

SOCIAL RELATIONSHIPS AS A DECISIVE FACTOR IN
RECOVERING FROM SEVERE MENTAL ILLNESS

ULLA-KARIN SCHÖN, ANNE DENHOV & ALAIN TOPOR

ABSTRACT

Background: Recovery research often describes recovery from mental illness as a complex individual process. In this article a social perspective on recovery is developed.

Aims: To ascertain which factors people regard as decisive to their own recovery and what makes them beneficial.

Methods: In-depth interviews were conducted with 58 persons in Sweden who had recovered from severe mental illness. Interviews were qualitatively analyzed using grounded theory.

Results: Three dimensions of contributing recovery factors were identified. Social relationships emerged as the core category throughout these dimensions.

Conclusions: The results show that recovery processes are social processes in which social relationships play a key role.

Key words: recovery, mental illness, contributing factors, social relationships

BACKGROUND

Recovery research in recent decades has shown that a significant number of patients with severe mental illness do recover (Harding & Keller, 1998; Harrison *et al.*, 2001). Researchers have, however, been unable to ascertain whether recovery can be attributed to any particular form of treatment. What is known is that the predominant medical paradigm is insufficient to fully explain the causes of mental illness or why people recover from it (Tew, 2005).

Recovery research undertaken in the past few decades has been predominantly qualitative, focusing on factors that contribute to recovery. In this research there has been a strong emphasis on the individual aspects of the recovery process (Anthony, 1993; Ralph & Corrigan, 2005).

To have hope and believe in the possibility to lead a good life is often described as a prerequisite for recovery (Deegan, 1996; Mead & Copeland, 2000). If hope is to have a beneficial effect in improving the individual's condition and situation, it must be transformed into a desire and firm decision on the part of the individual to recover (Young & Ensing, 1999). Another factor mentioned in recent studies is the individual's capacity to manage their symptoms, i.e. to be an active agent in the recovery process (Davidson & Strauss, 1992; Topor, 2002). The methods for managing symptoms are individual and can consist of medication, therapy, spiritual means and/or own coping strategies. This type of recovery is related to the individual as an active user of medical, therapeutic

or social interventions and having own coping strategies rather than being merely a recipient of other people's interventions (Deegan, 1996).

Having the social support of family and friends, professionals and other sufferers of mental illness is also mentioned as being a decisive factor in recovery (Davidson, 2003; Davidson & Stayner, 1997; Borg & Kristiansen, 2004; Topor *et al.*, 2006). Having a mentor in the recovery process can help the individual to understand what recovery means and what is necessary to achieve it (Mead & Copeland, 2000). Likewise, engaging in meaningful activities and feeling that one is important in a social context has been described as meaningfully contributing to the recovery process (Sullivan, 1994; Borg *et al.*, 2006; Sells *et al.*, 2006). Many patients mention the importance of other factors as well, such as having enough money to get by (Russinova, 2002; Jensen, 2006). Although social factors of recovery are mentioned in these studies, the emphasis is still on contributing factors, rather than on the social relationship within these factors.

In this article we investigate the recovery process through narratives of people who have recovered from severe mental illness in Sweden. Through 58 in-depth interviews, we determine which main factors the respondents themselves mentioned as being conducive to their recovery and what it was about these factors that made them beneficial, according to the respondents.

No conflicts of interest in this study were declared.

METHODS

The present article is based on three interview studies conducted by the three authors in Sweden between 1995 and 2003. The point of departure for all three studies was the respondents' narratives on what they regarded as having helped them to recover from severe mental illness. In all, 58 individuals (29 women and 29 men) were interviewed. The interviews were open-ended interviews starting with one similar question in all three studies, namely: 'What has contributed to your recovery?' An interview topic list was used in the last part of each interview to ensure that broad topics of relevance to the study had been considered for discussion. These lists consisted of preliminary codes that had emerged from the analysis of earlier interviews within each study. The interviews were tape-recorded and took place, according to each respondent's wish, mostly in the respondent's home, at cafés, at clubhouses or at the office where the research projects were located. The interviews ranged from 45 minutes to four hours. All respondents agreed to being tape-recorded and before the interviews took place, an agreement was made with the respondents, giving them the opportunity to read through their own, anonymized transcript. After reading the transcript, the respondents gave their written informed consent for using the data for research purposes such as this.

SAMPLE SELECTION AND RECRUITMENT

The selection of interview subjects was limited to individuals who had been treated in 24-hour psychiatric care and diagnosed as having schizophrenia, psychosis, a personality disorder or a bipolar disorder. A second criterion for participation in the three studies was that the individual had not been hospitalized during the two years prior to the interview; however, ongoing outpatient

care and/or being on medication did not pose an obstacle to participation. A third criterion was that the individuals considered themselves either recovered or in the process of recovery.

In Study 1 (Topor, 2002) nine respondents were recruited through staff in outpatient clinics in Sweden, and in direct contact with individuals who had recovered. The interviews were conducted by the third author. The 19 respondents in Study 2 (Denhov, 2000) were recruited mainly by outpatient clinic staff and the interviews were conducted by the second author. In Study 3 (Schon, submitted; Topor, 2004) 30 participants were recruited through the Swedish National Association for Social and Mental Health (*Riksförbundet för social och mental hälsa, RSMH*), a nationwide user organization, and through informal contacts. Interviews were conducted by the first author and another person. The recruitment base of the three studies gave us knowledge both of individuals who at the time of the interviews were in outpatient care and/or were clients of the social services, and of those who at the time of the interviews were active members of a user organization and/or were not receiving treatment or support interventions of any kind.

Interview group

The interview group consisted of 58 individuals. The respondents' age at the time of the interview varied between 23 and 66 years, with the majority being between 35 and 55 years of age. Two of the 58 interviewees were foreign-born and of non-Swedish parentage. All the respondents had a regular place to live and a regular income (from employment or from the government/as a social benefit) at the time of the interview. Table 1 gives demographic data. The diagnoses given are based on the respondents' self-reports, even though more than one third had been recruited to the

Table 1
Demographic data on the respondents ($n = 58$)

Sex				
Women			29 (50)	
Men			29 (50)	
Age, years	18–30	31–44	45–60	61+
Whole group (%)	5 (8)	23 (40)	22 (38)	8 (14)
Women (%)	3 (10)	14 (49)	9 (31)	3 (10)
Men (%)	2 (7)	9 (31)	13 (45)	5 (17)
Diagnosis				
Psychosis (%)			41 (71)	
Personality disorder (%)			9 (16)	
Bipolar disorder (%)			8 (13)	
Years since the most recent period of hospitalization	2	3–5	6–9	10+
Whole group (%)	6 (11)	25 (43)	10 (17)	17 (29)
Women (%)	3 (12)	12 (40)	6 (21)	8 (27)
Men (%)	3 (10)	13 (47)	4 (13)	9 (30)
Average number of years between the first and the most recent period of hospitalization				
Whole group			8.9	
Women			8.8	
Men			9.0	

study through psychiatric staff with knowledge of the inclusion criteria. The diagnoses should not be regarded as exact; rather, they should be viewed as indications of the nature of the respondents' mental problems. Several respondents reported that they had received various diagnoses over the years as patients. Individuals who reported that they had been diagnosed at any time as having a psychosis or being schizophrenic were categorized as such in the present study, regardless of whether or not they had received other diagnoses earlier or later in the course of their mental medical history. Self-reporting of diagnoses can, of course, be a source of uncertainty, but patients have elsewhere been shown to be a reliable source of information regarding their diagnoses and episodes in care (Sullivan, 1994).

The majority of the respondents had been hospitalized several times, but at the time of the interview nearly half of the respondents had not been hospitalized for at least six years.

ANALYSIS

In preparation for the present study, all the interviews underwent qualitative reanalysis. The three studies were put together to obtain a fairly large sample of in-depth recovery interviews. All 58 interviews had been transcribed verbatim and were analyzed for this article using a modified method based on grounded theory (Glaser, 2001). The purpose of the qualitative analysis was to ascertain which factors the participants outlined as decisive in their recovery and what characteristics of these factors the respondents found to be helpful.

All interviews had been transcribed verbatim and each transcript was read through in its entirety to gain a general impression. All transcripts were initially coded line by line using the NUD*IST software. The codes were collected into categories and preliminary concepts emerged. The coding was done by the first author but discussed repeatedly among all three authors of the article. Concepts and categories emerged through a cyclic process of coding and of comparing incidents. Concepts and categories emerged and theoretical memos were written throughout the process. The memos from the analysis of the interviews were compared in depth and relationships between categories and concepts were found using different theoretical and emotional codes (Glaser, 1998; Hartman, 2001).

Due to the extensive material for a qualitative analysis, the NUD*IST software was also used to quantify the codes and categories that had emerged in the analysis, in order to establish the extent of the concepts among the participants. This analysis revealed both the facilitating and the obstructing factors mentioned by each participant. The quantitative analysis also controlled for differences between the three different samples and any differences due to sex, age or diagnosis.

FINDINGS

Although the pattern of response varied between respondents, a number of facilitating factors were outlined in a large number of the narratives, irrespective of the respondents' sex, age or diagnosis. The core category that emerged in the grounded theory analysis of the interviews was *recovering through a social process*, which emphasized social relationships as decisive in recovery from severe mental illness. Recovery is an individual process, taking place internally and in relation to society in general. The social process of recovery was analyzed through three overlapping

dimensions that emerged as decisive in the analysis, starting with the *social self*, reflecting on the internal recovery process in terms of finding healthier parts of oneself and individual strategies to cope with the illness. The second dimension, *social interventions*, reflects on the recovery-facilitating interventions from psychiatry, the social services and self-help groups. The narratives outlined how social relationships within these interventions seem to be of utmost importance. *Connection to others* is the third dimension, which relates to how the participants recovered coherence by getting in touch with other people, being able to accept support from family, friends and other service users, as well as being able to give support to others.

In the following sections we take a closer look at these three dimensions.

THE SOCIAL SELF

In the material the participants themselves emerged as the driving force for their own recovery process. In many cases this insight was gained during the interview, when the participants gave their recovery narrative. Most participants started their narratives by outlining other people as having been decisive to their recovery, but often realized their own decisive role during the interview when the active self was visualized. Recovery implied a process of leaving a passive self behind and moving towards an active self, appreciating the role of oneself in contributing to improved health. Most of the respondents described how, at an early stage in their illness, they had developed various strategies for managing their problems and reclaiming areas that belonged to their ordinary life. These ways of managing had been successful for a while but had needed to be revised during the various phases of the recovery. The participants had set themselves small goals in a process characterized by continuous effort, setbacks, progress and personal growth. What had fuelled the journey to recovery were the individual's personal characteristics, such as pertinacity, curiosity, a sense of humour and a positive view of life. Differences in personality and personal interests may be one explanation for the individual differences in the recovery processes. The results illustrate that recovery takes place in different areas of life and that being successful in one does not necessarily imply success in all other areas.

Coping strategies

The respondents described a number of strategies they had used in order to control the illness and the social consequences of their disorder. These ways of managing had contributed to resolving the problems or reducing their destructive social consequences. Most of the coping strategies mentioned in the narratives can be categorized into one of four areas: *meaning making*, *self-expression*, *finding facilitating environments* and *regulating the pace*.

All the respondents described a process of exploring the meaning of the illness and its consequences on the life situation. Meaning making also included refining the facilitating activities and avoiding any activities that caused stress and illness. Expressing oneself by keeping a diary, writing down one's thoughts, making notes and painting pictures that depicted one's thoughts, voices or symptoms were all strategies that helped to make the individual's situation more comprehensible.

Most participants described how they had sought out healing environments. Several of them mentioned nature as a source of 'new images'. Spending time outside in the open and in a relaxing environment was described as 'healing' and 'comforting'. Other examples of socially rewarding

environments were places where it was possible to socialize with others who had similar experiences and where the respondents felt they could just be themselves. For some participants the own home was a refuge offering an opportunity to meet the self. Several described how they intentionally avoided environments that they experienced as detrimental, such as 'places with too much anxiety' or social contexts dominated by aggressiveness.

Most of the respondents also talked about how they 'consciously lowered their level of activity'. Several described stressful living conditions as one of the reasons they had become ill in the first place. Others talked about how they had had to lower their level of activity in order to mobilize their energy and concentrate more effectively on managing symptoms.

These strategies were in some cases developed by the participants themselves. In some cases they were also the product of cooperation with professionals from psychiatry or friends with their own experience of mental illness.

SOCIAL INTERVENTIONS

In most narratives both the in-care psychiatric and community psychiatry were described as important arenas for recovery. In these arenas social relationships with the professionals, rather than the interventions, were outlined as decisive.

Cooperation with professionals

Professionals in psychiatry were described by all but one of the participants as having played an important role in their recovery. This group also included contact persons in the employ of the social services. However, the professionals' role in the recovery process had been complex. Although the vast majority of the respondents in the present study mentioned one or several professionals as having had a decisive impact on their recovery, the interview material also contains descriptions of encounters that had had the opposite effect. Two thirds of the respondents also described detrimental encounters with professionals. The men in the study referred to professionals in a more positive light than did the women. Almost half of the male respondents, but only one fourth of the women, reported that having been in contact with the professionals they had met had been solely beneficial to their recovery.

When distinguishing between helpful and detrimental staff, the respondents referred almost exclusively to the staff members' personal traits. A recurring aspect of relationships with professionals had to do with whether or not the respondent felt that they had been treated in accordance with a fixed set of routines and procedures. Staff viewed as 'detrimental' were those who had 'strictly followed routines' or procedures and had shown no personal involvement in the patient as a person. Helpful professionals, regardless of formal title, had shown an interest and involvement in the individual over and beyond the patient and the diagnosis. What emerged from the narratives is that the helpful professional had done more for the mentally ill person than was regarded as standard practice at the institution where the encounters had taken place, or that they had done things other than what was customary or expected. The respondents described helpful professionals as those who had made sense of what was important to the respondent and 'showed an interest' in the respondent's experiences and knowledge. 'Cooperation' and 'reciprocity' were mentioned as characterizing the helpful relationships with professionals.

Medication as a joint effort

Most of the respondents regarded their medication as having had a positive effect on their recovery. But there were also descriptions of medication having had negative effects. Two thirds of respondents reported that medication had also been detrimental to their recovery. The female respondents' experience of pharmaceuticals was more negative than that of the men in the study. Half of the female participants described medication as having been both a helpful and a detrimental factor, while close to a quarter regarded medication as a solely negative factor in their process of recovery. Like the women, half of the men reported both positive and negative experiences of medication, but only a few reported having only negative experiences.

None of the respondents reported that they had received the correct medicine and dosage at the beginning of their time in care. Reports of side effects and of no appreciable effect on the symptoms were common, and often it seemed to be more a case of patients having first gone through one or more 'trial periods' of medication before the medication began to have beneficial effects.

However, the narratives about medication were also to a great extent narratives about power and inequality of power. The patients' feeling that they had a say in the choice of medication and in the dosage was reported as having influenced the effectiveness of the medication. Participation also implied the possibility to try other drugs and to reduce the dosage. Encountering a psychiatrist who listened to how the patient experienced the effects of their medication and feeling that the search for the correct drug and dosage was a joint effort was regarded by the respondents as being of decisive importance.

Hospitalization

As in the case of other forms of treatment, such as medication and psychotherapy, the patient's relationship with hospital staff determined whether they regarded their stay in the institution as helpful or detrimental. The majority of the respondents reported that being under 24-hour care had helped them in the recovery process. Here, however, the experiences of the men and women in the study differed. Two thirds of the men regarded hospitalization as having been conducive to their recovery, compared with half of the women; nine of the men and two of the women reported only positive effects of hospitalization on their recovery. The remaining respondents regarded hospitalization as having had both positive and negative effects.

Two thirds of the respondents referred to therapy and therapeutic contacts as a positive factor in their recovery. The terms 'therapy' and 'therapeutic contacts' cover all forms of formal therapeutic contact, including conversations that occurred on a regular basis, for example in connection with being prescribed medication. No specific psychotherapeutic techniques or programmes were mentioned as having been helpful. As previously, it was the nature of the encounter and the relationship with the professional (i.e. therapist) that was reported as having been the helping factor.

Organized activities outside the home

The participants also mentioned occupational activities, organized by the social services or psychiatry, as having contributed to their recovery. Occupational activities had provided them with work at the same time as contributing to their recovery. The respondents referred to occupational activities as 'a kind of link' between psychiatry and a job on the open market. What the individual respondents regarded as having been helpful or detrimental to recovery depended to some extent on how they defined occupational activities – as a means of leaving psychiatry or as a makeshift solution because they had 'no real job to go to'.

According to the respondents who found occupational activities to facilitate recovery, these activities had offered the possibility to enter into relationships with other people and the relationships had helped them develop better self-esteem. The relationships comprised both other service users and staff, and the respondents described both types of relationships as helpful. When comparing their relationships with the staff at the activity centres with their relationships with personnel in psychiatry, the respondents said that there was a greater degree of equality between participants and staff at the activity centres. Relationships were not based on the therapist–patient dichotomy, but rather on a collegial relationship between participants and staff. There was a tendency to form collegial bonds of friendship at the centres; both parties had a common interest in the ‘goods’ produced at the centres, and in some cases shared the responsibility for their production and even for the financial status of the centre.

The majority of participants emphasized peer support and self-help groups as having been helpful to their recovery; more women than men mentioned such meeting places as an important factor in their recovery. The extent of these activities was in part due to the fact that the majority of the participants in Study 3 were recruited through the RSMH. Other user organizations mentioned in the narratives were Fountain House, the Hearing Voices Network and Alcoholics Anonymous. The respondents described how they had ‘learned more about the consequences of their condition’ by meeting others in the same situation as themselves and that this had given them ‘living proof’ that their condition could improve.

These arenas for activity were also described as important for rebuilding one’s shattered social network, offering contact with others in the same situation. The respondents described how they had made new friends and entered into relationships that were symmetrical in power. The people they had met through the user organization were referred to as ‘friends who had a broader perspective’ because of their experience of mental ill health.

User organizations were also described as contributing to the recovery process through their attempt to create a meaningful life and a new identity for members by advocating and lobbying for better life conditions for people with mental illness. Working against inequality and stigma was described as ‘having given their life a meaning’.

CONNECTION TO OTHERS

As with their more formal social contacts, the respondents described their informal social network of family and friends as having been of outmost importance for the recovery process.

Most of the respondents described the period immediately before, and during, their time in care as one of increased isolation and disrupted social relationships. Nevertheless, social contacts were central to the recovery process, according to the respondents. They were a key to a social life outside psychiatry.

Friends

Almost all of the respondents mentioned having a friend who had contributed to their recovery. Friends included both those with and those without their own experience of mental illness. The friends from before the time when the respondents had come into contact with psychiatry had played an important role because they constituted a connection between the individual’s present problematic life and the past, when the respondents did not have such problems. The fact that the friendship

had continued was also described by the participants as a sign that there was hope of recovery. The friends the respondent had made during the recovery process were described as company where 'one could be just oneself', showing both strengths and weaknesses.

Family

Close family members – in this sample, the partner, children, parents and siblings – were described as important for the recovery process. The majority of the respondents referred to one or more family members as having been beneficial to their recovery process. Family members were described as having been helpful by giving practical assistance. Taking over the responsibility for the household chores or offering temporary housing or a cooked meal and lending the respondents money were practical contributions that respondents mentioned in several narratives. These contributions were described as reducing stress and giving the individual a sense of basic security. Giving practical support also had an important emotional dimension. Both aspects contributed to the material base that the respondents described as having been essential to their recovery.

Partners, children and parents were described as important as well, because they were usually the first to notice signs of problems and the onset of a crisis. As well as the practical help they offered, they were often the ones who initiated the contact with psychiatry and the social services. Besides the role of intermediary, they had often also taken on the role of advocate and lobbyist for the individual and their rights. The contribution of family members to the recovery process was therefore based on their special relationship with the individual. They had known the individual before the problems started and therefore had a more complex picture of the individual's identity. In many cases the basis for their relationship was the everyday life they had shared, and much of their help had consequently been based on the things that form a part of everyday life.

Nevertheless, a few participants' narratives illustrated broken or destructive relationships with family members. Some of the participants described their parents as the cause of their problems, which were rooted in childhood. In many of the interviews where parents and partners were outlined as helpful they were also described as having been detrimental to the recovery process, in that they had fixated on the helper role and had been unable to keep pace with the individual's development toward autonomy and reciprocal relationships.

SUMMARY

In this study we explored which factors people recovering from severe mental illness regard as decisive to the recovery process. Due to the complexity and individuality characterizing recovery, we chose to perform qualitative analysis of interviews. Factors such as medication, professionals and family could not be taken as factors facilitating or hindering recovery, but were rather described as complex. The narratives also illustrated recovery as a process that changed over time, with changes in personal growth, revised strategies and changing needs for support. Using a modified grounded theory method enabled us to analyze the characteristics and core categories of this process. Nevertheless, adding interview transcripts from three previous studies together to form a new study may have implications. Creating a recovery narrative is a process between the interviewer and the interviewee and there is always the risk of covering certain interests and overlooking others, according to previous knowledge and personal interests. In the three samples with four

different interviewers, we saw a tendency of focus of interests but no overlooking of areas. The risk of overlooking areas may have been reduced by using a similar topic list in all three studies.

The results from the interviews show that the factors identified as having contributed to recovery were other people, the respondents themselves and medication. All of the respondents mentioned one or several people in their informal social network – family members and/or friends – in this connection. Fifty seven of the 58 participants also mentioned a professional caregiver and their own coping strategies as having contributed to the recovery. The remaining factors were medication, hospitalization, therapeutic interventions and activities arranged by social services and user organizations. But even in the analysis of these factors, a social relationship aspect emerged. We saw a relationship between beneficial factors reported in recovery narratives and beneficial life conditions in general. These beneficial life conditions encompassed having access to the basic conditions of life, material but also emotional, such as being treated without discrimination and in a respectful manner as a person of value, having the ability to form and maintain social relationships with others, having friends and family, and having access to a meaningful existence. These findings confirm the importance of several of the factors that have emerged in qualitative research by others (*cf.* Spaniol *et al.*, 2002, Borg *et al.*, 2006).

But within these factors, several experiences are condensed. The key experience in all of these factors promoting recovery is *social relationships*. Interventions, both by the public authorities designed to provide support and care, and by the individual's informal social network, have to be understood in terms of the quality of the social relationships involved.

Social relationships

An individual's recovery takes place within a social context and the respondents in this study attached central importance to the relationships in their lives. The interviews indicated that the respondents had been able to cope at the relational level; they had formed and maintained relationships with others, professionals and non-professionals alike. Relationships are developed in a range of contexts that can be either conducive or detrimental to recovery. It is through social relationships that the individual is able to redefine themselves as a person (as opposed to a patient) – a person with problems but also with abilities.

Recurrent factors in the respondents' descriptions of helpful relationships included having a sense of continuity in life and having concrete experiences of being able to exert influence over one's own life circumstances. In our study population, such experiences had occurred in connection with situations where the individual had been able to get help but also where their own resources and capacities had come into play. The salient factor in these experiences is that in a relationship with, for example, health professionals, the individual had not simply been one among many, but rather had been seen as a unique person.

When professionals were mentioned as having been helpful, this was not with respect to any specific professional group or method of treatment. Rather, it was other characteristics of the professionals and the individual relationships with the professionals that were described in the narratives as having contributed to the recovery process. These results are contradictory to other studies where no mention is made of the professional's role, while in still others (Sullivan, 1994; Tooth *et al.*, 2003) relationships with professionals are described mostly in negative terms. The emphasis on social relationships does, however, agree with research on the beneficial factors that are common to various forms of treatment. Previous research describes the therapeutic relationship as a reliable predictor of patient outcome in mainstream psychiatric care (McCabe & Priebe, 2004).

Also, when it comes to the role of family members, it is the nature of the relationship itself that is the contributing factor in the person's recovery process. Family members usually know the individual before problems arise and therefore have a more complex picture of the individual's identity than do others who meet the individual only after the onset of the 'illness'. In the present study the family was viewed as simultaneously supportive and detrimental to recovery, implying that parents and partners also need to recover from the experiences of the individual's illness to facilitate their development toward autonomy.

CONCLUSIONS

In the recovery process the individual forms social relationships and seeks out socially rewarding environments as a way of managing, and reducing, symptoms. These results are contrary to the tendency in psychiatry to describe patients as unable to contribute to their treatment because of the severity of their condition. From Kraepelin, through Freud, to our own time, the long-standing tradition has been to regard mentally ill patients as incapable of forming and maintaining normal social relationships. Recovery research poses a challenge to clinical staff to take into account, and make use of, the patient's own efforts to manage symptoms and the accompanying stigma. Recovery from mental illness is a social process in which the helping factors have to do with the quality of social relationships, irrespective of whether these are formed in inpatient care, in medicinal circumstances, in psychotherapy, with family or friends, or in the company of other persons in the same situation.

In the present interviews the strong emphasis on social relationships as being conducive to recovery constitutes an important contribution to psychiatry research and the current demand for evidence-based practice. In evidence-based practice the results of scientific studies are weighed together with the experiences of clinical staff and the service users themselves (Sacket *et al.*, 2000). It is our view that the findings of our study concern the latter – i.e. the experiences of the service users themselves. The narratives provide important clues for the professionals with regard to their method and approach.

Another aspect that emerged from the present study concerns gender differences. This aspect has been little investigated in recovery research. The men in our study tended to put greater value on such factors as medication, hospitalization and their own strategies for coping. The women, on the other hand, talked more about therapeutic relationships, family support and organized activities outside the home as having been conducive to their recovery. Consequently, there is an apparent need for more research on possible gender differences in the recovery process.

REFERENCES

- Anthony, W.A. (1993) Recovery from mental illness: the guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal*, 16, 11–21.
- Borg, M. & Kristiansen, M. (2004) Recovery-oriented professionals: helping relationships in mental health services. *Journal of Mental Health*, 13, 493–505.
- Borg, M., Mezzina, R., Sells, D., Marin, I., Topor, A. & Davidson, L. (2006) What makes a house a home: the role of material resources in recovery from severe mental illness. *American Journal of Psychiatric Rehabilitation*, 3, 243–256.

- Davidson, L. (2003) *Living Outside Mental Illness: Qualitative Studies of Recovery in Schizophrenia*. New York: New York University Press.
- Davidson, L. & Stayner, D. (1997) Loss, loneliness and the desire for love: perspectives on the social lives with schizophrenia. *Psychiatric Rehabilitation Journal*, 3, 3–12.
- Davidson, L. & Strauss, J.S. (1992) Sense of self in recovery from psychotic disorders. *American Journal of Medical Psychology*, 65, 131–145.
- Deegan, P. (1996) Recovery as a journey of the heart. In *Psychological and Social Aspects of Psychiatric Disability* (eds L. Spaniol, C. Gagne & M. Koehler). Boston: Center for Psychiatric Rehabilitation, Boston University.
- Denhov, A. (2000) *Professionals' Contribution to Recovery: a User Perspective. Report 11*. Stockholm: VSSO, FoU-enheten/psykiatri.
- Glaser, B. (2001) Conceptualization: On theory and theorizing using grounded theory. *International Journal of Qualitative Methods*, 1(2), Article 3.
- Harding, C. & Keller, A. (1998) Long-term outcome of social functioning. In *Handbook of Social Functioning in Schizophrenia* (eds K. Mueser & A. Keller). Boston: Alyn and Bacon.
- Harrison, G., Hopper, K., Craig, T., Laska, E., Siegel, C. et al. (2001) Recovery from psychotic illness: a 15- and 25-year international follow-up study. *British Journal of Psychiatry*, 178, 506–517.
- Hartman, J. (2001) *Grounded Theory. Generating Theory on Empirical Ground*. Lund: Studentlitteratur.
- Jensen, P. (2006) *A Different Kind of Help – Recovery from Users' and Relatives' Perspectives*. Copenhagen: Akademisk Forlag.
- Mead, S. & Copeland, M. (2000) What recovery means to us: consumers' perspectives. *Community Mental Health Journal*, 36, 315–328.
- McCabe, R. & Priebe, S. (2004) The therapeutic relationship in treatment of severe mental illness: a review of methods and findings. *International Journal of Social Psychiatry*, 2, 115–128.
- Ralph, R. & Corrigan, P. (2005) *Recovery in Mental Illness. Broadening our Understanding of Wellness*. Washington, DC: American Psychological Association.
- Russinova, J. (2002) Use of alternative health care practice by persons with serious mental illness. Perceived benefits. *American Journal of Public Health*, 10, 1600–1603.
- Sacket, D.I., Strauss, S.E., Richardson, W.S., Rosenberg, W. & Haynes, R.B. (2000) *Evidence-Based Medicine. How to Practice and Teach EBM* (2nd edition) London: Churchill Livingstone.
- Schon, U.-K. (2008) *Are there gender differences in recovery from mental illness?* Submitted.
- Sells, D., Borg, M., Davidson, L., Marin, I., Mezzina, R. & Topor, A. (2006) Arenas of recovery for persons with severe mental illness. *American Journal of Psychiatric Rehabilitation*, 1, 3–16.
- Spaniol, L., Wewiorski, N.J., Gagne, C. & Anthony, W.A. (2002) The process of recovery from schizophrenia. *International Review of Psychiatry*, 14, 327–336.
- Sullivan, W.P. (1994) A long and winding road: the process of recovery from mental illness. *Innovations and Research*, 3, 14–24.
- Tew, J. (2005) *Social Perspectives in Mental Health. Developing Social Models to Understand and Work with Mental Distress*. London: Jessica Kingsley Publishers.
- Tooth, B., Kalyanasundaram, V., Glover, H. & Momenzadah, S. (2003) Factors consumers identify as important to recovery from schizophrenia. *Australasian Psychiatry*, 11(Supplement), 70–77.
- Topor, A. (2002) *Managing the Contradictions. Recovery from Severe Mental Disorders*. Stockholm: Stockholm Studies of Social Work 18.
- Topor, A. (2004) *What Contributes? Roads to Recovery from Mental Illness*. Stockholm: Natur och Kultur.
- Topor, A., Borg, M., Mezzina, R., Sells, D., Marin, I. & Davidson, L. (2006) Others: the role of family, friends, and professionals in the recovery process. *American Journal of Psychiatric Rehabilitation*, 1, 17–37.
- Young, S.L. & Ensing, D.S. (1999) Exploring recovery from the perspective of people with psychiatric disabilities. *Psychiatric Rehabilitation Journal*, 3, 219–231.

Ulla-Karin Schön, BSW, Doctoral Student, Department of Social Work, Stockholm University, Sweden.

Anne Denhov, MSW, Research and Development Unit, Psychiatry, SLSO, Stockholm South, Sweden.

Alain Topor, Assistant Professor, Department of Social Work, Stockholm University, Sweden; Research and Development Unit, Psychiatry, SLSO, Stockholm South, Sweden.

Correspondence to: ulla-karin.schon@socarb.su.se