; Reason, 1994). The duration of the meetings was from 1.5 to 2 h. All meetings were led by the researchers.

Participants and co-researchers

Inclusion criteria for the study were: (1) adults with experiences of mental health crises and (2) persons with experiences with mental health services. The participants were recruited through the local mental health service user organization.

Four women and two men participated in the focus groups. All six took part in the first group, while in the second and third groups five participants (four women and one man) were present. The youngest was 24 years and the oldest 64. Three were married, one was divorced, and two were single. Four had children and they all had a stable and permanent place to live. One participant was a student, two others were students and also active in voluntary work, and one was unemployed and on a disability pension. The sixth participant did not report on occupation. In terms of service use, two participants had received services from the local crisis resolution home treatment team, two had

received care from acute admission wards, and four had attended outpatient clinics between 2 and 4 years. Two participants were receiving mental health services at the time of the focus groups.

This study was performed to elicit and interpret experiences and meanings of the participants' descriptions of mental health crisis situations.

Data analysis

Having subjective experiences of mental health crisis from first person perspective as our major focus, we chose to analyse the interview texts using a phenomenological hermeneutic method of interpretation described by Lindseth and Norberg (2004) and drawing on our own previous research (Borg et al., 2010; Davidson, 2003; Karlsson, 2004). The phenomenological hermeneutic interpretation consists of four phases: the naïve understanding, the structural analysis, the comprehensive understanding, and formulating the findings. In the naïve understanding, the texts were read several times to grasp their meaning as a whole. This phase guided the second one—the structural analysis, where we divided the texts into meaning units following the objective and research questions of the study. The meaning units were condensed and divided into subthemes and themes. The final phase, the comprehensive understanding, was developed from and supported by the naïve reading, the structural analysis, and reflexivity on the researchers' understanding and interpretation of the material (Finley, 2002; 2011). At the end, the researchers returned to the transcripts to verify and supplement findings and discussions, and develop a new comprehensive understanding (Lindseth & Norberg, 2004).

Ethical issues

The project was approved by the Regional Committee for Medical Research Ethics South-East Norway and Norwegian Social Science Data Service in 2007 for both the protection of the research participants and the safeguarding and protection of data.

Findings

Our findings are presented through the following themes: (1) Crisis as multifaceted and varied experiences; (2) losing the skills and structure of everyday life; and (3) the complexities involved in family support.

Crisis as multifaceted and varied experiences

All participants reported a long history of crisis events, some for more than 20 years. They also had experiences of involving family members and social networks in these situations. The crisis experiences described in the context of the focus groups differed in several ways. For example, some participants talked about crises developing gradually, whereas others had stories of crises appearing instantly, with no warning. One participant talked about the gradual onset of a crisis as:

"You know, it's like walking around and having a dark cloud hanging over your head constantly. I feel like being all on my own, burdened with all my thoughts and feelings and not able to share them with anyone."

Another person put it this way: "I feel so lonesome and I'm thinking all the time whether or not, or how, I should commit suicide. I kind of store up all my feelings and suddenly it says bang." For some, the experiences of the gradual crisis could be familiar, something the person had experienced earlier:

"I don't feel that anxious like the first time I had a crisis. Now I recognize the signs, I know my feelings, and I can take my precautions. I stay inside; I go early to bed, take my medicine, and call my general practitioner if I need to."

The instant crisis was characterized as coming out of the blue. It appeared suddenly and unexpectedly, and the person had no indication of a crisis emerging. This experience was described as similar to being thrown to the ground by thunder and lighting. One participant reported:

"I was sitting and watching TV, and suddenly it felt like an earthquake surrounded me. I didn't see anything, hear anything, or feel anything. The next thing I remember was finding myself in my bed waking up after three days of sleeping."

Another participant said:

I didn't understand what was happening or what was coming. I thought it simply would pass, but suddenly it said BANG. I didn't manage to do or feel anything, everything was dark. I had hit the wall.

And in the words of a third participant:

I woke up and realized that I had harmed myself. I got very anxious because I felt that I was out of control in the way that somebody else dominated me and told me what to do.

Another difference in the experiences of a mental health crisis was related to participants' reflections on why it had happened. What were the reasons? Why did this happen to me, and how can I explain these experiences to myself and people around me? All of the participants had experienced these questions coming up whether the crisis was described as developing gradually or instantly. Some of them talked about the experiences of the crisis being related to their childhood and family relations. One participant said:

> I'm thinking of why this crisis happens to me. There is a clear pattern from my childhood and how I was brought up, to how and why I experience a crisis. It's all about the emotional and relational experiences in my family. I grew up very tense and sensitive of my own feelings and reactions towards myself and others. In a way I feel more vulnerable the older I get.

Other participants reported that their crisis could contribute something positive to themselves or others. For them, a mental health crisis could imply that they, as well as their family or others involved with them, could learn something new about themselves, even if that was how they are best able to handle a crisis. As one participant explained:

> I feel that my own experiences offer me a very useful competence in helping myself next time there is a crisis. I know what to do and whom I should speak to. At the same time I feel more conscious and aware of my own emotional reactions toward myself and others.

Another participant reported:

> I feel that all my experiences of being in a crisis help me in recognizing when a new crisis is building up. Now I know how I can handle it and I know precisely what helps me and how I can help myself.

A third participant described:

> I know that my emotional experiences of a crisis have been very helpful for friends of mine when they have been in similar circumstances. That gives a win-win situation; I know how to help them and they know how to help me.

A diversity of perspectives and explanations of mental health crisis was disclosed by these experienced service users. Although representing a heterogeneous group when it comes to personal and social background and situation, they demonstrated wide-ranging insights and ability to give their life experiences meaning and understanding.

Losing the skills and structure of everyday life

The participants explained in detail the various ways they experienced mental health crises and how these crises affected their daily lives. The concrete impact of the crisis could imply not being able to get out of bed in the morning as well as feeling stigmatized and socially excluded in the local community. Some participants described experiences of not being able to remember how to carry out ordinary daily activities, whereas others lost their jobs or friends due to their mental health problems. One participant explained:

> I lost my sleep and got more and more like a zombie. I didn't know how to cook or wash dishes. I couldn't make dinner and have it ready as usual when my children came home from school. I remember I went to the supermarket to buy something. I felt I couldn't move my body between the shelves. I was like paralyzed. The last think I remember was some of my neighbors laughing at me and whispering something.

Another participant put it this way:

> When it became known among our friends and relatives, that I have had serious mental health crisis, they all by a sudden backed out and withdrew. When it comes to our friends it is all about me losing my job, my position in the company, not getting the invitations to the right parties and so on. All our friends that are merely focusing on their own careers stopped calling us and inviting us to dinner parties.

A third one said:

> After I had experienced my first crisis I talked to my boss. I told him that I would like to inform him and the rest of the guys at work that I had been through a mental health crisis. The boss said no. He told me that he wouldn't have that kind of emotional talk at work and my feelings had nothing to do with the work we did.

Participants also talked about the paradoxes involved in staying at home when experiencing a mental health crisis. On the one hand, everyday living seems to represent a concrete connection to crucial elements of life, like being able to take care of yourself and others, and being able to handle emotional, practical, and social obligations. On the other hand,

participants described activities of daily living as being so demanding and challenging in the middle of a crisis that they knock people off their feet and become an extra burden. For example, some participants talked about cleaning the house as an overwhelming activity that could take all day, if they made it at all:

> "I feel the demand of carrying out the daily tasks as very stressful. I feel overstretched having the pressure on me to take care of all the daily life demands, the family, the children and my husband."

Said another:

> I'm not able to do all the things at home. Trying to do something helps me to understand and tolerate my difficulties. How it affects me, my children and my husband. It helps me to become aware of what I can do and can't do. In that way they understand at the same time what they have to do to help all of us.

Although the participants found different pathways to live with or overcome the crisis events, some general themes emerged, such as endurance, not giving in, and finding out what makes life easier. In spite of recurrent and long-lasting painful and strenuous periods, they explained how they could find strength and hope by, for example, being with their children or partner, withdrawal or solitude, or having an understanding general practitioner available.

Complexities involved in family support

The value of the care and support received from family members was highlighted in the focus groups. It could be a husband, a wife, a child, sisters or brothers, parents, and even former partners. This support was described as being of two natures at times, although, that presented further challenges for the person to deal with. On the one hand, participants needed and appreciated family support consisting of respectful care, practical help, and the simple sharing and enduring of strenuous emotional experiences and situations. On the other hand, participants expressed concern with the complexities involved in trying to reveal and share difficult emotions and situations with others. Participants could be afraid of appearing "too emotional" or as being a source of stress for others, often wanting to protect family members from exposure to the trauma and resulting intense emotions evoked by the crisis. They somehow wanted to keep the family out of it

and tried not to be a burden, especially when it came to their children.

At the same time, the family as a whole often became automatically involved in the persons' experience of the crisis and a part of the overall situation. It was almost inevitable as long as the person was living at home during the stressful and often chaotic period. One participant said:

> I sometimes find it very hard to try to share my feelings and experiences with my husband and children when I often myself don't understand or can express what's going on in and with me.

Despite these concerns, some participants reported that sharing and disclosing the distress and feelings associated with the crisis had created more openness regarding emotional expressions in their family. This had been a positive and comforting development for several of the participants, and had reinforced their feelings of being an accepted and valued member of the family. Furthermore, some participants reported that sharing their experiences of crisis and the emotional distress and social and practical turbulence that followed had strengthened family ties.

Particular concerns were raised by participants who were parents. Parents, who often strive to provide emotional and social stability for their children, found involving their children in crisis situations to be painful and to result in a sense of guilt or shame. As one participant who was a mother reported:

> This is very difficult subject for me. I feel I bring shame into the family and especially my children. My mental health problems reduce their quality of life and the way they can live their lives. They always have to keep me in mind at school, in their leisure time and in vacations. This really bothers me, and I feel really sorry for them.

Another aspect of this situation involved participants' reflections on whether their children could be hurt by their experiences of having a parent who had a several mental health crisis. Did having a crisis mean that they were no longer a good enough parent? In relation to these reflections, participants often felt shame and anxiety both for the crisis situation itself and for the emotional damage they might have caused to their dearest of all: their children.

Discussion

The main aim of this article was to explore the subjective experiences of mental health crisis from a

first-person perspective and also the meaning for the person of involving family members in the crisis situation. What we have learned from these participants is that mental health crisis are multifaceted and complex, they can emerge gradually or suddenly, and for some appear with recognizable early warning signs and for others without. Mental health crisis affects peoples' everyday lives in many ways, and both the person with the crisis as well as the people he or she lives or spends time with. Perhaps the most striking insight to be gained from these qualitative findings is that mental health crises more often than not occur to families rather than to isolated individuals. These often overlooked social and contextual aspects of mental health problems are particularly emphasized in the social network theory named Open Dialogue (Seikkula et al, 2006), and in the recovery literature (Borg & Davidson, 2008; Davidson, 2003; Tew, 2005; Wallcraft, 2005). Recovery and coping with mental health problems is as much about overcoming contextual barriers such as family and social life challenges, school or employment problems, unsafe housing, financial issues, or loneliness, as dealing with the actual symptoms (Borg et al., 2009; Wallcraft, 2005; Wilson & Beresford, 2002). In addition to recognition of this family context, these findings also suggest that crises pose meaningful challenges to the individuals involved; challenges that may be damaging, but that also may present opportunities for learning and growth. All of these findings suggest that a mental health crisis cannot solely, or even primarily, be regarded as an individual, or a biomedical event on the order of a heart attack, and cannot be addressed adequately solely through the administration of medication or an individually based treatment manual at a program site or in the person's own home.

Rather than generating a straightforward recipe or guideline for crisis management, these data are perhaps best viewed as highlighting several tensions that need to be considered in assessing and responding to a mental health crisis. A first tension relates to the impact of the crisis on the person's home life and whether or not crises are best managed within this context. Although the mental health system in Norway is moving decidedly in this direction of home-based crisis response—and participants appeared to agree that staying at home allowed them to remain connected to crucial elements of their ongoing lives, including their loves ones—some participants also pointed out that there are challenges that will need to be addressed if this model is to be optimally effective. For example, some participants found the activities and obligations of daily living to be so taxing that they posed an added burden on top of the

crisis, draining what emotional and instrumental resources the person might otherwise have had to attend to the crisis. Having identified the importance of, but simultaneous difficulties involved in, remaining grounded in one's everyday roles and responsibilities might encourage mental health crisis response staff to consider the value of securing additional assistance or support for people in terms of such things as home making, child care, and paying bills. Like recovery literature has revealed (Borg & Davidson, 2008; Tew, 2005; Wallcraft, 2005) when it comes to understanding mental distress and ways of dealing with these challenges, the trivialities of everyday life must be seen as anything but trivial. Living and dealing with mental health crisis is described by the participants as processes that unfold in variety of contexts, alone or together with others, and through actions and activities and rest. It is these small bits of life that are often experienced as being of critical importance in a person's recovery processes. Everyday life tasks and skills need to be addressed as part of the practitioners' agenda as well as if not more than such issues as insight or medication compliance (Borg & Davidson, 2008).

Going through a crisis and being immobilized at home also appeared at times to have detrimental effects for the person's loved ones, especially his or her children. Although it certainly could be argued that being hospitalized would also have had detrimental impact on the person's loved ones, these effects typically fell beyond the scope of the hospital staff's responsibilities. By bringing mental health practitioners into the person's home, these effects become a legitimate, and pressing, concern for the staff, who, therefore, will need competence and training in family support and interventions.

A related tension has to do with whether or not, or how much, the family members need to know about the person's struggles. As one person explained:

> I sometimes find it very hard to try to share my feelings and experiences … when I often myself don't understand … what's going on in and with me.

Participants appeared to be torn between keeping the crisis to themselves that obviously is more difficult to do within the home context, and risking exposing their loved ones to additional stress by sharing the crisis with them. On the whole, they appeared to find the benefits of increased openness and strengthened family ties that came from sharing their struggles to outweigh the appeal of trying to protect others, but this issue presents an additional challenge for crisis response staff: How to help the

person include his or her loved ones in the experience while also trying to protect them from undue harm.

Finally, the positive aspects of crisis resolution that participants identified pose a new challenge for staff responding to crises. From the perspective of these participants, it is not enough simply to survive a crisis to return to one's precrisis physical and psychiatric status. Rather, it is possible, and preferable, to learn and grow from crisis experiences, even if this growth may be limited at times to learning how to handle crises more effectively. Although some people may similarly suggest that they have learned lessons from a heart attack, for example, about the importance of exercise, the growth and learning that can come from mental health crisis appears to be more directly related to the nature of the crisis itself. Crisis staff are, therefore, encouraged to join the person in his or her efforts to make sense of the crisis and why it happened as well as in figuring out what lessons can be learned from the crisis for future efforts to prevent or address crises earlier in the process.

This study reflects a subject matter of much interest in today's mental health field, namely the understanding of mental health crisis both on an individual and personal level and in addition on a contextual level. In recent years, available and accessible crisis support tailored for the individual service user and the family members has been emphasized in national policies as well as in service transformation. However, understanding what the crisis situations actually mean and involve for the person and his or her loved ones is less attended. The findings of this study reveal that mental health crises are complex experiences that challenge attempts to streamlining and manualizing of mental health services (Borg et al., 2009; Wilson & Beresford, 2002). The participants described multifaceted meanings of crisis, where some could be more socially oriented, whereas others were more personal. The tensions discussed as well as the complex experiences reported call for services and supports valuing person-in-context perspectives and person-centered ways of working (McCormack & McCance, 2010).

The research team in the present study included a coresearcher with lived experience of mental distress. In our experience, there is an added value in bringing together professional and service user perspectives in mental health research, in its potential of enriching and expanding the understandings of the participants' experiential horizons, and in identifying and developing issues of importance to service users. However, it is important to note that although the researchers and coresearcher in the present study formed a research team with multifaceted experiences and perspectives, we were all sharing the interest of user involvement in research and service development and of improving mental health service users' situation. This might represent a bias in our research, and it is plausible to imagine that researchers with more distance from the field of mental health care would identify other important aspects of mental health crisis.

This study represents a collaboration between six participants with crisis experiences and four researchers. Although the small sample size of the focus groups may be seen as a limitation, the exploratory nature must be emphasized. The participants shared their comprehensive experiences and narratives of mental health crisis and everyday life situations. They willingly talked about distress and despair, sadness and sorrow, hopes and dreams in a context of tears as well as humor and laughter. The themes emerging through the explorative collaborative partnerships were reached through active involvement of the participants in the focus groups both in the exploring of new meanings and the understandings of phenomena associated with and embedded in the crisis.

Conclusions

This qualitative study of experiences and meanings of mental health crises has suggested that there are several aspects of crises that require an expansion of the current biomedical model of acute intervention to include consideration of the personal and familial meaning of the crisis, attention to the home context and the activities of daily living that might be disrupted by the crisis, and ways for the person and the family to share in and learn from resolution of the crisis that strengthens family ties and personal resilience. Living and dealing with mental health crisis is described as unfolding in various contexts and settings and through various actions and choices. Practitioners may do well in giving priority to elicit, listen to, and appreciate the dramas and the trivialities of everyday life as well as the persons' and the families' own expertise in managing these tasks.

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