

RESEARCH AND EVALUATION

Recovery-oriented professionals: Helping relationships in mental health services

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Abstract

Background: Traditionally mental health services have been based on the view that health professionals effect changes within a person with psychiatric problems via a range of treatment methods. Service users have had little opportunity to speak for themselves about their view of professional help or about what supports their recovery process.

Aim: Explore helping relationships from the perspective of service recipient experiences.

Method: Qualitative study based on interviews with 15 service users with lived experience of severe mental illness.

Results: Certain common factors about helpful relationships were identified. Service users valued professionals who conveyed hope, shared power, were available when needed, were open regarding the diversity in what helps, and were willing to stretch the boundaries of what is considered the “professional” role.

Conclusions: Recovery-oriented professionals were those who had the courage to deal with the complexities and the individuality of the change process, and were able to use their professional skills and expertise in a collaborative partnership with the service user. A recovery-orientation in professionals also involves the willingness and ability to shape services to the needs and preferences of each individual service user.

Keywords: *Recovery, helpful relations, professional competence, service user experience.*

Introduction

Traditionally, mental health services have been based on the view that health professionals and services effect changes within a person with mental health problems through a range of treatment methods and therapeutic programs. Recipients of mental health services have had little opportunity to express their views about treatment and about what actually supports their recovery process. Furthermore, professionals have typically offered little hope to persons with severe mental illness diagnoses, instead conceptualizing these experiences as chronic conditions with limited prospects for recovery. The schizophrenia spectrum disorders in particular are often thought of as having a long-term course with limited potential to benefit from treatment. However, recent research and increasing interest in the affected individuals’ own stories suggest that the great majority of persons with such disorders do (or can) recover

in a variety of ways. Research also demonstrates the importance of carefully reflecting upon what individuals suffering from severe mental illness have to say about their struggles, what they experience as helpful in the midst of these struggles, and about their various paths to recovery (Warner, 1985; Harding, Zubin, & Strauss, 1987; 1989, 1996; Davidson & Strauss, 1992; Harding & Zahnister, 1994; Tooth, Kalyanansundaram, & Glover, 1997; Borg, 1999; Harrison et al., 2001; Borg & Topor, 2003).

Research and other relevant literature concerning first-person accounts of recovery from severe mental illness are very few. Those that exist show that the treatment relationship has a central role in helping to bring about recovery. One of the ways to extend our knowledge about what is helpful is by examining the personal experiences of service users, and to do so within the context of the helping relationship. Attention to how the affected individual is personally understood is also essential. For example, is s/he seen as a fellow human being with insight and expertise, or, by contrast, as a person with a chronic illness who needs to be taken care of, perhaps forever?

The primary purpose of this article is to provide a first-person perspective on the characteristics of helpful relationships. It draws on empirical material from a larger study examining what is helpful in recovery from severe mental illness (Topor, 2001; Borg & Topor, 2003). The aim of this research is to understand the characteristics of helping relationships in mental health services, including the ways in which recovery-oriented professionals can most effectively collaborate with service users. A recovery orientation for professionals means a reorientation from being an expert on other peoples' lives towards supporting individuals in their own ways of dealing with problems and struggles.

Methodological approach

Studying recovery

This research is inspired by a phenomenological approach to knowledge, with the aim of deepening our understanding of personal experiences in recovering from severe mental illness, as well as the nature of helpful relationships with professionals. A complete description of the larger study is reported elsewhere (Topor, Svensson, Bjerke, Borg, & Kufås, 1998; Borg & Topor, 2003; Topor, 2001). Qualitative interviews were used, with the intention of capturing the nature and meaning of the personal experiences of recovery in our participants. Our qualitative approach provided an opportunity to generate subjective forms of knowledge from personal experiences, ones that are embedded in a network of meaningful relationships. As Davidson so clearly argues, a phenomenological approach analysing the experiences of people provides a theoretical foundation for developing a helpful approach that is grounded in meaning as opposed to causality (Davidson, 2003).

Informants

Research participants were 15 people who had been treated for severe mental illnesses, including nine who had been treated for schizophrenia, one for schizoid personality, one for paranoid psychosis, two for affective psychoses, one for personality disorder, and one for borderline psychotic personality. The study was limited to people who (a) considered themselves as having recovered or being in recovery from severe mental illness, (b) were coping well in their lives, (c) had improved their lives with help from mental health services and/or other sources, and (d) had not received inpatient psychiatric care during the past 2 years.

Seven women and eight men (age range 29–63) were interviewed. All except one had a history of inpatient psychiatric care. At the time of the interviews, all participants reportedly had stable housing, steady incomes, described themselves as functioning well in their everyday lives, and in general were satisfied with what they had done with their lives. Four participants were married, one had a stable partner, three were divorced, and seven were single. With respect to employment, five had ordinary jobs, seven had sheltered or voluntary jobs, one was an artist, one was an author, and one was a student. At the time of the interviews, three individuals reported that they did not use mental health services, while the other 12 indicated that they continued to receive at least some form of support. This included sporadic contact with mental health care professionals, weekly contact with community mental health services (often focusing on medication and counselling), and more traditional psychotherapy sessions. Eleven of the participants used some kind of psychotropic medication.

Procedure

Our interviews began with the open question “*What was helpful in your process of recovery?*” The research team was especially interested in finding out how informants coped with challenging life situations, including their experiences with mental health care professionals, services, and other sources of personal support. A central aim was to learn more about the person’s own role in recovery, as well as the impact of social support and other contextual factors. Aspects of the recovery process that participants identified as particularly important were examined further through in-depth questioning intended to capture the diversity of their experiences. The open-ended interviews were audio-taped, transcribed, and then returned to each informant for their review and approval. The research team read through all transcribed interviews, noting recurrent themes pertinent to recovery. Summaries were developed inductively and discussed with the entire research group (Kvale, 1983, 1997; Davidson, Stayner, Lambert, Smith, & Sledge, 2001). Group-level analyses of the summaries were used to identify specific aspects of recovery. These included the active role of the person, support and influence of others, events, environmental factors, and the understanding and meanings underlying the experience of mental illness and recovery. For the more focussed purpose of this article, topics concerning experiences and perspectives on helpful relationships with mental health care professionals were explored more fully.

Results

Participants in this study shared numerous positive and negative experiences, revealing mutually challenging journeys towards recovery. These stories about the recovery process are punctuated by bouts of fear, loneliness, hopelessness, anxiety, and inexplicable pain. The stories thus succeed in revealing both the individual people behind the diagnoses, as well as informing us about the individual people in professional roles.

The human distinction: discovering fellow humanity

What informants regarded as most helpful in their “treatment” relationships with mental health professionals were demonstrations of empathy, respect, and a general person-to-person investment. For example, Nina described her relationship with the psychiatrist she had been seeing for years in this way:

I found him so balanced in a way. . . didn't have all kinds of programs of his own that we had to go through. I could talk about anything . . . everyday life things that were important to me, not necessarily problems. . . I was the one who decided what to talk about.

Through these comments, Nina reveals what for her are key considerations for how mental health care professionals develop helpful relationships, including careful listening, showing interest in *her* priorities, and being open to discussing more than just problems. Similar to other informants, Nina was not particularly concerned with traditional criteria of professional competence, such as intervention programs or methods, but rather a willingness to share power in the interests of creating an atmosphere of trust, where the professional provider and the consumer recipient have the possibility to collaborate on the therapeutic agenda.

Other key elements of helpful relationships had emerged in the original set of interviews (Borg, 1999), where several of the participants emphasized regular contact and collaboration with supportive professionals as vital to their recovery processes. While the specific ways in which service users and providers worked together varied greatly, the elements identified as truly therapeutic in these relationships did not, and were described as unique, dynamic, and resilient. Overall, helpful relationships seemed to consist jointly of equality and collaboration, the nature of which shifted corresponding to changes in, and development of, the treatment relationship itself.

Throughout their personal narratives, informants highlighted the importance of *being seen* within their relationships with their helpers (mental health care professionals). Although seeing the patient as a person has long been emphasized as an ideal psychotherapeutic principle, we know little of what *seeing* involves, in terms of how it is experienced by the one being seen (or not). Informants in this study provided very concrete personal stories of "having been seen". Examples include a mental health care provider who asked how a person's mother was doing, a staff-member at a day center who shared stories about her dog, and a nurse who gave a person a rose as a present for staying in a new job for over a month. As reflected in the informant narratives, these apparently small acts, and often just a few words, were often experienced as having profound positive value to the person struggling with everyday life.

When the person and the relationship are in focus, and when the diversity of personal experiences can be expressed, understood, and valued, only then can we begin an examination of what is meant by "helpful" in relationships. Anne described helpful relationships in this way:

Respect when we meet. A little imagination . . . treated as a human being. I guess that's what they've had in common. Those I've met in psychiatry that have been helpful. That they are not afraid to tell me that they don't understand how I feel. You don't have to understand my situation to be human.

Anne's statement points out that demonstrating respect and empathy may often be more important than that of intellectual comprehension in the process of establishing a foundation for a "therapeutic" relationship that can be truly helpful.

The possibility to be seen as *both-and* also seemed to be central. People using services valued those professionals and services that allowed them be *ill and well* at the same time. They were ready to share the good and the bad experiences of a fellow human being's totality, both the times of suffering as well as the hopeful opportunities.

The interviews also showed great variation about the characteristics and qualities of the professionals involved. Some service-user informants reported that meeting or finding a

certain helper who showed feelings of genuine interest represented a critical turning point. For others, helpers who could bear with them, staying on through the course of several years, were the important ones. Perhaps especially valued was the presence of a single particular helper who was an essential thread of continuity and safety needed at certain difficult times. Also helpful were professionals whose main contribution was simply “just being there”, available for a chat or doing something together, or offering support in a number of ways.

For some informants on the other hand, professionals seemed to have a rather limited impact on their process of recovery. Recovery was instead experienced as having to do with other factors deemed helpful, such as faith in God, having a job to go to, having enough money, or having a pet dog as a companion and source of comfort.

Available everyday helpers

Dedicated professionals available for the large and small challenges in everyday life were experienced as particularly helpful, especially in periods when a person had great troubles, such as hearing tormenting voices or having extreme anxiety, or when practical daily activities were difficult to accomplish. At such times, it was experienced as essential to have a helper who was open to the individual person’s own priorities, in the sense of being there when required and being there to assist in doing whatever was required. What does this kind of “availability” actually involve? First and foremost, it has to do with time. It seemed to be crucial that professional helpers find time for “just being there” and also to have sensitivity to understanding the person’s own unique and most pressing needs.

Furthermore, “being available” has to do with the set of professional beliefs and attitudes that allow time and practical help to be key elements in the art of helping. Sigrun spoke of it this way:

Last time Ragna (a community nurse) called me, I wasn’t able to answer even a single question properly, so I was . . . so miserable and useless, feeling so bad, and she noticed while we were on the phone, that I wasn’t well at all. And she came and visited me, 3–4 times a month, on her own time and just came here.

Not only did this nurse confirm that she was aware of Sigrun’s situation, but she also made space (in her probably busy schedule) in order to come and visit, and she used her own free time. Several informants expressed deep feelings of gratitude when they spoke of helpers who seemed to leave their professional roles for a while and do something other than that which is expected. Helpers that use their own “personal” time and not paid “professional” time is experienced as surprising and extraordinary.

“Availability” however is not necessarily restricted to one single helper’s being available. Some informants, such as Karen, spoke of a group of people that she experienced as being available for her. When daily life felt unbearable, Karen would call the community team and someone turned up, and she felt she could talk about anything with them. In her words,

What’s good about them is the fact that they don’t just talk about problems, but ordinary stuff too. Even when I want to talk about a problem. I want someone to feel sorry for me. But they didn’t. At least they didn’t say anything. You can’t just sit there and talk about problems all the time. They kid around with me, even though I am sensitive. So we talk normally.

Karen mentioned how she appreciated their sense of humour and that they could chat about more than just her troubles. In addition to the community team, Karen had others on

hand she felt she could contact, including a doctor, a community nurse and a voluntary helper. Good talks, a visit to the café, knowing each other over time, help with practical things, as well as dealing with her pain and hearing voices, were all important according to Karen.

Interest and engagement in the individual's everyday life was also mentioned when talking about psychotherapy. For Helen, it was her therapist's patience and endurance that mattered most. Although he changed job settings three times during her treatment period, he did not discharge her, nor did he turn her over to others. He took Helen along with him on his professional journey. He gave her priority, and they worked together for more than 6 years. As with many others, Helen felt that developing a long-term relationship with her helper, getting to know each other, and having continuity, were essential:

What really matters is that you have not many, but a few good helpers over time. Someone who can keep it up, who's there. . . That's what I feel is the most important my therapist has done for me . . . that he stuck with me all these years.

Experiencing what is "therapeutic"

Several of the informants mentioned "psychotherapy" as helpful in their recovery process, and for those who felt this was helpful, what it entailed and why it was experienced as helpful varied considerably. For some, psychotherapy represented a major turning point. Meeting or finding someone helpful was often described as a finding a "saviour", initiating a process that allowed the individual to feel safe and secure enough to be able to talk about both inner feelings as well as their surrounding chaotic circumstances. Anne, a woman in her 50s, put it this way:

He understood what it was I had to say and I could. . . With him I found confidence – and the strange charisma that he had, made me dare to look at my life and talk about it. I think he was the first person who ever listened to me and treated me with respect. I hadn't felt that before, even though I was then almost 40 years old.

Such helpers are described as someone almost divine, and clearly seemed to have had a tremendous impact in the lives of those they serve. Genuine trust becomes apparent in the following where Erik describes his psychotherapist:

I can see it. . . that glow that tells me she has understood what it's all about. It is not just theoretical knowledge. She doesn't sit there for her own sake and talk about it. She wants to help. She wants to help someone.

At the same time the more ordinary person comes through in Petter's following description of his therapist:

Now she has become sort of like a grandma, an ordinary grandma, who also has her faults. And. . . I know, of course, that she is very competent and knowledgeable in her field. But, that is not what I think about when I'm together with her, in therapy.

We often heard: 'One professional helped me to keep hope alive', when we asked why some professionals were experienced as so important. Hope and courage to move on were feelings that emerged over time in these relationships, especially where time and flexibility and being

available seemed to be vital elements. Some kind of stability and continuity was present, at a time when no one else in the person's life could offer that.

Other psychotherapists were given less divine roles, and were described by informants in more commonplace ways, often for example as pleasant partners of conversation they had met. These interactions do not seem to represent a turning point in their lives on the journey to recovery, but were more of a supportive companionship, perhaps just for the time being, and without much longer-term meaning.

Professionals are mainly referred to by their unique ways of being and acting, as persons rather than specialists in psychiatry. Some appear to be saviours, whereas others are ascribed much less impact. These informants, most of whom have been "patients" in a variety of therapeutic settings, are a tremendous source of valuable knowledge: both about the unique partnership that can be developed between user and helper, and also about why these relationships are experienced as helpful and special.

The emphasis on human relationships is worth noticing, as is the value of developing a therapeutic partnership characterized by equality. Helpers who initiated a string of standard activities and procedures, and who prioritized their own professional agenda over that of the person seeking help, were often described by informants in ways such as "cold" or "not really interested in me and my situation".

Breaking the rules

Informants often mentioned unexpected, even surprising, acts and gestures when speaking of those they experienced as "good" helpers. They referred to apparently little things, but ones which for them had great meaning and impact. This included behavior that may be seen as on the edge of what is typically considered as "professional conduct". One example was a community nurse who lent a person some money over the weekend because his welfare check would not come through until the next Monday. Another example is a helper who accepted a present from a person, thus allowing *her* the chance to offer something to someone else. Perhaps these gestures make the individual feel both more human and valuable, a person who means something for someone else. Friendly terms were used when informants talked about those professionals they considered caring and supportive. "Good helpers" were portrayed through words such as kindness, patience, sense of humor, wanting to help, giving time, and also just acting in ordinary ways. This is illustrated by this example:

But, what also helped me through this period was the fact that I was in contact with a doctor from America that was at the out-patient clinic. We were like buddies. I could go see him for an hour or so, without him writing journals or demanding payment or anything like that. . . I guess he thought it was nice to get a visit, so it was sort of a mutual joy.

Two women talked about their community nurses as people who were valuable along the way. These nurses had a "way of being" that seemed to be rather different from other helpers they had met. Both Sigrun and Nina spoke about feeling that they could talk about anything with these nurses and felt confident that they would help them with whatever was required. As Nina expressed it: "*We established such good contact, . . . and she was like a friend. . .*".

Through this friendship-like relationship, Nina felt she could give the nurse presents (such as poems she had written, magazines, or music-tapes) and that she would accept them. This was important to Nina, as she explained:

I felt that it was allowable for me to feel that trust—and to receive trust, without her rejecting me. She accepted it and handled it very well and I was allowed to be myself. . . Lent her books that I thought she would like and enjoy.

Nina was a generous person who enjoyed showing and giving affection. By feeling she could be herself in relation to the helpers she had contact with, she became someone more than “a patient with mental problems”, and she experienced herself as an equal human being, way beyond the service-user role.

Giving and receiving presents are quite common in ordinary human relationships. The exchange of gifts is usually a way of showing respect and appreciation. But, between “patient” and a professional, gifts are in general not allowed or at least are discouraged. Such acts are not supposed to be a part of a paid, helping relationship. Some believe that such gift-giving contributes to an unhealthy dependency for the patient, or is a threat to the therapeutic alliance. The very fact that rules such as these are broken in actual day-to-day practice should instead be an openly discussed issue about what constitutes “good” professional and therapeutic conduct.

People in general think about friends as someone who would go “that extra mile” for them if needed, someone willing to make an effort beyond the ordinary. The informants in this study seemed to feel the same way about certain helpers, and believed that these helpers really are “on my side” and sincerely want to help. The friend-like helper is also someone who “pushes buttons” when needed. One participant needed some assistance in order to reduce her working hours. Her situation was at times just too overwhelming for her, filling in forms and dealing with all kinds of financial issues. She had to wiggle her way through countless social benefit systems, and in this situation she described her community nurse as: “. . . *the authority I needed. She could push a little if they don’t listen to me. . .*”.

The helpful professionals are not only talked about as nice and pleasant. It is not enough to be kind, although of course it may help at times. “Supporting” people was also described by informants as meaning that they could make demands of their helpers, including challenging them. For example, disagreeing and even getting one’s “butt kicked” could be experienced as supportive. One example is someone who felt pushed into attending a day-center he felt was pointless and really beneath his level. Another felt pressured into attending group therapy sessions that he found extremely frustrating and demanding. What made the situation bearable for both of these individuals was the support of one or more helpers whom they trusted, and who explained that they felt such participation was necessary, at least for the time being. Both these helpers had said that these individuals needed to get out of their flats during the week, to meet other people and join in some sort of activity. When there are just a few “good” professionals around, it can be experienced as possible to endure what feels like meaningless or tough programs.

Another noteworthy point is that although the informants in this study spoke of good professionals as “friends”, they are at the same time well aware that these friendships are not like ordinary friendships. For example, Karen talked this way about her community nurse:

Without him, I would never be able to go to town. To go together with someone is fun because you can sit down and have a cup of coffee together. I call him a lot, just to talk, because I have found a friend in him, even though I know he is not really my friend. He doesn’t visit me at home after work. I can only call him during working hours. . .

“Good chemistry” or expressions such as “we just got on with each other” were frequently mentioned ways to describe helpful professionals. It seems that in this kind of

partnership, offering simple and concrete services works best. Help is given in a collaborative relationship, where there is opportunity for negotiation. Discussions about support at home, supports at the work-place, social activities, and medication need to be based first and foremost within a helpful relationship, where the individual feels comfortable with the helper. A critical issue here is whether the opinions of service-users concerning what “good help” is, matches with the professionals’ own ideas and their identity as a specialist-expert in psychiatry. As the participant informants in this study clearly point out through their stories and examples, knowledge about mental illness, professional guidelines, and therapeutic treatment programs, are quite inadequate and insufficient to support recovery. The high value given to helpers that go beyond their professional role is an interesting and a rather striking paradox, and raises the question of what professionalism is, or should be, about.

Discussion

The main purpose of this article is to explore what is “helpful” in relationships with professionals, and to do so from a service-user perspective. Is it possible to find some common factors of what is experienced as helpful, especially on the path to recovery? According to the views of informants in this study, becoming a recovery-oriented professional includes a reorientation of what being a “professional” means. This is at least the most logical line of argument if one wants to develop services that correspond to the needs and preferences of service-users, instead of the usual pattern of trying to assess, adjust, and fit service-users into existing services. The participating informants in this study welcomed more professionals with open attitudes about what kind of assistance actually helps. This does not mean that specialist knowledge and experience is worthless or irrelevant. Rather, it involves courage on the part of the professional in dealing with the richness and the unpredictability of life in general, as well as the frequent paradoxes of an individual’s recovery process. Such a recovery orientation also requires learning how to apply one’s skills and expertise in a more collaborative way. This again means sharing power with the service-user and acknowledging the wisdom and insight of people with the lived experience of mental illness. It is clear from these stories that recovery includes, and must be understood and addressed as, a concrete and practical process of gaining and maintaining more control over one’s own life. And that this is a process where competence and knowledge are developed and tried out in a joint venture, with a variety of helpers along the way. This collaborative role is substantiated by previous research in recovery and rehabilitation (Onyett, 1992; Topor, 2001; Sells et al., 2004; Davidson, 2003). Recovery is an active process on the part of the affected individual; it is not something professionals do for or to the passive individual. The job of professionals is rather to discover and support and engage the individual’s capacity towards recovery. Sells et al. (2003) suggest that treatment services would do well if they adopted a more person-centered, and less illness-based, approach. This of course requires a quite different understanding of what is understood by “severe mental illness”, different from the typical picture as described by the diagnostic criteria of schizophrenia. It also involves developing the roles and competences of helpers and services in general, towards more open perspectives of what actually helps (and also what hinders) recovery.

The study discussed in this article indicates that both relational and contextual awareness are essential for the professional, in order to create and develop a dedicated and mutual relationship with the individual seeking help. In other words: a true, collaborative partnership. Such a partnership requires a genuine interest and understanding of the person’s experiential situation, as well as the ability to deal with the person’s pain, worry,

anxiety, and at times perhaps “challenging behavior” that may appear in these (as in many, if not most) human encounters. Professional helpers in this study were experienced as supportive when they gave priority to establishing a positive relationship with the person seeking help, where optimism and focus on the individual’s inner resources were emphasized. Helpers whose major interests were symptoms and deficits were also experienced as contributing to less hope for the future.

Listening to the experiences of those participating in this study suggests very clearly a need to look more closely at the position of collaborative relationships in present-day mental health services. What is valued as a positive relationship between service-user and professional-helper has varied in different psychiatric settings throughout history. This diverse position is (unfortunately) still present, and some will continue to argue that such relationships are simply the foundation of all help, yet make this claim without thinking about what this actually entails. Others may claim that supporting and caring relationships should be subordinate to what they consider the “real” and important professional efforts, such as medication or treatment programs. Caring relationships then become reduced to a “nice but not necessary” humanistic phenomenon. Such notions persist despite research showing that the quality of the therapeutic relationship is the best predictor of outcome for people with mental health problems (cf. Tallman & Bohart, 1999), and that this relationship is one of the central common factors of what is experienced as helpful. Our study further confirms this stance, and also has tried to place the role of the professional helper in the therapeutic relationship under scrutiny.

Lambert (1992) has proposed four factors considered vital for improvement: extra-therapeutic factors, common factors, expectancy or placebo factors, and techniques. Hubble, Duncan, & Miller (1999) develop further the significance of what Lambert terms “common factors”, and introduce relationship-factors as the central common element of what works in therapy. Research indicates that characteristic features of a “good” helping relationship include empathy, caring, acceptance, mutual affirmation, mastery, and encouragement of risk-taking. The therapist’s own theoretical beliefs and approaches actually do not influence outcome that much. According to Lambert’s studies, specific models and techniques used seem to account for only 15% of improvements (Lambert, 1992). The focus on “common factors” is interesting, considering the findings of the material gathered in our study. Determining some of the core ingredients of common factors that seem to work in the context of clinical treatment and rehabilitation may contribute to developing helpful relationships and services that correspond in better ways to the actual needs and preferences of service-users. It also calls for recognizing and acknowledging new types of indicators to measure what is meant by service quality, namely those factors and characteristics that exist in what is experienced as helpful in the relationship.

A reciprocal relationship involves seeing the service user as a person and fellow human being, not as an ill individual affected by a chronic disease. The stories told by our informants represent both encounters with collaboration and genuine care, but also encounters of hopelessness and humiliation. Some services and helpers still seem to be influenced by Kraepelin’s long established legacy of schizophrenia as a chronic disease with poor outcomes (Davidson, 2003), and this belief is unfortunately often transmitted to the help-seeking individual. This may occur unconsciously on the part of the mental health professional, but the consequences are none-the-less potentially disastrous. The many existing variations of how the person-as-chronic-patient is seen and treated is alarming, considering that research has long confirmed that recovery from severe mental illness is possible and realistic, with many good reasons for hope (Strauss, 1989, 1992; Harding & Zahnister, 1994; Harrison et al., 2001; Davidson, 2003).

Literature and research studies developed by service-users with personal, lived experience of mental health problems has provided much-needed challenges to the traditional view of a person with severe mental illness (Deegan, 1997a,b; Leete, 1997; Glover, 2002). Individuals as well as consumer/user/survivor movements have contributed to a growing awareness of the importance of an active consumer role, aimed at greater participation and control over one's life situation.

Returning to the idea of a partnership between helper and service user, one is reminded of Martin Buber's contention that in a relationship, both parts must contribute in an active way (Buber, 1986). The essential factor is not what is inside each individual, but what is created between them. This, however, requires that both parts see themselves as being in a position for active participation and having something to give that is valued.

A reciprocal relationship between helper and service user will involve a view of the affected person as capable and resourceful. This is in contrast to traditional psychiatry, where in conditions such as schizophrenia, the individual's subjectivity and inner-life is understood as being disturbed. This is typically described as a disturbance in the ability to receive, integrate, and give information, in addition to "emotional" disturbances. Davidson and Strauss (1992) suggest that rediscovering and reconstructing a dynamic sense of self must be valued as central in the improvement process. In our study, we found many examples of people with a vigorous and responsible self, struggling to cope, and finding very unique and creative ways of handling difficult situations. The informants portray themselves as both active and goal-directed in dealing with their symptoms and everyday challenges, as well as in trying to find good helpers to support them. They are "getting on with their lives", which is the major feature of how we understand recovery. And they are resilient enough to do this with their lives, even facing tremendous odds at times, often threatened by extremely disadvantaged living conditions, unbelievably painful and chaotic experiences, and even being threatened or neglected by the service workers who are paid to understand and help them. Another remarkable aspect is that while people who have severe mental health problems are often described as being unable to develop mutual relationships with others, those participating in our study revealed that it was actually in the development of the helping relationship that essential turning points on the road to recovery emerged. What is also noteworthy in this connection is that this mutuality seems to evolve from the recognized and shared strengths, weaknesses, possibilities and limitations of *both* parties.

Another characteristic of what constitutes a helpful relationship is that helpers are seen as someone who goes beyond the common expectations associated with the professional role. Human qualities seem to matter much more than titles, professional training backgrounds or methods used. Unexpected acts and ways of being, and helpers that go out of their way to give something extra are greatly valued. When both helper and user are willing and able to expose their "human" side, daring to be themselves and disclosing a bit of who they are on the inside, mutual collaboration seems to be a more likely. More than just collaboration, this shared disclosure is in itself experienced as important if not essential in recovery.

When professionals show a little bit of themselves, might it also be easier for the service user to do the same? An interesting question in this regard is what we actually mean when we talk about "being professional", and what kind of competence is then considered relevant or important. The emphasis on flexibility and open attitudes from the helper's side is a paradox considering today's service systems where increased attention is placed on routine procedures and treatment approaches based on specific diagnoses. Our study raises some important questions related to the expectations of professionals to be competent in so-called "evidence-based" practice, while at the same time claiming, and perhaps even striving, to be faithful to a user-based perspective. Evidence-based approaches have made some important

contributions to the mental health field by providing systematized reviews of research, for example attempting to identify what is meant by “best practice”. Evidence-based health and social care is typically promoted as both efficient and cost-beneficial. Two central questions here are: how do we understand what is to be meant by “beneficial”? and whose “evidence” is to be listened to and given priority?

However, we cannot ignore the organizational, social and cultural contexts of both the difficulties to be solved and those of the service arena (Ekeland, 1999). It is also a problem if the complexity of mental health issues and the diversity of recovery processes are ignored. We must be ever mindful that any collaboration, including that between users and helpers, does not take place in a contextual vacuum. As with any relationship, it is influenced by many factors, such as the attitudes of what “being professional” means, environmental conditions, economical structures, and the arenas where meetings between mental health care professionals and users take place.

Believing in the prospects for recovery and hope for a better life seem to be essential. In contrast to the pessimism existing in many professional cultures and textbooks, the informants in our study did not see themselves as passive victims of an chronic illness. Hopefulness and a positive, expectant view of the future have been given limited attention in psychiatry (Nunn, 1996). Hope involves both an orientation to the future, and more specifically includes wishes, dreams and ambitions. A better and more desirable future needs to be experienced as something that is both possible and probable, and part of the recovery process. Although hope is used extensively to explain good outcomes, it is often diffusely defined, as illustrated by these types of comments from our informants, “*I never gave up and always kept hope alive*” and “*He helped me to keep hope alive*”.

Nunn emphasizes some central issues to be considered when discussing hopefulness: “*Any disorder may constitute a threat to personal hopefulness. Lack of personal hopefulness may constitute a vulnerability to psychiatric and physical disorders. Loss of hopefulness may constitute a disorder in its own right, jeopardizing active survival or predisposing to suicide*”. (Nunn, 1996: 240).

Hopefulness brings our attention to what may come. Being able to hope for a better life helped many of the individuals who participated in this study to get through their day-to-day lives, especially during the more difficult times. Thus, a central and greatly valued support from the professionals was finding ways to convey optimism, encouraging the person’s belief in him/herself, and in general, keeping hope alive.

Being able to look forward to a better future ahead is essential, perhaps especially for those who are going through the most difficult times imaginable. Helen Glover (2002) calls on professional helpers to take seriously their role as “holders of hope”. We conclude this article with her words, ‘The ability to act as holders of hope for those who cannot hold it themselves, as well as having the courage to give it back, is critical to good practice.’

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