

## Social relations in everyday activities among patients with persistent mental illness at a psychiatric centre

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Social relations benefit health but are challenging for people with persistent mental illness. Carrying out activities with other people facilitates social relations. What is less clear, however, is how social relations are established in everyday activities. The aim of this exploratory study is to gain an understanding of how social relations emerge in everyday activities among people with persistent mental illness. The study was inspired by ethnography and used participant observation to gather data in the context of a psychiatric centre. The participants were inpatients with persistent mental illness. By using interpretative analysis with a focus on narratives we identified one core finding as ‘daily routines as a facilitator for social relations’, along with narratives that illustrate dimensions of the core finding. These were ‘caring’, ‘belonging’ and ‘memory-sharing’. The study highlights how the context with its focus on everyday routines creates social opportunities that facilitate the emergence of social relations.

**Keywords:** social relations; everyday activities; persistent mental illness; ethnography

### Introduction

Social relations are crucial as well as challenging for persons with persistent mental illness (Nyström, Dahlberg, and Segesten 2002; Onken et al. 2007; Perlman 2007; Topor et al. 2006; Yilmaz et al. 2008). And unfortunately, mental illness often involves significant disruption to everyday social life (Bowie et al. 2010). Research shows that people with mental illness tend to avoid social relations and spend most of their time alone, thus living a sedentary lifestyle (Bejerholm and Eklund 2004; Leufstadius et al. 2008; Yilmaz et al. 2008). Nearly half of people with mental illness did not participate in any social activities during the day. General psychiatric symptoms, such as anxiety, feeling insecure and frightened and difficulties in co-operating with others may be the reasons for avoiding social activities (Jansson, Sonnander, and Wiesel 2003; Leufstadius et al. 2008). However, research on experiences from persons with mental illness has stated that a key factor facilitating a good life for these people was having opportunities to grow and develop through meaningful activities (Mancini, Hardiman, and Lawson 2005). Additionally, Jansson, Sonnander, and Wiesel (2003)

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have argued that if people with mental illness do not participate in any social or planned activities, they miss the opportunity to establish relations with others. Accordingly, participating in everyday activities with other people is important for both well-being and establishing social relations (Davidson and Strauss 1992; Gould, DeSouza, and Rebeiro-Gruhl 2005; Honneth 1995, 2003; Yilmaz et al. 2008). The social relations and activities are intrinsically inter-related, and sociality is created through participating in events (Lawlor 2003). Moreover, events and ‘little things’ in everyday life that most people take for granted, may be very important for individuals with mental illness (Borg 2007). According to Mattingly (2010) the ability to grasp the intrinsic value of the ‘little things’ can be extremely powerful in forging bonds. Everyday life is considered mundane, with rules and routines that make life predictable and familiar (Scott 2009). Several studies found that to have and to maintain certain routines, including certain activities, during the day is perceived to be difficult, but meaningful among persons with mental illness (Eklund, Hermansson, and Håkansson 2012; Hasselkus 2002; Leufstadius et al. 2008).

The literature reviewed above demonstrates that social relations are central, but challenging, in order to live a good life for those experiencing mental illness, and that carrying out activities with other people in everyday life is crucial for the emergence of social relations. However, despite the existence of research in social relations and mental illness that consider the importance of activities and everyday life, there is a lack of knowledge about how social relations emerge through the participation in, seemingly mundane, everyday activities. There is a need to carry out empirical research into how social relations come into being.

Continuing the above line of reasoning, the aim of this study is to explore how social relations emerge and how they are facilitated among people with mental illness in the context of everyday life at a psychiatric centre during a treatment stay.

## **Method**

### ***Research context***

The study was carried out at a psychiatric centre in a town in Norway. This study deals with the inpatients on the general psychiatry ward and their everyday activities, both inside and outside the centre, during a treatment stay. The centre is a local hospital that provides general inpatient and outpatient psychiatric care to patients aged 18 and over. The centre has 30 beds in open units for inpatients. These are distributed over several wards, covering acute admissions, psychosis and general psychiatry. Patients are admitted from both the specialist health services and from the community health services if there is a need for special support and treatment.

### ***Physical context***

The psychiatric centre is located in an established residential area with shops, schools, kindergartens and other service facilities nearby. The area has a rural feel with lots of trees and a nearby forest and plenty of footpaths. The centre consists of several wooden houses that blend naturally into the surroundings. In between the centre buildings, there is a garden with grass, trees and flowers, shielded from the walking paths and neighbours. This is a nice place to sit outside, and in the summer, it is used for various outdoor games.

The central place in the centre is the living room. This is where the morning meetings for the patients from the general psychiatry ward take place, and where the patients at the centre have many of their everyday social activities in their leisure time. The living room is shared by everyone at the centre and is accessibly located on the main floor near the entrance hall. The living room also has a door out to the terrace, where the smokers can go and have a cigarette, and to the garden, which is frequently used in the summer. The living room is also close to the staff section of the centre. This makes it easy not only to see the staff passing by but also for the staff to say hello to those who are in the living room and to pop in. The living room also has a kitchenette and a refrigerator that can be used by patients. The furnishing is similar to a real home, with comfortable sofas and armchairs, a bookcase, dining table, piano, potted plants, cushions, curtains and tablecloths. At Christmas and Easter, the room is given additional festive decoration.

### *Therapeutic context*

The above-described physical context is also part of the treatment programme. The treatment is individualized and includes milieu therapy, one-to-one sessions and therapy, drug therapy and electro-convulsive therapy. Although the treatment is individual, part of the milieu therapy treatment was group-based. At the centre, patients in different contexts meet social and emotional challenges that were designed to be tailored to individual needs and function. Treatment stays ranged anywhere from a few days to several months, depending on the person's needs and benefit. Inspired by the treatment of milieu therapeutic practice, the centre has an everyday structure as an integral part of the treatment they offer. All patients have to take an active part in this everyday structure, around which the days and weeks are organized for the patients. Literature (Gunderson 1978, 1983; Mahoney et al. 2009; Skorpén and Øien 2008) often refers to milieu therapy as a planned organization of daily life in a psychiatric institution. This includes the centre's overall physical, social and cultural context where the milieu itself is recognized as an active therapeutic agent for promoting and facilitating 'positive' changes. Furthermore, milieu therapy emphasizes relationship work.

The patients engage in different everyday chores and other activities such as a morning meeting, a morning walk or other exercise, fitness training, different group and individual treatments and sessions. Reading the newspaper, playing music, drinking coffee, going to the shops, playing games, having breaks or just sitting together in the living room, etc., are part of the leisure activities. The days are mainly divided into work duties and responsibilities and leisure time. The centre has a timetable, and every patient has his own schedule with meetings, appointments, treatments, etc., which is fitted into the ward timetable. All patients take part in the general daily structure that starts with breakfast from 8 am, followed by different activities until 3 pm, when it is time for the main meal of the day. In the evening, the only organized activity is a walk. The scheduled activities end with supper from 7.30 pm. Sometimes, there is evening entertainment on the ward. The primary goal of the centre is to create an almost normal everyday life, with varied work commitments, appointments and leisure. The milieu-staff works shifts and always participates in the patients' various everyday activities.

The context provided opportunities for relational experiences in an everyday setting. Parts of the group-based treatment in the centre include physical and creative

activities and cognitive group therapy. The patients are grouped according to their needs and goals, which allows for an easier evaluation of functioning. Outside of the centre, scheduled group activities include ball games, walking and hiking and other outdoor pursuits. In between all the activities scheduled during 'work' time, there is also time for leisure or breaks with relative freedom, where patients can meet and do something together, such as smoke, eat, drink coffee, read, play different games or listen to music (Table 1).

### ***Participants***

The inclusion criterion for this study was inpatient status at the psychiatric centre on the ward of general psychiatry, and the participants were people with persistent mental illness. Most of the patients on this ward had been admitted because of incidents of deep depression or severe anxiety symptoms and needed a period of treatment in a psychiatric centre in order to be able to cope with their everyday life at home. There was a generally rapid patient turnover, and the patients, therefore, changed while the fieldwork was carried out. However, the everyday structure was maintained. Some people were also readmitted to the centre some weeks after being discharged. The number of patients who joined different activities fluctuated, with 4–9 people attending at any time. The demographic data collected were gender and approximate age. Ten patients participated and were given pseudonyms. The milieu-staff were nurses, social workers, occupational therapists and physiotherapists with post-graduate training in mental health (Table 2).

### ***Data collection***

Inspired by ethnography, data were collected through participant observations and followed recommended guidelines (Fangen 2010; Hammersley and Atkinson 2007). The data collection period lasted approximately one year. The first author participated in the different everyday activities and general conversation among patients in their everyday life. This provided direct access to the narratives that emerged in this everyday context. When collecting the data, the first author balanced the interaction by keeping up the ability to relate and reflect about the interaction simultaneously in order to avoid 'going native' (Geertz 1973). The focus was on the ongoing stream of communication between the patients during their social activities. The first author, therefore, positioned herself as actively passive (Alsaker, Bongaardt, and Joshepsson 2009) and carefully thought through the responses she brought into the field situation in order to support the ongoing conversation and to allow the situation to develop naturally. In the beginning of the data collection period, the encounters were frequent. The focus was on gaining access to the centre, establishing the researcher's role and developing relationships with patients and milieu-staff. This meant becoming familiar with the general routines and rhythms of practice, as well as beginning to map out the social context of the centre. After the first two months, the encounters became weekly for a period of six months and then every other week for another six-month period. Each encounter lasted from two to six hours. By collecting data over a whole year, we had the opportunity to capture the seasonal differences in the context: summer activities, winter activities, activities at Easter and Christmas and activities both inside and outside the centre. Detailed field notes from the observation and the narratives were written down soon after the observation. The



Table 2. Patients.

Pseudonymes	Age	Status
Helena	Thirties	Single
Anne	Forties	Single
Brit	Sixties	Married
Fritz	Twenties	Single
Siri	Thirties	Married
Inger	Fifties	Divorced
Anita	Thirties	Single
Kari	Forties	Divorced
Astrid	Sixties	Married
Hans	Twenties	Single

field notes were structured by facts, descriptions and reflections. The research material had a narrative form and consisted of approximately 100 pages of written text.

### ***Data analyses***

An interpretative analytic method was used, and in accordance with the ethnographic method (Denzin and Lincoln 1994; Fangen 2010; Hammersley and Atkinson 2007), the preliminary analysis started after the first encounters and continued throughout the whole data-gathering period and afterwards. Data consisted of field notes and reflective notes, and when the data-gathering period was over, they were read and reflected on several times to obtain an overall understanding. The analysis followed three analytic phases of interpretation and resulted in one core finding and three subdimensions. The focus of the analysis was on how social relations emerged in the context in which the data were collected.

The first phase was a naive reading of the field notes. The authors went back and forth in between data and the interpretation in order to gain an understanding of how social relations emerged in the data. Each time we met, we discussed emerging interpretations of the material in order to delve more deeply into it. We identified different narratives that illustrated relational dimensions, which became more and more clear after repeated discussions as the analyses proceeded. Then we went back to the aim and the field notes several times to search for the most pertinent content for those different, identified, relational dimensions. In the second phase, the contents in these dimensions were further discussed and reflected upon by reading literature related to the aim. This phase contributed to a further understanding of the dimensions, the relationship between them and differences and similarities within and among them. In the third phase in our analysis, a core finding emerged. This finding shows how the structure of the ward facilitated social relations through everyday activities. Further in our analysis, three subdimensions of the core findings were identified as relational dimensions of caring, belonging and memory sharing.

### **Ethical considerations**

The study was a part of a larger study about relations in the context described above. It was approved by Regional Ethical Committee (REK) and the administration at

the psychiatric centre. During the research period, we had monthly research meetings with the centre management. Both patients and staff were informed verbally and in writing about the study, and they knew why the researcher was there and when she was coming. Written information was accessible in the living room and in the staff section of the centre. Critical appraisal was applied, as the researcher was aware that she could seem intrusive. The researcher followed patients who wanted to participate and did not confront patients who clearly did not wish to take part.

## **Findings**

The findings included one core finding: daily routines as a facilitator for social relations and three relational subdimensions showing narratives of caring, belonging and memory sharing. The findings are presented below.

### ***How daily routines facilitate social relations***

The analysis showed that routines served a taken-for-granted structure, which gave the patients the opportunity to do everyday activities together with others and to develop social relations. The patients knew when they were expected to be with somebody and with whom and for what reason. In some group-based activities, patients had to join in and talk with others. As Helena said:

I knew that I had to say something, everybody in the group had to. It became better each time. After some time I was the one who started to talk, just to get it over with. But it was not so bad, so I continued to talk during my stay at the centre, even when I did not have to.

Helena's story was not unique. The findings uncovered several stories about patients becoming talkative after spending some time at the centre. Moreover, everyday life at the centre was characterized by routines, and from the analyses, it became very clear that routines played a special role in this context for emerging social relations. The daily routines were present and influenced all activities at the centre. Patients often looked at the timetable to get an overview of the day and the week. The daily routines were already scheduled for the patients staying at the psychiatric centre, so they did not have to make them all by themselves.

The routines brought predictability and helped to maintain a normal circadian rhythm for the patients at the centre. Patients in this study often emphasized the importance of having scheduled daily routines. As Anita said: 'Here I always know what to do'. The analysis further identified that it was not only the physical context that upheld the routines. The actions of the milieu-staff were tailored to help the patients follow the routines and their planned schedules. Some patients identified the milieu-staff's support in making patients follow the routines and their individual planned schedule as 'positive pressure'. As Helena said:

Sometimes I got very angry with my contact person at the centre because I had to do all the things in my schedule, although I knew it was for my own good. I, after all, put the schedule together along with the staff.

Several of the patients stressed that it was difficult having routines at home, because it was too easy 'to stop doing things, even if you know it is good for you'. As one patient said: 'It is like a vicious circle, and you end up just lying in bed all day long'. Further on, comments like: 'I wish I could manage to do this at home' or 'Somebody should come home and push me off the sofa' were commonly heard among patients, for example, when they were going for a walk or doing some exercise. As one patient said:

Here at the centre I can't just sleep until the afternoon because I have so much to do. In the beginning I thought it was impossible to get out of the bed so early in the morning, but it is not impossible.

The patients got used to carrying out activities together and experienced that this was in fact not a problem. After a while, this 'enforced' activity with others became tacit activities driven by the patients themselves, including during their free time between all the scheduled activities at the centre. As Helena further explained: 'At the centre I know what to do and what to say, and the others know who I am and understand me'. This is worth attention, and we will get back to it, but first, we want to present the three subdimensions of relational experiences facilitated through the daily routines.

### *Caring*

The first relational dimension from our findings was 'caring'. Findings show several examples of how people with mental illness take care of each other. The milieu-staff were also caring, which is expected, given that is part of their role in such an environment. What was interesting, however, was all the care that emerged among the patients. Despite the patients being ill and needing a lot of care themselves, they constantly offered care to one another during the day. The patients were taking care of each other, using both gestures and words. They were observed nodding, smiling, patting each other on the shoulder and stroking cheeks. As Helena stated: 'I like the way we take care of each other in this place'. This caring quality was also prominent in the following examples.

One patient encouraged a fellow patient who resisted joining the fitness group at the centre by affirming and praise giving:

I am sure you will make it; you have such a strong body. I was also doubtful the first time, and look at me now. I do not have a strong body, but I am doing well.

Further on, Anne told Brit, who was always knitting and had knitted different decorations placed around the living room: 'You are making the living room so nice with your knitting Brit, I wish I could knit like you'. Brit answered: 'Knitting is the only thing I can do'. Anne then went to Brit and gave her a pat on the shoulder, smiled and told her that her knitting was highly valued by the people using the living room. Or when Fritz, a young man who was new to the centre, was standing alone in the lobby, looking at the information board on the wall while some of the patients and milieu-staff were preparing a game of Trivial Pursuit in the living room nearby. One patient looked at Fritz and shouted: 'Hello Fritz, come and join us in Trivial Pursuit!' Fritz looked at them, smiled and went into the lounge where the game was



starting. 'He is a living encyclopaedia, I know because I played with him yesterday,' Siri told the others, and smiled at Fritz when he entered the room. With a happy smile, Fritz nodded politely to the others and joined the game.

Another example of care between the patients was an event when Inger was very upset prior to discharge. She did not understand how she would be able to manage life on her own when she got home. Looking very sad, she said: 'I really don't know how I will get started when I get home, I do not know what to do'. Helena understood Inger's anxiety and with a keen look on her face, she leant forward, took a piece of paper, asked if somebody had a pencil and said while looking at Inger:

Let me help you. I suppose you have an empty refrigerator at home. We'll make a shopping list for you. That will make it easier when you get home, because you have to eat, and you have to do your own shopping. Besides, you need to get out of your flat and not isolate yourself. I know all about loneliness, and I am sure that you do, too.

Then Helena and some of the other patients who were sitting in the lounge started asking Inger what she liked to eat and what she needed to buy. With great enthusiasm the fellow patients made a shopping list with Inger, trying to make it easier for her when she got home. With a satisfied look, Inger said out loud: 'Thanks, I wish I could be with you at home too'.

Finally, an example, where one patient came into the living room and went directly to the computer without saying hello. She looked upset, cursed loudly and looked around the room while stamping her foot on the floor. Suddenly, she ran off, then two fellow patients looked at each other, and without saying a word, they went after her. After a while, they came back with the upset patient and went to the computer with her. It did not take long before they concluded by telling her: 'You have to take bus number 9 to get to the place, and the bus is coming in ten minutes'. The upset patient smiled at the helpful fellow patients and said: 'Thanks, I am not used to taking the bus in this area'. The fellow patients helped her to find which bus she had to take and what time the bus came to take her to the place she wanted. The upset patient got help from her fellow patients without asking. The fellow patients took charge of the situation and helped her.

Events like the ones described above show how care among the patients was expressed and performed in different situations.

### ***Belonging***

From our analyses, it was clear that 'to belong' was an important relational dimension for the patients. As Anne told after having spent a long time at the centre:

In the beginning I thought that they were totally different from me, I was afraid of them and I did not want to go into the living room when they were sitting there. But after a while, I began to go into the living room more and more because some of the patients were really nice to me and I felt included. In the end I also made a close friend on the ward.

And further on, as Anita said:

It was a shock for me, I was afraid, everybody but me seemed to be mates. I felt that I was alone and different from the others. But now I am not afraid anymore, I like being with the other patients at the centre.

Stories like this were often told. Patients spent more and more time together with others after they had been at the centre for some time. Patients asked each other to join different activities that they were going to do or were supposed to do, like: 'Are you coming with us in our group today?' and 'we are going on a trip tomorrow, do you want to join us?' 'We' was often a theme among the patients. Patients often said: 'We understand each other', 'we take care of each other' or 'we have something in common'. As Helena described it:

Here you can tell a fellow person the same thing over and over again, and still get sympathy, whereas others usually get tired and do not listen to you anymore.

Moreover, as Anne said: 'We know what it's like to have a hard day'. Being part of the 'we' made you part of a fellowship. The patients also came up with comments like: 'We from the general psychiatric ward' to specify who 'we' were. As Brit once said: 'That lot from the other ward always came and helped themselves to coffee', or 'there is more trouble from those on the other ward'. The feeling of 'we' also showed in different group-based activities, and there were comments such as: 'I am part of the fitness group', 'join us who like the morning walk' and 'we in the brown group'. Kari, who seemed to talk to everybody at the centre, told that she belonged to the brown group, and in the beginning, she only talked to the people in this particular group. She also said that it was good to be a part of this little group in the beginning of her stay at the centre.

This dimension shows the various ways the patients managed to develop a sense of belonging.

### ***Memory sharing***

The third dimension, sharing of memories from past experiences, was strong among the patients. The tendency to talk about the past, 'the life before' as one patient called the past, was pervasive when patients were together doing something like, for example, exercising in a group, going for a walk or just relaxing together without doing anything 'special'; such as having a cup of coffee, smoking or just sitting on the sofa. There was an informal mood with lots of small talk. There would nearly always be someone commenting aloud on, for example, the song playing over the loudspeaker, an advertisement in the newspaper or just on what they were doing at the moment. Comments such as 'Oh, that reminds me of the time when I was young', or 'this song makes me happy' or 'we used to have chairs like that in our holiday cottage, they are comfortable' often facilitated response from several other patients, who then further participated with their comments or longer narratives from earlier memories related to the first comment. Several examples from the field showed that talk about memories of experiences were important at the centre. Everybody has past experiences and that gave them something to talk about when they were together.

One example is from the exercise group when patients were doing some movement with their hands, one patient loudly commenting that this special movement was like rowing and telling the others that she used to row with her uncle when she was a little girl, and she liked it a lot. She then got responses from some of her fellow patients in this exercise group. Somebody just smiled at her, one

asked where her uncle lived and another said that she also used to row when she had a holiday cottage near a lake.

The others also often commented on music coming from the loudspeaker in the living room, and findings show that the music often created opportunities for memory sharing among the patients. For example, when Astrid, a shy and quiet middle-aged woman suddenly shared with the others that when she and her husband were young with small children they often played Gluntan (a dance band from Norway) when they were on camping trips during holidays. She shared this memory with a dreamy look in her eyes when a song from this particular band came on the loudspeaker in the living room at coffee time. Anita commented: 'Ah yes, I remember that my mum and dad used to play Gluntan too'. Astrid smiled at Anita and continued by sharing a story from a camping trip. She finished by saying quietly: 'Those were the good old days'. This story then made several of the patients present talk about their experiences from camping trips. These conversations often became very lively and created an inclusive mood in the living room. Likewise, when Helena asked if somebody could put on something by Elvis and said: 'I like Elvis, he reminds me of my mother, she used to listen to him'. Hans, a young man, commented loudly:

When I was a little boy I also used to play Elvis, he died in 1977. I like the seventies, there is a lot of cool music from that time. It was the time when hard rock really started.

Then a quiet person who always looked down suddenly said with a straight neck and a shy smile: 'I love hard rock'. This prompted smiles from his fellow patients on the sofa.

Another example clarifies this dimension. One morning in the living room, Kari, one of the patients, downloaded from YouTube the song 'Everybody Hurts' from the group REM while waiting for the morning meeting. Everybody looked sad while the song was playing loudly to all who were present. When the lyrics of the chorus appeared, the patients looked at each other, nodded appreciatively or sang along with the lyrics '...everybody hurts sometimes...'. After the song, one patient looked up and shared with the others that she had cried a lot to that song. One of the fellow patients smiled gently at her and said: 'We know'. Everybody then nodded affirmatively at each other and that was the start of a lot of chat about their favourite bands and the songs they used to play.

## **Discussion**

The aim of this study was to gain an understanding of how social relations emerge in everyday activities among people with persistent mental illness during a treatment stay at a psychiatric centre. Our results show that patients both had opportunities to develop relational experience and demonstrated the typical features of social competence at the centre. Further results showed how emerging social relations can work for persons with persistent mental illness in this kind of setting, and our findings indicate that daily routines facilitate relational dimensions that support emergent social relations. In the following, we will discuss these findings in relation to (1) social relations as a challenge in general for persons with persistent mental illness and (2) the role of the context regarding structure, opportunities and activities for these persons.

Current research shows that social relations are challenging for persons with persistent mental illness, and they are missing opportunities for relational experiences (Bejerholm and Eklund 2004; Jansson, Sonnander, and Wiesel 2003; Leufstadius et al. 2008), but our findings show how patients use their social ability in different ways and make use of social opportunities in the context of the psychiatric centre. This finding is noteworthy, as current literature states that social relations are what persons with persistent mental illness find challenging. Although the literature stresses that social relations are important for the well-being of this group, there is only very limited research showing how people with mental illness actually do get relational experiences and how they establish social relations. Our findings, however, show how patients take care of each other, share memories and experiences and create a sense of belonging by using both narratives and gestures. In line with the attachment theory (Bowlby 1969), it can be argued that the patients in these situations actually show attachment in their social relation to others. Thus, our findings make it visible how social relations can work in the everyday life of persons with persistent mental illness at the psychiatric centre. Further, the findings show that there were a lot of minor social events among the patients during the day, patients were usually doing something together, and there was a social atmosphere in the living room. This is almost the opposite of the findings from a comparable study carried out on a psychiatric acute ward (Hem 2008), which stressed that not much was happening, the patients were usually in their room, and only occasionally another patient passed by (48–49). A plausible explanation for the different finding of that study might be that the context was different, as it was a locked ward, and the study focus was interaction between patients and nurses, not everyday activities among patients as ours.

The identified relational dimensions illustrated in the patients' narratives describe how connections and social relations unfold as a product of the patients' interactions in everyday settings and situations. Findings show how the context provides social opportunities and, thereby, creates social situations, or what Lawlor (2003) calls a sociality, a sociality based on basic human needs and social roles. How this sociality works is shown by the way the patients at the centre used the relational opportunities that emerged all through the day. In these social situations, the patients were able to use their social competencies. This means, in our interpretation, that when patients with mental illness are being offered a context involving social situations, they have and are able to use their social skills.

Another way to understand our findings is that the daily routines provided the participants with a variety of relational opportunities in which they managed to find use of their social abilities. To be confronted with social situations and be given the opportunity to make use of these situations was part of the treatment setting at the centre. Being under such a 'positive pressure' to take part in social situations, as some patients said, may be seen as a good thing for the patients. Hence, they were given opportunities to actually try out and get relational experiences. The findings show how small glimpses of social connections to another patient or group work as an opening for emerging social relations as shown in the examples in the findings. This may indicate that being at the psychiatric centre puts patients in a setting where relational opportunities are created by tailored participation in everyday routines. Accordingly, when the environment is adapted, people with mental illness may have relational experiences and manage to deal with certain social aspects such as to take care, to belong and to share memories. We, therefore, argue that in the context of

everyday life at the psychiatric centre, patients had access to powerful relational experiences by responding to relations' options in the everyday setting at the ward. As Kielhofner (2008) argues, when one looks at the context, it provides some opportunities and constraints. We, therefore, assume that it is this special context that contributes to the emergence of social relations, due to the strong impact of daily routines. In our interpretation, it is these routines or structures that enable the patients to be together in a special way that makes connections as shown in the findings. Statements from the literature such as: in the daily routines, there are social opportunities (Jansson, Sonnander, and Wiesel 2003), and everyday activities are intimately tied to social relations (Mattingly 1998) and are supported from the findings in this study in that the context ensured that these relational dimensions appeared. As shown in the findings, the daily routines at the ward seem to link the everyday life together and provide social experiences, feedback and exploration in a safe environment. The ongoing quality of everyday activities in this special context are already linked together and, thereby, provided predictability so that the patient knew what to do, with whom, when and where.

One way to interpret the findings of this study is to portray the patients as competent in handling social relations, but it is important to take into consideration that our findings are limited to this specific context. Also, all the patients that participated in this study struggle immensely to manage being with someone in social settings and keep up such relations over time. Additionally, the relational qualities of the everyday activities among patients also show what are called the crucial aspects of therapeutic factors (Yalom 2005), which are also of significance and should be taken into consideration. However, the positive social involvements that they experienced during their stay at the ward can hopefully be taken back with them into their home context.

### **Methodological considerations**

The purpose of this study has not been to generalize or evaluate, but to gain an understanding of how social relations emerge among persons with persistent mental illness in everyday life situations at a psychiatric centre. We realize that our previous experiences and understanding of the subject led us to emphasize some themes and discount others. Thus, we admit that the findings of the study offer an interpretative portrayal of emerging social relations among patients in this context, not an exact picture of it (Chamaz 2006). The first author (the researcher) was close to the social relations among the patients and was conscious about the process of creating and maintaining a relationship between the researcher and the patients (Lawlor and Mattingly 2001). It is important to consider that with participant observation as method, the researcher becomes a part of the field and is thereby not only a part of what happens and is created but also what is being studied (Holloway and Biley 2011). The first author, therefore, carefully considered each response and used her reasoning skills to the fullest extent. To enhance the trustworthiness, the first author also took the opportunity to have impromptu, informal discussions about the emerging analysis among patients and milieu-staff during the data-collecting period. The trustworthiness was further ensured through rigour in the process of analysis. Both the first author and the third author have actively participated in the process. We have also outlined our analytical procedure in detail in the hope of making it as transparent as possible. It is important to consider that the participant observations

took place among several different patients over time and that the group of patients changed. The observation is, therefore, based on those patients who were accessible when the observation took place. On the other hand, some of the participating patients were present over time and became key informants in the study. The purpose was not to study individual persons but rather to study what happens between the persons in this context. There was no active recruiting of informants; they were recruited because they needed a treatment stay at the psychiatric centre.

## Conclusion

A central conclusion is our actual finding that people with persistent mental illness can handle social relations, in this special context. This study highlights how social opportunities emerge in this mundane, everyday context. Hence, the findings from this study may express a need for support regarding structure and routines in everyday life, as the context of the psychiatric centre stands as a safe place tailored to help those with mental illness break the vicious circle of loneliness and a sedentary lifestyle. Our findings, therefore, have significance for both research and practice in this area, especially with regard to transferability to society and social inclusion, by focusing more on supporting participation in activities at home and in neighbourhoods. Our findings also support that there are too many barriers for the emergence of social relations in the ‘outside’ world.

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