The contribution of professionals to recovery. (Re)building social capital

Everydayness, doings and reciprocity

Alain Topor

> »The actions speak louder
> than the words.«
>
> *(Keb' Moe',* Just like you*)*

Introduction

This text presents the results of research on the experiences of individuals with severe mental health problems (SMHP) in terms of how professionals contribute to their recovery process.

From a traditional standpoint, this aim involves a number of contradictions:

➢ People with severe mental health problems are often considered to be beyond recovery.
➢ Their experiences are not rooted in reality, and cannot be taken for granted in a scientific context.
➢ Any contribution made by professionals to an eventual recovery process is understood to be the result of an »evidence-based intervention« by specialists, and not due to the personal capacity of the professionals themselves.

This article therefore begins by presenting a range of quantitative studies which establish that it is possible for a person with SMHP to undergo a recovery process, and indeed it is probable that they will do so. The results of these studies also indicate that there is no connection between recovery and different types of specialized treatment interventions.

Following these results, the challenge for research was to look for the factors which helped people on their journey to recovery. The findings challenge the dominant bio-medical paradigm, as they include the role of the person him/her self, as well as the family, friends and peers of the person. This article presents some of these findings before focusing on the role of professionals.

The article is therefore based on the experiences of users and former users during their process of recovery. In other words, it is not about what professionals *should do*, but about *what they are doing,* according to individuals with their own experience of mental health problems and services. These experiences have been collected in a range of scientific studies. An analysis of the findings resulted in three central themes: everydayness, doings and reciprocity. The concept of recovery capital is introduced as a possible tool for measurement not of the person, but of his/her context. These measurements could guide further professional work.

The »psy field« (Rose, 1996) has a strong ideological foundation. The concepts used in the field therefore convey a specific understanding of the nature of its core aspects. Words such as »illness« or »schizophrenic« reflect a bio-medical approach to the nature of both the problems and the individuals managing these problems. This text will therefore use concepts such as »user« or »person with mental health problems«. It will also use the concept of the »psy field« to refer to the whole armada of actors, organizations, professions, theories, etc. involved. These concepts are not free of problems, but should be seen as indicating divergence from the bio-medical understanding of phenomena in this field.

The impossibility of recovery

In the 1980s, several long-term follow-up studies were published on people who had been given a diagnosis of schizophrenia. The results common to these studies led to debate in the field of mental health, as they completely contradicted the prevailing beliefs of that period.

Classic psychiatry defined schizophrenia by its course. The person affected by the condition progressively lost most of their human abilities and ended in a state of dementia. Recovery was not considered possible. »If a patient who had all the symptoms of dementia praecox improved, Kraepelin routinely considered the patient to have been originally misdiagnosed« (Harding, Zubin & Strauss, 1987).

Eugen Bleuler (1911, English translation 1950), who coined the term schizophrenia, wrote: »As yet I have never released a schizophrenic in whom I could not still see distinct signs of the disease; indeed there are very few in whom one could have to search for such signs« (Bleuler, 1950, 256).

According to Bleuler, psychiatrists who claimed that a former patient had totally recovered were either lacking in psychological skills or had had insufficient time to carry out their examination of the patient (Bleuler, 1950, 256).

The discovery of recovery

Interestingly, most studies in Table 1 followed the participant for decades, in Manfred Bleuler's case (the son of Eugen Bleuler) up to 36 years, and in Courtenay Harding's research, for 30 years.

Harding (1988) reviewed the data from a number of studies (Table 1) and concluded that: »Together these studies found that one-half to two-thirds of more than 1,300 subjects studied for longer than 20 years achieved recovery or significant improvement« (Harding, 1988, 479).

Table 1. Results from five follow-up studies of patients with a diagnosis of schizophrenia. (Source: Harding, 1988).

	No of patients	% total recovery	% social recovery	% improved
Bleuler, 1972	208	23	43	66
Harding et al., 1986	269	34	34	68
Huber et al., 1975	502	26	31	57
Tsuang et al., 1972	186	20	26	46
Ciompi & Muller, 1976	289	29	24	53

Recovery in these studies was assessed by professionals. Total recovery would be known as »clinical recovery« today, and involved an absence of symptoms, no hospital stays in psychiatric hospitals and a good level of functioning. Social recovery meant that the person might still show certain symptoms, but these did not prevent the person from living outside mental health institutions.

Earlier, in 1979, the World Health Organization (WHO) published an initial report from a nine-center study. The results added one aspect to the results of the other studies. The proportion of people diagnosed with schizophrenia who then recovered was higher in low-income countries than in high-income countries. These results were confirmed in more recent studies (Harrison et al., 2001).

Finally, Richard Warner (1985/2004) published a review of follow-up studies on people with a diagnosis of schizophrenia published during the twentieth century.

Table 2. Percentage of people with a diagnosis of schizophrenia who recovered socially or totally during the twentieth century. (Source: Warner, 1985/2004).

Years	Total recovery	Social recovery	Improved
1901–1920	20	40	60
1921–1940	12	29	41
1941–1955	23	44	67
1956–1975	20	43	63
1976–1995	20	33	53

Warner's study showed that a surprisingly high percentage of people diagnosed with »schizophrenia« recovered throughout the century. According to Warner's compilation, the introduction of first-generation neuroleptics did not influence the probability of recovery for these individuals. In other words, the so-called psychopharmacological revolution was not seen to be involved in the recovery.

Controversial conclusions

These publications resulted in a great deal of controversy about the diagnosis itself, as it was clear that »schizophrenia« was defined and diagnosed very differently during different periods of the twentieth century, in different countries, by different doctors. This was also true of the definition of recovery. Nevertheless, some troubling conclusions could be drawn from these studies.

First of all, recovery, even from an »illness« that was considered to be chronic, was not only possible but seemed to be the most probable development. Diagnosis did not appear to be a safe basis for understanding or helping people with severe mental health problems.

During the twentieth century, psychiatrists had a variety of treatment interventions at their disposal, such as malaria cure, electroconvulsive therapy, first and second-generation neuroleptics, diverse psychotherapeutic methods, and inpatient and outpatient institutions. However, as the percentage of people recovering was relatively constant, it seemed that psychiatric treatment was not crucial for the probability that a person could embark on a process of recovery. This conclusion was strengthened by the WHO comparison between high and low-income countries. The latter had few psychiatric professionals, yet indicated a higher percentage of recoveries.

Other, socially-oriented explanations were proposed for the results from these studies. Warner suggested that the sudden decrease in the percentage of people in recovery during the period 1921–1940 might be explained by the great depression and the consequent high rate of unemployment. Since then, a number of hypotheses have been formulated to explain the difference between low and high-income countries. Most of these hypotheses have a social character, such as differences in family structure, conditions on the work market, cultural beliefs about mental health problems and medical practices with shorter and crisis-related psycho-pharmaceutical interventions (see e. g. Waxler, 1979; Mezzina et al., 2006).

Users as a source of knowledge

The results from the above-mentioned research paved the way for a new field of investigation about what could influence recovery processes. A large proportion of these new studies consisted of qualitative approaches to the subject, characterized by the use of information not only from high-ranking professionals such as psychiatrists and psychotherapists, but also from users themselves, and from professionals involved in users' everyday life, such as support and social workers (Davidson & Strauss, 1992; Deegan, 1988; Borg, 2007; Topor, Skogens & von Greiff, 2018).

This should be seen as an important shift in psychiatric culture, as users had previously been reduced to their diagnosis. Their utterances were mostly seen as signs and symptoms of their illness, and thus of no importance as sources of knowledge.

Recovery as a personal process

Accepting a person with severe mental health problems as a source of knowledge developed in tandem with a shift in the definition of the concept of recovery. This changed from a professional structured but also subjective assessment to a subjective definition, involving a person's own appreciation of his/her situation.

Bill Anthony's classic and much-quoted definition of recovery is an example of this:

> »Recovery is a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and con-

tributing life even within the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness« (Anthony, 1993, 15).

Here, recovery is described as a process inside the individual, and as a cognitive modification of a person's perception of him/herself and his/her context. In reality, even »living a satisfying life« sounds like a distant possibility for many poor people with mental health problems in the neo-liberal workfare system which has replaced guaranteed welfare (Wacquant, 2009). In the US, for example, »In 2012, there were approximately 356,268 inmates in prisons with severe mental illness, while there were about 35,000 severely ill patients in state psychiatric hospitals« (Lithwick, 2016).

Nevertheless, the individualistic approach has deepened understanding of recovery. It considers people diagnosed as mentally ill to be agents in relation to their problems, and also in relation to professionals, interventions, institutions, families and other people involved in their lives.

Recovery as a social process

However, recovery is also a social process involving relationships with others, structural factors and social definitions.

Social definitions

Individualistic definitions of recovery tend to adopt established definitions in the field of psychiatry. The core definition is that a person's problems are symptoms of an illness, or trouble in the person's brain. As an illness, mental health is about health, mostly understood as a somatic-based state. Doctors therefore have more or less a total monopoly in terms of defining the field.

However, the very definition of certain behaviors and thoughts as symptoms of an illness, and the issue of which behaviors and thoughts should be considered expressions of these illnesses, are not scientifically based as they are in somatic illnesses like cancer. The history of psychiatry is paved with illnesses that appeared and disappeared as a result of negotiations between different lobby groups. The most famous case is homosexuality, which was considered and treated as an illness until the end of the 20th century, and eventually disappeared as a specific diagno-

sis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) after pressure from the gay movement (Kirk & Kutchins, 1992).

France (2013), who was the head of the American task force which worked on the fourth edition of the DSM, later wrote that DSM IV led to three epidemics: depression, neuropsychiatric disorders and bi-polar disorders. How could a diagnostic manual cause three epidemics? France's response was that it lowered the criteria for these diagnoses, and this lowering of criteria was partly a result of pressure from the pharmacological industry.

There are other examples of the social construction of diagnosis, such as schizophrenia (Boyle, 2002), Post-Traumatic Stress Syndrome (Summerfield, 2004; Young, 1995), Mad Travelers (Hacking, 1998) and Depression (Horwitz & Wakefield, 2007). For the 5th and current edition of DSM, see Greenberg (2013).

These could be anecdotal stories from the dark ages, except that these social constructions still have very concrete consequences today. People with these socially constructed diagnoses have been treated with concrete medicines with a concrete impact on their health in terms of side effects (Whitaker, 2010; Moncrieff, 2009). They also impact on the way mental health problems are understood to be assimilated into the bio-medical paradigm (Rose, 2018).

Structural factors

Individualistic definitions tend to be blind to structural factors, and focus solely on the individual journey as the road to recovery. The risk with this view is that the person can be made responsible for his/her own recovery. Crises and setbacks risk becoming signs that the person is not making sufficient efforts to fulfill his/her recovery plan (Rose, 2014).

However, structural factors are present in both the onset of what are considered mental health problems and in the recovery from these problems. Priebe and colleagues published a range of articles on the different structural factors that influence mental health, both on an individual level and in a population as a whole (Priebe, Craig & Burns, 2013; Priebe, 2015; 2016). Users often note that economic issues are their main problem: »The life domain of finances had the highest proportion of dissatisfied patients, and consequently demonstrated the lowest mean satisfaction score« (Bengtsson-Tops & Hansson, 1999, 261). Several studies on »supported socialization« have shown that an improvement in the finances of people with severe mental health problems resulted in improvements in what are considered symptoms of mental illness, such as depression,

anxiety, isolation and quality of life (Davidson et al., 2001a; 2001b; Sheridan, 2012; Ljungqvist et al., 2015; Topor, A. & Ljungqvist, 2017. See also Read, 2010).

Other examples of the impact of structural factors on mental health and recovery include unemployment (Warner, 2004), work (Bond & Drake, 2014), housing choices (Borg et al., 2005).

In 2020, Topor et al. proposed a social redefinition of Anthony's classical definition of recovery. They wrote:

> »Recovery is a deeply social, unique and shared process in which our living conditions, material surroundings, attitudes, values, feelings, skills, and/or roles are changing. It is a way of living satisfying, hopeful, and reciprocal lives, together with others even though we may still experience distress, unusual experiences and troubled or troubling behaviour. Recovery involves engaging in new material and social contexts and in open dialogues where new ways of understanding and handling the situation are created as we move beyond the psycho-social-material crisis« (Topor et al., 2020).

Social relationships

In 2013, Priebe, Burns and Craig published an editorial in The British Journal of Psychiatry entitled »The future of academic psychiatry may be social«. In this article, they argue for a shift from a bio-medical to a social paradigm. Their main argument is that: »Even the hardest skeptic must acknowledge the abundant evidence of the importance of personal relationships in shaping both cause and cure of disorders« (Priebe et al., 2013, 320). Thus, »A social paradigm requires research to study what happens between people rather than what is wrong with an individual wholly detached from a social context« (Priebe et al., 2013, 320).

Social relationships are developed between a wide range of people in different situations, such as organized or spontaneous peer support, in churches and other spiritual settings, and in coffee houses and bars. Social spaces organized by users' groups offer other locations for interaction. The role of family members will be discussed briefly below before moving on to mental health professionals.

Social relationships are partly dependent on structural factors, as noted in the above-mentioned studies on »supported socialization«. Relational conditions in people's upbringing are important for their future mental health and their capacity to manage problems in adulthood (Hesse & Main, 2000; Romme & Escher, 2010). In terms of social relationships in adulthood, a number of studies

show that social networks tend to shrink where there are mental health problems. They also tend to change character, going from a mixture of friends, parents and acquaintances related to study and work, to a situation dominated by parents and a range of professionals, who become part of a person's social network because of that person's problems. This means that the number of people who know the person's personal history, passions, interests and capacities diminishes, while a growing number of people only know the person because of his/her deficits, failings and problems. These changes also influence the emotional atmosphere surrounding the person, as the newcomers, regardless of their personal characteristics, are employed and paid to meet and help the person. These transformations in a person's social network could influence how his or her problems are constructed, as well as his/her sense of self, making the recovery process more difficult.

It has been noted that parents can be both the cause of a person's problems and a protection against being abandoned. In the past, one of the main functions of an asylum or mental hospital was to separate patients from destructive environments, including their families (Castel, 1988). Later theories involved a »double bind« (Batesson et al., 1956), and psychiatrists like Laing and Esterson (1964) and Cooper (1972) pointed out how family dynamics could be a cause of severe mental health problems.

Whatever the role of the family in both the above-mentioned cases, the social dimensions of the family dynamic are considered influential in causing problems, as well as contributing to the recovery process. This brings the problems involved in the onset of mental illness into the social sphere (Topor et al., 2006; Hanssen et al., 2020).

In the experience of users, the same contradictory role is assumed by professionals in the psy field. Even when the focus is on how professionals support them, users often choose to contrast experiences of helpful and unhelpful professionals, as a way of helping themselves and the researcher to capture the essence of situations they describe as helpful (Topor, 2012).

Common factors, regardless of the orientation of professionals

Different psychotherapeutic schools describe the role of the therapist in different ways. Parsons (1951) had a great influence when he analyzed the basis of a professional approach to patients. According to him, professionalism was built

on a clear role division between the confused, incompetent and over-involved patient and the neutral, distanced and equitable professional who possesses scientific knowledge about the patient's illness and how to treat it. Parsons also mentioned the patient's »attempt to ›seduce‹ [the therapist] into reciprocation«. Nevertheless, the doctor/therapist can manage these attempts thanks to the values characterizing a professional stance, such as »universalism, functional specificity and affective neutrality«.

Parsons' formulation of a traditional image of professionalism had and still has a great impact on the health field and is in total counter position to another perspective. In psychotherapeutic research and practice, the importance of the role of relationships was first highlighted in the 1930s. Rosenzweig's (1936) paper suggested that all forms of psychotherapy seemed to have the same effect, regardless of the therapist's theoretical orientation and method. He called this puzzling finding »the Dodo-bird effect«, named after a figure in Alice's Adventures in Wonderland (Carroll, 1865/2017), where the Dodo holds a competition with confusing rules. After a period of chaos, where all participants set off running in different directions, the Dodo stops the race and proclaims that »Everybody has won, and all must have prizes« (Carroll, 1865/2017, 25).

Modern studies of the Dodo-bird verdict have elaborated on the concepts of »non-specific« or »common« factors, central to which is the »working« or »therapeutic« alliance (Wampold & Imel, 2015; Lambert, 2004; Frank & Frank, 1991; Hubble, Duncan & Miller, 1999). These factors are considered to have contributed to the Dodo-bird verdict.

These studies present different possible components of common factors in helpful psychotherapeutic interventions. One classic example is Frank's four-point list (Frank & Frank, 1991):

1. »… a particular type of relationship between the patient and a help-giver«. The main factor in this relationship is the patient's confidence in the healer's competence and his/her desire to help him/her. Frank writes of the »genuine acceptance of the sufferer«, and situations where health professionals »genuinely care about his welfare« (Frank & Frank, 1991, 325). This article also mentions emotional investment, active participation, warmth, empathy and enthusiasm (Frank & Frank, 1991, 326).

2. The *setting* is of special importance. The person must feel protected from the demands of everyday life. Special temporal boundaries can help create this protective experience necessary for change to take place. Interestingly Frank mentions the home as a possible healing setting, but only where it has been purified to allow it to play a healing role.

3. All helpful interventions involve »*a rationale* or a myth which includes an explanation of illness and health, deviancy, and normality« (Frank & Frank, 1991, 327). They have an optimistic view of a person's capacity for change, suggesting that it is not the degree of truthfulness that is the helpful factor, but its capacity to organize chaos and show a way out of the suffering by following certain procedures. Frank writes: »The first step in gaining control of any phenomenon is to give it a name« (Frank & Frank, 1991, 328).

4. *Procedures* are the final ingredient in constructing a working alliance. The procedures usually require the joint efforts of both the person with mental illness and the healer. Here again, it is not the specific procedures themselves, but their function which is important.

Common factors also reinforce the person's hope that changes are possible, and include experiences of success which will prove that hope is not an illusion. Another consequence of common factors is a feeling of connectedness with others. These include people with the same kinds of problem and people who care for them. Finally, change is connected to awakening emotions in the person. Together, these new experiences lead to feelings of mastery and an improved sense of self (Davidson & Strauss, 1992; Davidson et al., 2006; Skatvedt, 2016).

Common factors involve users meeting professionals specialized in a variety of different psychotherapeutic techniques in fairly structured special settings (time, place etc.). Where mental health problems are severe, encounters with professionals take place in a different context. The person's problems are more severe, the professionals may have different educational backgrounds, and sometimes they may not be trained in care. The setting may be a ward, a community mental health center, supported housing, the home of the person or even a public place in the community. Neither the user nor the professional can decide how often and for how long they will meet. Most of the time, even the goal of their encounters differs from goals in a psychotherapeutic setting.

Can encounters in these conditions be of any help to people with even more severe problems than those in psychotherapeutic settings? In fact, users note that helpful professionals in everyday encounters make an important contribution to their recovery process. This is also shown in some studies. Priebe and McCabe (2008, 522) note that: »[...] the existing evidence clearly suggests that the quality of the therapeutic relationship is of major importance across different kinds of psychiatric settings and treatments.«

De Leeuw et al. (2012) found that an alliance could have a positive effect on individuals with severe mental health problems. They noticed improvements in

terms of symptoms, level of functioning, social capacity and quality of life. Users who were part of a working alliance also appreciated interventions by the care institutions.

Since the discovery of the possibility of recovery, scientists have studied the role of professionals in this process, and researchers now have access to comprehensive literature on the topic. Most studies asked people with experience as users about factors they considered helpful, and sometimes focused on the role of professionals.

Individual solutions in a social context

One conclusion from these studies is that certain common factors could be considered helpful for different people with different types of problem, who meet professionals with different educational backgrounds in different settings.

On the other hand, gender, socio-economic status and cultural background influence expectations and preferences (Johnstone & Boyle, 2018). The majority of studies lead to the conclusion that no one size fits all.

People are different, even if they have been given the same diagnosis. They are different from each other, but they are also different in different periods of their life, and sometimes change over the course of a single day. People's needs, desires, capacities and options also change in relation to the setting and to the people they meet. Thus, even if official policies expect users to become involved, and even if many users prefer to take part in the decision process about the help they will receive (shared decision-making, empowerment, etc.), some nevertheless want professionals to make decisions about appropriate interventions (Schön et al., 2009; Hansen, 2020).

Recovery capital

If professionals are to grasp the complexity of an individual through his/her personal history and current social and living conditions, certain structures may be helpful. The concept of recovery capital could act as just such a framework.

Recovery capital was used in early addiction research, and is defined by Cloud and Granfield (2008) as »a body of resources that can be accumulated or exhausted«. Tew (2013) transposed it to the psy field and proposed five types of recovery capital:

➢   economic (money at one's disposal),
➢   social (resources in one's social network),
➢   identity (relations with significant others),
➢   personal or mental capital (coping and ways of seeing oneself),
➢   relationship capital (the quality of close relationships).

The impact of a person's recovery capital depends on both its quantity and its spread. Tew also suggested that access to different forms of capital was not sufficient to start and maintain a recovery process. It also required a person to be motivated to set out on this uncertain and demanding journey. In contrast to traditional treatment, which works independently of the user except for the fact that he/she complies with it, recovery cannot be dictated from the outside. It is not possible to ›recover somebody else‹.

However, even if many people in recovery describe the importance of making their own decisions, they also highlight the need for external help. »You need a strong will of your own. Then you need help from society, but help doesn't make you change.«[1]

The components of helpful relationships

Central aspects mentioned by users in referring to helpful professionals include »being heard«, »being seen« and »being respected«. Although these characteristics provide a flavor of these encounters, they remain quite abstract in terms of the question at the center of this text. What do professionals do to co-create experiences which help people in their recovery process?

Three central components recur in studies about helpful professional relationships:
1.   Reciprocity
2.   Everyday life
3.   Doings

Reciprocity, in the sense of recognizing the other as »a fellow human being«, mostly develops through concrete actions by a professional. These are often developed together with the user, or on the user's behalf, and often focus on problems which emerge in the person's everyday life. Experiences gained in this kind of co-

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1   If not specified, all quotes in the following are from Topor, Skogens & von Greiff, 2018.

creative collaboration result in changes to users' living conditions and to their sense of self.

The impact of recovery capital on practice

Professionals do not use the concept of recovery capital, but their practices can be interpreted as a spontaneous application of it. For example, professionals might approach users differently. Users with little experience of positive relationships or few resources might be treated differently to users who have previous experience of trusting relationships and an associated positive self-image (personal or mental capital and eventually identity capital), combined with access to supporting and wealthy social networks (social capital) whose resources are made available to them to initiate a recovery process.

In the latter case, professionals may focus largely on reconnecting the user with his/her social network.

> »There is some discrepancy between how it is now and how it has been in the past. Something worked for them earlier and it creates a discomfort; ›I do not want it to be like this!‹ This is something we can use to help the person.«

In the former case, the user and professional have to begin to build up his/her recovery capital. The article will focus primarily on this group.

Doings and identity capital

To help people begin to trust themselves if they have a background of profound insecurity, abuses and betrayals, professionals note that the first step is to establish trust in the professional. The basis for this trust is to establish a reciprocal relationship.

The effort involved in the person's doings may be an acknowledgment of the professional's sincerity, credibility and accountability. Thus, doings which result in palpable changes in living conditions form the basis for another important ingredient in the recovery process: trust.

Basic factors involved in establishing a relationship include being predictable, accountable and engaged.

Generating trust in people whose sense of self has been exposed to discrimination and stigmatization is based on paradoxical challenges. *First, helping somebody*

to change involves starting by accepting him/her. Seeing and hearing in practice are associated with taking the person's wishes and dreams as a basis. »When they do realize that there is no one here who wants to correct their behavior, then our relation might be calm. This is when things might start to happen. It goes in the right direction.«

Secondly, accepting a person with »lived experience« of mental health services may also involve challenging the fact that his/her sense of self is dominated by or even reduced to a diagnosis. This can be done in very mundane situations which nobody would notice in a clinical setting. The following example is given by a support social worker who visits people in their homes who have both addiction and mental health problems:

> »I knock on their door and say hello when they open the door, that's important. I am visiting this person in his/her home. Some tell me: You don't have to take your shoes off, but then I say: You'd take your shoes off if you came to my home. Some people are quite institutionalized. Anyway, I say hi, take my shoes off and then we sit in the kitchen and start to talk/chat. These small things are important. Relationships are built on them.«

Taking your shoes off when you enter somebody's home is common behavior in Sweden, and by taking his shoes off, the social worker is acknowledging an inherent equality in their relationship. This is further emphasized in his comment about how he would expect the user to behave if he went to his home.

A third paradox involves how people's sense of self evolves. Starting to trust oneself seems to involve starting to trust somebody else. Furthermore, professionals have to prove themselves worthy of trust.

> »To create trust, it is important to be predictable. We do what we say. We followup what we have done and show curiosity about, and interest in the person. We do not judge them, even if that is not always so easy. They have to feel that we see and respect them.«

Accountability, acceptance and respect are developed from doings where the professionals show that, in the journey they propose to the user, his/her wishes, dreams and preferences are paramount. Although words are important in this process, the doings must be in harmony with the words, even if this sometimes involves the professional taking the user's side in confrontations with other professionals, organizations and rules.

»I had never looked for treatment earlier, and I had heard that they lock you up and you're treated badly. You have to sign a lot of papers and follow a lot of rules. If you break them [...]. When I came here, I was really honest with the staff, and they accepted that. I was given some privileges and never needed to follow all the rules. I got the feeling that if I made some progress, then they let me continue. That was very important to me. Here, I gained their trust, which I had never got from my parents. I was trusted to go to the shop by myself, and then trusted to do other things because I managed the previous step. I made it a part of me. A long time after I'd left, I came back here. They made me feel that I was an important person to them. I believe that was really important.«

A fourth paradox could involve the importance of small, mundane, practical actions. Mental health interventions are generally associated with medication and different forms of treatment involving talking. Users mention events related to situations involving medication or psychotherapy, but mostly talk about situations outside these interventions. Even as part of their stories about helpful psychiatrists and psychotherapists, they stress mundane doings. These doings might also be actions by professionals with different positions in social and mental health organizations. Doings, often defined as »extraness«, are characterized by not being part of a professional's formal duties (Borg & Kristiansen, 2004; Ware et al., 2004; Topor, 2012).

Thus, the experience of being trusted often grows out of very practical doings, where professionals put aside the rules of their institution for the sake of a specific user. Going beyond the institutional rules seems to form a basis for this person to understand that he/she is important to the professional, and thus also to him/herself.

Personal capital, the way one sees oneself, originally seems to be accumulated through identity capital, in other words through relations with significant others.

Doing basic economic capital

However, positive interaction with significant others is not enough if people do not have a material base for their everyday life. Many professionals know this, but the division of labor between different agencies which specialize in different aspects of the users' lives counteracts integrated holistic approaches. As one professional expressed it:

>You become a spokesman for the person in different instances. Low self-confidence is a common factor, so it is important that they dare to trust me. Many have an earlier experience of betrayal. Trust is created through being there, taking time, listening and being careful to see that things go according to their plans.«

The presence of professionals in different fora where the fate of the user is discussed is a concrete act of solidarity which counteracts earlier experiences of betrayal. This is particularly the case where the professional acts as a user's advocate, sometimes against his/her colleagues. The following quote highlights one of the main factors preventing professionals from being helpful: they have too little time (Topor & Denhov, 2012).

Being a »spokesman« often means taking care of the person's basic needs in these instances:

>Necessary conditions are decent housing and an acceptable financial situation. We have to help a lot of them with the social services and with practical questions, because their situation is chaotic. It is difficult to talk about their problems before they have achieved some basic stability in their life: a roof over their head and food on the table.«

This professional clearly considered economic capital to be a basic condition for further steps in a recovery process. The importance of this is stressed by users:

>He helped me get rid of my debt incredibly fast. I had a bank loan. […] And suddenly Chris comes and says: >You are out of debt<.«

>But Ninni, she goes on … without her, things would have been a lot harder anyway. […]. I would probably have lost my apartment while I was in prison. Six months is the most you can get covered for, and I had a seven-month sentence. They take away your security if you lose your apartment, she said, so we went to their office and she didn't give up …« (Lindvig et al., 2019).

Thus, personal capital is developed in relation to others who engage in the relationship beyond their formal duties (identity capital), and is strengthened through the experience that it is possible to influence one's life, one's living conditions.

In these situations, professionals can become a central part of a users' social network, both in terms of their close relationship (relationship capital) and as people who can help them find support on their journey to recovery (social

capital). From this perspective, the traditional fear of creating dependency in professional relationships seems misplaced. In fact, dependency could be a necessary step toward greater independence from professionals in the form of new dependence on a wider social network, just like everyone else (relationship capital).

In terms of traditional professional roles, where the professional is the expert who assesses the user through a scientific, objective lens, the way professionals are presented in this section is problematic. An even greater contrast with the traditional ideal is the recurrent observation, made by both users and professionals, that a professional's personal engagement in a specific user also gives him/her something back on a private level.

This reciprocity is not only about meeting the user as a human being, but also about accepting that this human being is able to give something back to the professional and to others.

> »When they feel that they have something to contribute, that they are able to give something to others, to the community. That they are needed. It can be just by washing the plates, or if they like dogs, to help at a day center for dogs. That they have something to give.«

One aspect of recovery may be this capacity to end their unilateral dependence on others, and to become someone who gives to others, especially to those who have given so much in difficult times (Offer, 2012).

Two forms of doing

It is possible to distinguish two types of doing in the research about helpful professionals. The first could be called »micro-affirmations« or »small things«, and the second »broadening practice«. In interviews, they may be referred to as »little extras«.

Micro-affirmations

In studies of oppressed groups, some researchers have focused on microaggression. This can be seen as small gestures and words, or simply co-silence, eye contact and demeanor which, almost invisibly, convey a definition of the other as subordinate (Sue, 2010).

Micro-affirmations are defined by Rowe (2008) as follows: »Apparently small acts, which are often ephemeral, hard-to-see, events that are public and private, often unconscious but very effective, which occur wherever people wish to help others to succeed« (Rowe, 2008, 46).

Micro-affirmations are experienced as spontaneous, genuine acts of allegiance. They are defined by their size, small and micro, and often occur between two people in social situations without being perceived by the others present (Topor et al., 2018). The magnitude of these affirmations is also related to what are usually accepted as formal, recognized treatment interventions. Paradoxically, micro-affirmations may have great importance for the person they are directed to. Even if micro-affirmations lack »formally declared therapeutic value« (Skatvedt, 2017, 5), they can make an important contribution to a recovery process. In the words of a user: »I had broken off all my relationships, so I came here and someone put his hand on my shoulder and asked, ›How are you today?‹ Then you feel you can cool down. You have a human relationship« (Skatvedt, 2017, 38).

Sometimes the importance of small things is even recognized at an organizational level:

> »After a while, (the users) might say that they've been treated with respect and that we do things for them. How we treat them is important, that we welcome them and offer them coffee. We care about creating a nice atmosphere. A lot of the alliance relies on coffee breaks.«

There is an overwhelming gap between the huge problems these individuals are confronted with and the smallness of the actions described, and it is surprising that such micro-affirmations could be part of a recovery process. Nevertheless, users also tell the same kinds of story. This was the fourth paradox mentioned above.

Asked about his journey of recovery, a man diagnosed with schizophrenia 20 years ago mentioned the crucial role of his mother, who always stood by his side (Topor, 2012). When specifically asked if there had been any professional who helped him, he mentioned one whose name he remembered, but he did not know her formal position, nor which organization she belonged to. He described her as »nice and kind«. When asked what she did to be nice and kind, he answered:

> »After I worked for a month she gave me a rose. I dried it, and keep it at home. Small things like that. (...) She phones me and asks how I am doing. She phones my mother and tells her how things are going for me at the job. That's made my mother feel a lot better« (Topor, 2012, 305).

This kind of micro-affirmation clearly goes beyond the duties of the professional, and may not even be allowed, as it involves an emotional engagement with a specific user. It is likely that the professional in the story does not give roses to all the people she is in contact with. Interestingly, the storyteller himself refers to the actions he chooses to call helpful as »small things«, such as a gift, a rose he has dried and keeps at home as a memory. Small things can create a secret bond between the co-actors, and thus support and even strengthen a person with mental illness.

Small things are thus emotionally loaded as an expression of mutuality and engagement. Creating and maintaining a secret bond between a professional and a user, even through micro-affirmations, might be seen as a professional standing up for the user against his/her own organization. This occurs when he/she recognizes the other as a »whole human being« (Grim et al., 2019, 9) and »a fellow human being« (Bjornestad et al., 2018), or when the situation is recognized as an expression of »shared humanity« (Shandu et al., 2015) or »humanness« (Shattell, 2007).

Micro-affirmations in themselves broaden the professional role, as they transmit to the user the sympathy of the professional. In social encounters, professionals and users seem to respect one another's roles, but micro-affirmations transform them into accomplices in terms of breaking institutional rules and roles.

Broadening actions

Broadening doings, as defined here, includes two other aspects where professionalism is extended. It involves breaking the institutional rules and roles around time and place/space, making them more visible and thus also repressible.

In other studies, this »breaking« is called »going beyond« (Borg & Kristiansen, 2004; Laugharne et al., 2012; Ware et al., 2012; Topor, 2012; Topor & Denhov, 2015). Expressions such as users' involvement, and the practice they refer to, run the risk of remaining well-intentioned terms in quality-control documentation and formalized routines (Matscheck et al., 2019). It is therefore interesting to observe how these words have been used in helpful everyday practice in different contexts.

Smythe et al. (2018) stress the importance of local cultures in building a helpful professional relationship. Cultural differences in New Zealand are more evident in the country as a whole than in other countries, but they can also be found in local cultures on the various islands.

A mental health support worker (MHSW) was working with a young girl and her family. After a period of improvement, the relationship ended. The MHSW was later contacted by the mother as her daughter had committed suicide. The mother needed help, she said, and asked the MHSW to follow her and her other daughter to a remote island to collect a headstone for her daughter. This island was also where the MHSW's family lived, and she had had no contact with them for many years. She spoke to her boss, and decided she would take some unpaid leave in order to make the journey. She therefore went to the island with the mother and daughter.

During the interview, the MHSW said that the mother and daughter were »really happy, as they felt they could actually give something back«. In fact, it gave her the chance to re-connect with her own family.

The MHSW also linked this trip to the mental health of the mother: »Without that time and that support, I think she would have become a patient of the mental health service« (Smythe et al., 2018, 292).

In a very different context in Norway, Skatvedt (2017, 405) presents another story from her ethnographic research about people with mental health and drug problems:

> »Andreas told me about a fishing trip with a staff member, close to Andreas' home: He wanted to come fishing with me! On his day off! He came with me to my place, and the way he was at home with me and ... I asked him in for some hot dogs and coffee and things like that, and he was there, it was ... like ... It was so okay! [he laughs] ... He wasn't there with a strict face on ... like ... ›Here is a staff member‹ ... you know ... he was just ... ›Hey, shall we eat soon, or what?!‹«

Skatvedt (2017, 405f) comments: »A staff member's participation in something ›without having to do so‹ is in itself a powerful sign of authenticity.«

The tales above exemplify powerful symbols of identification that occur in everyday interactions, often even wordlessly, but they are not about empty doing. The situations provide authentic messages about being somebody, and about a subject interacting with another subject, across status and power differences.

The extension of time and place/space does not need to be spectacular; it occurs mostly in connection with everyday routine situations, as a former user noted: »I was sent to a ward and then came the doctor. He sat by my side in the patients' dayroom and listened to me for two hours. [...] That was what I needed« (Topor, 2012).

Sitting in the patients' day room for two hours listening to a user breaks with the routine of the ward, and the user is fully aware of this, but it was »what she needed«. Broadening out mundane actions can have important consequences for people with severe mental health problems, as they convey to them a sense of their own importance for somebody else. When users are approached beyond fixed routines, it gives them the chance to become individuals and not simply a diagnosis. It is practical proof of basic reciprocity.

Another person with experience as a user related how his journey of recovery had started:

> »I had mobilized all my energies to meet my social worker at her office. The meeting was over and I had just come home when she called me, telling me I had to come back. I had forgotten to sign my demand, and without my signature it could not be accepted, and I would not get any money before the holidays. I was still overwhelmed by anxiety and exhausted, so I told her I would not be able to make another bus trip to her office. A little later I hear the doorbell ring. I jumped and went to the door to look through a gap in the curtain. It was the social worker. Why had she come? Cautiously I open the door and let her in. An hour later I was filled with gratitude. She had come to my place during her lunch break to get my signature. And she did it for my sake, so I would be able to get my money. Never before had anybody gone so far for my sake!« (Michalsen & Bachke; submitted).

Here, the storyteller connects the situation to the start of his journey of recovery. At the same time, it is reasonably clear that the social worker had not told her colleagues or her boss about her actions. She probably kept them invisible as it could have been seen as unprofessional. This can be seen as a final paradox, that *helpful actions are often made invisible* as they break with the routines and image of professionalism. Thus, helpful practices are not discussed openly, but made invisible, as if they do not exist.

The above testimonies highlight how the professionals involved engaged in social interactions beyond the usual professional limits. The situations took place outside professional places and outside the usual time frames. Where time and place/space regulations help the professional to maintain an apparently neutral and objective image, being together for extended periods in public and private settings in the community helps to break down so-called professional distance. As a consequence, the relationship with these helpful professionals is often described as »friendship-like« (Ljungberg et al., 2015; Skatvedt, 2017), or »like friendship« (Berggren & Gunnarsson, 2010; Topor, 2012). Users are generally

aware that the professional is not simply another friend, but the relationship goes beyond what they have been used to in earlier relationships with professionals. It is also important that these relationships remain different to friendship, because: »[...] the professional is bound by confidentiality, is not connected to the social network of individuals, has unending patience, and is someone with whom problems and needs can be discussed« (Ljungberg et al., 2015, 484).

Some conclusions

It is important to remember that professional interventions are often only a restricted part of the person's social interactions. Equally, not all ›broader‹ doings and micro-affirmations support recovery processes. They are neither a new rule nor a new technique. They can be associated with pleasurable situations (Davidson et al., 2006) and are experienced as genuine and spontaneous. In other words, they cannot be planned. However, for individuals with a restricted social network and/or a network struggling with its own problems, the doings of professionals can have an important impact, as they can convey a different and more positive image of the professional, and can help co-create an improved social environment and sense of self. This process of development can be interpreted in terms borrowed from symbolic interactionism (Skatvedt, 2017), and also from recovery literature (Davidson & Strauss, 1992; Strauss, 1992; 1994).

In this contribution, I have chosen to use recovery capital as a frame to understand helpful doings and situations. Generally, when asked about their experience of helpful professionals, users describe them as persons acting in mundane, everyday life situations. Most of these situations are common ones and it is difficult to understand how they could contribute to the process of recovery from severe mental illness. Social situations and human interaction might be pleasurable, but they cannot cure illnesses.

To understand how social situations can help people, one has to leave the biomedical field and its explanations of the causes of mental illness. Instead, one has to shift from illness to problems and distress. If the problems have developed in social situations and interactions, it becomes meaningful that they can also be helped in other kinds of situations and interactions. It also becomes plausible that traditional professionalism, where patients are assessed and reduced to diagnoses, risks exacerbating the person's problems.

Micro affirmations mainly target personal and identity capitals. Therefore, they might repeal the condition of de-moralization, a result of a combination of

distress and subjective incompetence (de Figueiredo & Frank, 1982; De Figueiredo, 2012) that often characterizes service users. Widening doings/practices might even strengthen other forms of capital, such as social, economic and relational capital. Thus, these practices might give the user instruments for developing and maintaining their ongoing journey. Doing things and just being together are forms of co-production of capital and important moments in the re-moralization of the person.

Recovery is a process of changes. It involves changes in an individual's living conditions, as well as changes to his or her sense of self and how she/he relates to others. It is also a process of change for professionals in relation to how their professional role is usually defined. A professional's understanding of his/her role and sense of self undergoes change. Thus, recovery cannot be considered a process involving only users. It also influences professional roles, the instruments and methods professionals have at their disposal to help users, and importantly, »psychiatric« knowledge.

A common feature of the doings presented above involves questioning one-sided definitions of users as mere diagnoses, reduced to a collection of flaws and inabilities as in the traditional basis for professional interventions.

However, if professionals question their own organization's knowledge base and arsenal of interventions, they can work with users to broaden the understanding of who a person with mental health problems can be. They clarify what these problems are when they are seen in the social context of the person involved, and highlight how professionals can contribute to a recovery process.

Broadening professional practice is therefore based on developing a reciprocal relationship which recognizes both participants as subjects and agents. This process broadens traditional roles by expanding traditional structures around the encounter between reason and madness, and in so doing blurs this dichotomy.

Deinstitutionalization was not only intended to be a departure from institutions of brick and mortar to micro institutions in the community. It was meant to include radical changes in the practice and knowledge base of psychiatry.

The change of location for mental health interventions, from mainly psychiatric wards to different places in the community, opened up new possibilities for a range of professions to act beyond the controlling gaze of the medical professions. However, even with total institutionalization there were, and still are, spaces for an »underlife« (Goffman, 1961, 187–280). These are never acknowledged, as they do not theoretically exist, but they are nevertheless »tolerated« (ibid). Foucault (1976/2006, 81–82) wrote about »people's knowledges« as »subjugated knowledges«, referring to »doctors', nurses', psychiatric patients'

and delinquents' knowledges«. He defined these as »unqualified, even directly disqualified knowledges« as opposed to »general common-sense knowledge«.

Helpful relationships are often about this »underlife« and these »people's knowledges« which still exist in practice and which, regardless of how effective they are, largely remain disqualified.

Today, there are contradictions between two approaches or paradigms: the bio-medical and the social (Priebe et al., 2013). These include:

➢ Considering the brain of the user to be the focus of therapeutic work, or focusing on his/her social situation and relationships.
➢ Reducing options to national guidelines, gold standards and evidence-based practice, or focusing instead on empowering users.
➢ Encouraging users to comply, or highlighting the alliance between users and professionals.
➢ Proletarianizing professionals such as nurses, psychologists and social workers by introducing pre-determined, schematized interventions and invasive bureaucratic forms of control, or broadening practice as highlighted in this contribution.

Do the poor results of the evidence-based revolution (Every-Palmer & Howick, 2014) and bio-medical psychiatric research and therapies (Priebe, 2016; Johnstone & Boyle, 2018; Rose, 2018; Priebe et al., 2019) point to the need for a paradigm shift? In fact, this shift may already be taking place in practice.

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