
Social Support and Relational Recovery in the Age of Individualism: A Qualitative Study Exploring Barriers and Possibilities for Social Support in Mental Health Work

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Abstract

Objective: Several studies point out social support and social work as crucial for mental health recovery. There is a need for extended knowledge in the discussion of what actually hinders and facilitates social support. This study aims to explore the experiences with social support of professionals, service users, and volunteers in three districts in Oslo. Through these conversations, we want to target and explore potential facilitators and barriers for social support and mental health recovery in the context of community mental health.

Research Design and Methods: Author 1 and co-researcher 2 conducted seven focus group interviews (N=32) with semi-structured guiding. Using collaborative thematic content analyses, we organized the findings in three themes, with an additional six subthemes.

Result and Contribution: This study aims to explore the experiences with social support of professionals, service users, and volunteers in three districts in Oslo, and findings are generated through the following themes: 1) the quality and vulnerability of social support: a) lived experience, mutual support, and understanding, b) “ghosting” and shame; 2) conditions that facilitate social support: a) stable

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environments and room for diversity, b) social rhythm and healing rituals; and 3) conditions that hinder social support: a) economic barriers, and b) social challenges in contemporary society.

Conclusion: We found that stable environments, social rhythm, and healing rituals were important facilitators for boosting different layers of social support and mental health recovery. Crucial barriers for social support were connected to poor economy, the socio-economic challenges the services face, and feelings of shame related to struggle with mental health. In our discussion, we invite our readers to relate to and reflect on the findings in view of emerging socio-cultural trends and the ongoing pandemic.

Introduction

Mental health challenges are anticipated to be some of the most demanding problems in public health globally in the years to come, and to face these problems, we need to focus more on socio-ecological conditions to prevent and solve these challenges.¹ In this study we focus on the barriers and facilitators for social support viewed from service users, professionals, and volunteers in the field of mental health work. There is a clear link between reduced social support and mental health challenges and vice versa; social support is crucial for good mental health and mental health recovery.^{2-4, 5} Several systematic reviews of existing literature on mental health and social support have suggested linkages between social support and mental health or mental health service use in general and in specific population groups.^{3,4,6-9,10} The essence of this research is that social support is crucial for mental health recovery and for solving social problems, and that social work and arenas where people can meet when struggling in life are of great importance for mental health recovery, and generally for increased quality of life.

We know less about what actually hinders and facilitates social support, especially through the lens of people situated in the field and understood in a contemporary socio-ecological context.^{11,12} This paper therefore aims to explore barriers and possibilities of providing and receiving social support in community mental health.

This article is part of an ongoing research project developed at the Center for Mental health and substance abuse, University of South Eastern Norway. The project was developed by focusing on service user involvement from the start inspired by earlier work on co-research and the recovery tradition in mental health.^{13,14} We believe people with relevant survivor experience contribute to crucial perspectives considering what is needed in the field. We discussed the topic “social support and community mental health—what can it be?”—a topic that was our starting point and main focus. Both author 1 and 2 have lived experience in terms of mental health challenges. Over several meetings, the first author and five other people with relevant experience (people using mental health services or having challenges with mental health problems over time) developed the research project further and formulated three research questions, of which this paper aims to explore two:

1. What do professionals, service users, and volunteers within the community mental health field experience and describe as facilitators of social support for persons with mental health challenges?

2. What do professionals, service users, and volunteers within the community mental health field experience and describe as hindrances to social support for persons with mental health challenges?

Social Support: Theory, Definition and Relations to the Recovery Tradition

Social support is generally theorized as the amount of perceived and mutual support one has with family, friends, and loved ones. Cohen and Wills describe social support as an important factor in determining access to resources.¹⁵ The protective role of social support is cognitively mediated by our interpretation of life stressors or knowledge of coping resources we perceive, but also to be available to help others and to meet other's needs.⁵ In an attempt to clarify a definition of social support, Finfgeld-Connett defines social support as ". . . an advocative interpersonal process that is centred on the reciprocal exchange of information and is context specific".¹⁶ From ethnographic work exploring social support, we know that cultural and structural components are always important when we do research with the aim of understanding what is supportive and what is not.¹⁷

The conceptualization of social support is typically arranged in the following categories: (a) emotional, (b) instrumental/tangible, (c) and informational.^{18,19} Emotional support refers to having someone to talk to, having close relationships with family and friends, and feeling loved and cared for. Instrumental support refers to having someone to trust and count on in difficult life circumstances and dealing with the demands of daily living, such as getting to appointments, shopping, cleaning, help with money matters, paying bills, and so forth.¹⁹ Informational support consists of exchanges of practical information, such as providing the name of a good professional, tips on new health care services, new medications; having someone to have important life discussions with; and having support for one's actions or statements.⁵ Practice and support that contribute to better social rhythm are also crucial components when exploring social support and severe mental health challenges.²⁰ Our focus is mainly on emotional and instrumental support and both direct and indirect ways to work with support. We will more closely describe how we approached preparing the interviews in the methods section for the purpose of creating a shared understanding of the conceptualization of social support.

Our Socio-Ecological Point of Departure

In the mental health field, the recovery tradition stands strong and receives immense support. The authors within this tradition find themselves in many ways grounded in the orientation that embraces social living conditions when understanding mental health, social support, and recovery. The recovery tradition is deeply rooted in service user movements and professionals that have emphasized psychosocial aspects of working with and recovering from severe mental health challenges.²¹ However, it also faces extensive critique, especially considering its way of defining what recovery practice actually is, where some argue that within this tradition the attention is directed more toward excessive individual orientation. Consequently, one can here lose focus of the very nature of recovery as relational.²¹ We can say that this tradition relates to a broader range than, for example, how the psychiatric tradition works with the different layers of social support, and it has created new perspectives that unfold in the field from the scale of building recovery communities

to its influence in social policy in the wholesome work to support the individual recovery process. From our perspective, the recovery tradition works with the nature and ecology of social support with, for example, Bronfenbrenners' ecological model in mind, that human development and social support are something that happen and are nurtured (or not) at different levels and layers in our history and contemporary life—from micro to macro levels.²² Even though we do not explicitly refer to this in our method, results, or discussion sections, it is embodied in our work and implicitly used as an analytical tool and therefore deserves epistemological recognition.

Research Design and Methods

Inspired by a phenomenological-hermeneutical approach by Brinkmann and Starks and Brown Trinidad, we attempt to explore and describe the participants' subjective experiences.^{23,24} For this article, the use of focus group interviews is the main method. Further, we relied on service user involvement from the start to better develop the research questions, and we employed a co-researcher with user experience throughout the whole research process. Author 1 and author 2 (co-researcher) organized and conducted the focus group interviews, the following analyses, and finally the writing of the paper. Author 3 contributed with critical comments and perspectives during the writing.

The research context is the community mental health field in three various districts in Oslo, including volunteers that collaborate with community mental health services.

Recruitment

We recruited participants in collaboration with leaders and professionals in mental health services in the various districts. The inclusion criteria for service users were 1) having a case decision of mental health support, and 2) having mental health challenges over time. Inclusion criteria for mental health professionals and volunteers were to have clinical experience and close collaboration with service users. Leaders and mental health workers communicated the information sheet and informed consent to relevant participants who met the inclusion criteria and contacted the participants after confirming their consent for participation. After agreeing to participate, we were connected with each other, and then we agreed to meet in familiar locations for all participants in the related districts.

Sampling

For the focus group interviews, 32 adults were recruited: service users (n=11), professionals (n=12), and volunteers (n=9). The focus groups were then divided into seven groups: three groups in one district, three groups in the second district, and one additional group in a third district. The groups were not mixed. That means there were three focus groups with service users (SU) in various districts, two for professionals (P), and two for volunteers (V).¹ The focus groups were divided in the various ways to explore the research questions from different perspectives. Participants were purposely sampled. Demographic data considering the main criteria and aim of this study, which revolves around having experience with service

¹ Focus groups will also be referred to by the first letters in the groups: SU, P and V.

use and service work, were collected: age, gender, time of experience, main challenge/diagnosis, district belonging, and socio-economic status.

In the service user groups, the age ranged from 22–67 years. Among the service user groups, the contact with the mental health system ranged from 4 to 25 years, and all participants reported to have one or more than one psychiatric diagnosis and struggle with long-term mental health challenges. All the service users received some kind of social welfare benefit and did not have a regular income. Types of psychiatric diagnosis reported varied from long-term depression, bipolar disorder, complex anxiety, and personality disorders. All the participants were Norwegian citizens, the majority with Norwegian ethnicity, while four participants had different cultural backgrounds. In the professional groups, the age ranged from 25–65 years. The professionals had backgrounds from different types of occupations: social work, nursing, mental health work, occupational therapists, and physiotherapists. In the volunteer groups, the age ranged from 42–75 years. Further, the volunteers were retired workers from different types of occupations, where some had service user experience from the mental health field and others were connected to the voluntary work for job training. All volunteers worked at a local meeting place for service users in two of the districts that were providing social support.

Data Collection

We wanted to create a room for broad discussion about the topic and research questions. In short, focus groups can be described as a form of group interview with the aim to gather several informants to discuss one or several topics.²⁵ This type of data collection can, at its best, be less threatening for the participants when opinions, experiences, and ideas are discussed.²⁶ All authors contributed in the making of an interview guide where a selection of a few open questions acted as a support through the interview and discussions. Author 1 and 2 facilitated the focus group discussions and informed the participants about our background. The focus group interviews had a duration between 1 and 1.5 hours, and the author and co-authors transcribed them verbatim. We used some time with each focus group to talk informally to build a relationship and to create a relaxing atmosphere—something of great importance in these types of settings, where the topic can be quite sensitive.²⁷ We also explained the typical definition of social support from social support theory in the information sheet to better create a common understanding of the concept of social support. The starting point for all focus groups were the following questions (selection from the interview guide):

- *Short description of the conceptualization of social support: how is it typically understood in theory and daily life?*
- *Can somebody start to tell a little bit about how you understand and experience social support in your daily life (or work)? Give examples from your daily life and services.*
- *Can you tell us about and describe experiences that you believe can facilitate social support?*
- *Can you tell us about and describe experiences that you believe can work as barriers in facilitating social support?*

Collaborative Data Analysis

In the process of analyses, our approach has been to adopt the essential guidelines of thematic analysis as inspired by collaborative analysis.^{14,28} Author 1 and 2 prepared the analysis by reading and discussing ongoing literature in the field of participatory research.²⁹ By ensuring a phenomenological-hermeneutical approach, the aim of the analysis was to capture the participants' personal experiences and discussions connected to social support, and the researchers' interpretations of the participants' lived experiences.^{30,31} Our analytical approach and interpretation are semantic (explicit and data driven) and latent (connecting and theorizing data with a deeper interpretation). To a large extent, our analytic process follows the hermeneutic circle of interpretation. Ideally, as Braun and Clarke argue, the analytical process involves a progression from semantic description to a broader interpretation, and therefore our discussion will largely seek to theorize the significance of the findings in relation to other literature.²⁸

Inspired by Braun and Clarke, our collaborative analysis followed several steps in order to achieve enhanced rigour in the organizing of the material: (1) naive reading; getting familiar with the data, (2) generating units of meaning, (3) developing emerging themes, and lastly (4) reviewing, defining, and naming themes.²⁸ In the final stage, we considered the themes once again and tried to identify main themes that could describe both commonalities and differences. Consequently, after achieving an overview, we were able to observe themes that developed in what we found as domain discussions, and simultaneously, we were able to agree upon the main themes. Accordingly, we critically questioned the data continuously in the search of new insights and perspectives.

In our analyses, we systematized the findings in three organizing themes, each with two additional subthemes, related to the essence of the data material after inductive coding and our own interpretation. In our presentation of the total seven focus groups (FG), we will use FG Professionals 1 and 2, FG Service users 1, 2, and 3, and FG Volunteers 1 and 2. The numbers represent the groups and participants from the districts. Since this is an explorative study, the result section is essentially descriptive and data driven.

Further, our presentation will use different terms to say something about the variations and similarities in the focus group discussions. For instance, we use "All focus groups mentioned," "Several focus groups lifted" when three or more, "Some focus groups lifted" when more than one group touched a central topic, and "Focus group discussions among service users" to point out role-specific topics and points. We believe that this makes it possible for the reader to find and evaluate ideas across the groups and to understand where perspectives differ or overlap.

The reason why we are not organizing the findings in a role-specific presentation is because the themes that inductively emerged from the data link the perspectives between the groups and in turn represent the essence of the major points that interweaves the descriptive discussions. The framing in the result section aims to capture the domain discussions in the focus group interviews.

Ethical Reflections

Participation in this study was voluntary, and both the information sheet about the study and an informed written consent was obtained prior to the interviews. Before each interview, we reminded the participants about their possibility and right to withdraw from the study at any stage and gave the relevant contact information to do so. We are not including any original or fictive names in this study and our focus on anonymization has been comprehensive. Accordingly, the Norwegian Centre for Research data (NSD) has approved the study under assigned project number 57041.

Results

In this section, we give a presentation of the significant empirical data through the domain discussions across the data sets. At the end of the findings section, we sum up some core commonalities and differences among the groups. The findings are presented in following themes: 1) the quality and vulnerability of social support: a) lived experience: mutual support and understanding, b) “ghosting” and shame; 2) conditions that facilitate social support: a) stable environments and room for diversity, b) social rhythm and healing rituals, and 3) conditions that hinder social support: a) economic barriers, and b) social challenges in contemporary society.

The Quality and Vulnerability of Social Support

Throughout the discussion, all the participants in different ways expressed the importance of the quality of the support to achieve recovery. Hence, the participants discussed different layers that constructed helpful support and the challenges one faces with emotional and instrumental/practical levels of support when, for example, struggling with long-term depression or substance abuse. Some service users discussed how hard it was to maintain relationships when struggling with severe mental health challenges, and that social life in general gets more demanding—thus severe mental health challenges could be “the worst disease,” to cite one participant. As expressed by these participants, friendship and relationships are harder to sustain when faced with mental health challenges. Further, the participants in all groups stressed that quality of support will help to sustain friendships and relationships, which is harder to do when faced with mental health challenges.

Lived Experience: Mutual Support and Understanding

In all focus groups, the quality of social support showed as an important topic. Several SU participants suggested that having someone that could cheer in the background and truly understand their situation and create hope were presented as a crucial element in the quality of given support. One group among service users discussed what one called “vicarious hope” as a factor when you lose hope, a factor with many layers; for this kind of hope to appear, several things need to work together which our findings will show. Several focus groups discussed the value of lived experience to create the room for helpful support and that this was related to being really understood:

P2: “. . . I feel that it is about understanding and being understood.
To be clear, it depends on the quality of the social support . . .”

P3: “. . . and then it is about having someone that can create vicarious endurance when you cannot hold that hope or patience yourself. Vicarious hope . . . like these cheerleaders when I struggle to cheer myself up. . .”

P1: “. . . but suddenly you are alone with all that experience. And there is nobody that can support you or that experience if you have not experienced it; maybe it is difficult to have empathy related to what’s going on, and people get scared. . .” (FG, Service users 1).

All groups among SU discussed how important it was for the quality of the support that one could help one and another. We know that mutual support is important. It is not only about receiving but also about being able to give. How one succeeded or not was mainly connected to the structure in the services, neighbourhood, and society:

P2: “. . . the place that I lived before I didn’t have any support or feelings of belonging. I got some help to find a new place, and it was the best thing that happened to me. At this place we help each other, we can go together to the supermarket, walk in groups and so on. . .” (FG, Service users 2).

Several focus groups discussed how vulnerable you are when experiencing long-term mental challenges; everything in life becomes more difficult, and the social life more challenging.

In the discussion among volunteers that collaborated with mental health services, the term “love” was mentioned several times. Some stressed that there was some kind of mutual love. One engaged in this because one had an idealistic wish to contribute in people’s lives for support.

P1: “. . . well it is like this mutual love. We come here because we want to meet these people. Because we want to see how they are. We come here without any salary, at fixed schedule. . .” (FG, Volunteers 1).

Several focus groups also listed lived experience as crucial when talking about the quality of support. This did not mean that the professionals or volunteers should have lived experience only from mental health struggle. The discussion was often nuanced, and most participants agreed that offering something from your own life, showing that you also can be vulnerable, was the most important thing to develop connection, trust, and a better quality of relationship.

P5: “. . . again, it is something about experience. That you tell us you have been struggling yourself with x. That helps a lot. Maybe it is more integrated now, that the services create jobs for peer support workers. That’s very positive. If we meet people without any lived experience . . . it gets very difficult. . .” (FG, Service users 3).

'Ghosting' and Shame

During the discussions with the service users, they stressed that taking care of friendship was especially difficult in challenging periods, something discussed among all the different perspectives. It is not always easy to be eager to spend time with somebody who is depressed, and isolation tends to be the most common strategy to avoid being a burden for others. However, the discussions presented several nuances in this topic and shared experiences of finding coping strategies to maintain friendships. The hardest thing, as several participants expressed, was to be forgotten or only appreciated during good times. Many experienced 'ghosting,' which means the people one considered as friends stopped reaching out when they were needed the most, as this dialogue shows:

P3: “. . . you get so tired because of the depression . . . I was so deep down in the darkness that I couldn't stand anyone. . .”

P1: “. . . I feel that it is absence of, absence of that support. When they are pulling back or start to ghost you. . .”

P4: “. . . it is this power that you don't have. And then it is difficult for others to take your perspective and then there will be no feeling of mutual support. They don't understand, and then you often feel so alone. . .”

P3: “. . . yeah, because you can't force people to understand. It is not something you can order. . .” (FG, Service Users 1).

All SU focus groups talked about the greater risk of falling out of track from regular society, losing friendships, and in general the overall cost of experiencing long-term mental health challenges. The struggle of being accepted and working with feelings of shame were things that circulated in the discussions, and several participants pointed this out:

P5: “. . . it is (long-term mental health challenges) pretty stigmatizing still. I feel that I often need to struggle with feelings of shame. Actually, every day. . .”

P1: “. . . Yeah, I feel the same. . .” (FG Service users 3).

This leads us to the next part of our findings, showing that some of these challenges could become more manageable in stable environments and in places there is room for diversity.

Conditions That Facilitate Social Support

***“We are Each Other's Network”:* Stable Environments and Room for Diversity**

All focus groups discussed conditions that could facilitate social support when struggling, and conditions that could make social life flourish in general. Consequently, discussed in all the focus groups were the potential of stable environments and the room to express oneself. Additionally, the focus groups

expressed the importance of being able to just exist, without the need to contribute all the time, and to experience social environments that had patience and understanding. Connected to this, an important aspect was the 'stayer-ability' of the environment. If one experienced this, and the people that surrounded you had some kind of faith in you, one was more likely to be able to recover and contribute to the community again. Stability and stayer-abilities were listed as important aspects of helpful support over time:

P1: ". . . it is about stayer-abilities. To be able to be present in someone's life over time, despite the challenges. That you have that person or those that endure. . ." (FG, Service users 1).

The room for diversity, openness, and breaking down taboos, connected to both people using the service and people working in the service, were important topics in all focus groups. One group among SU discussed the following:

P3: ". . . I have some experience with the importance of getting help from professionals that have both lived experience and professional competence. That 'technical' knowledge is important, and to have that mix is crucial. With the lived experience you can feel that maybe I will be able to recover again, and with the professional competence you have someone that knows the system . . ."

P5: ". . . and yeah, someone that is a bit stable in life, educated. That there is somebody that is healthy enough to get up in the morning. . ."

I: ". . . yes. But what is education . . .?"

P1: ". . . well, that openness that you showed before the interview started. I would guess that many social workers and 'professionals' that have lived experience still experience taboos. It is still like you should not get too personal, you should be professional and keep a distance . . ."

P2: ". . . yeah, and then we keep a distance as well. . ." (FG, Service Users 3).

In all the focus groups, the importance of (having) social meeting points was the main ingredient in the 'lasagna' of support. Accordingly, the ingredient of having stable environments in your local neighbourhood stood out as one of the most discussed layers when it came to creating support, and further, during the mental health recovery. Professionals stressed the importance of the fact that social aspects and activities also could be low key:

P1: ". . . somebody comes for a walk with us, some will do craft activities, but they come mainly for the social interaction. One of the service users that doesn't say much is often just sitting in the living room, and I asked him why he sits there, and he said: 'to feel the

social life.' But he doesn't talk with anybody. . ." (FG, professionals 1).

It seems that getting beyond traditional therapy and embracing people's social lives were the most important when building social support. Many of the service users stressed that, after years with severe mental health problems, building networks and meeting people could be one of the most important ingredients in recovery—namely, getting out of the therapy room:

P3: ". . . I was seeing a psychologist and psychiatrist for many years . . . in the end we needed to end the treatment and find something else. Find other people. Enough of being alone. When you meet other people, you understand you are not alone. . ." (FG, service users 2).

Especially where the communities could offer meeting places that could enhance social support, mental health recovery was established to be more active. To achieve this, one of the secrets seems to be able to create places with some kind of stability in relationships that also can offer social rhythm and meaningful activities. One group of volunteers discussed this:

P1: ". . . I guess the secret is relationships over time. Many service users have been here for a long time. We are in a way each other's network. We know each other's histories. Service users, volunteers, professionals. We know each other, and it is all about the environment. It is not us that bears the hardest days for the service users, it is the environment. And the sum of *us* . . . we know the good days, so we can handle the bad days. . ." (FG, Volunteers 1).

During the interviews, the participants in different ways discussed the importance of rhythm and the possibilities for connection or "just hanging out with someone" that happened in this rhythm. This builds a bridge to our next sub-theme.

Social Rhythm and Healing Rituals

Social rhythm is important to achieve or work toward a euthymic mental and physical state, and several participants talked about the lack of rhythm caused by psychosocial stressors. The term refers to the regularity of engaging in social activities throughout the week. All focus groups described in their discussions the importance of social rhythm when you feel like you are 'losing it.' When experiencing serious life crises and mental health challenges, some activities can work as rituals in the absence of rituals and rhythm in everyday life. Several activities could boost the feeling of emotional and practical support. Especially meals, something quite universal for us all, crystalized as a healing ritual:

P2: ". . . we talk at breakfast, and during lunch. And we talked about this with a new guy that was a refugee, that this is the most important activity. To meet and feel the sense of community. It seems like for many this is the most important thing we do, the meals we have together. . ." (FG, Volunteers 1).

The process of creating these ritual activities offered both rhythm and a stable point in an existence often characterized by uncertainty and struggle. Many of the participants in all focus groups pointed out that maybe these kinds of activities also filled a hole in an individualistic society, which is clearly connected to our last major theme.

The professionals discussed how their activities could be connected to social support, in the meaning of both emotional and practical support. In both focus groups, the participants reflected upon how crucial it is to try to embrace the potential support in all activities. Just the possibility to have someone to share a meal with could be that one activity that opens up many aspects of togetherness:

P2: “. . . I believe that all our activities in some way are related to social life. And then it gets like naturally supportive, sometimes at least. We have a lot of service users that have no family and are going through hell. Just the fact that you can share a meal with someone, walk for a trip, play games with. . . and we can be there and support. Many people come to get the feeling of support. . .”
(FG, Professionals 1).

Another aspect related to the quality of social support was to have a place to go and to meet people that can help with practical matters in everyday life. Sometimes, just knowing that a meeting place exists can be enough to get some relief. Other activities that the focus groups discussed were meeting points where people thrived and got the chance to meet both old and new friends. For instance, every Friday, one of the services organized a quiz followed by coffee and cake:

P4: “. . . for example the quiz on Fridays tends to gather a lot of people. It is very social, and many are always showing up. . .”

P1: “. . . It is the ‘high point’ of the week, there are good vibes all day. For many that come, closeness and distance can be challenging, but they come anyways. It is kind of important to not miss the weekly quiz. And at least the cake and coffee that follow (laughter) . . .” (FG, Professionals 1).

Conditions That Hinder Social Support

Economic Barriers

The discussions touched upon several aspects related to the barriers for social support. One aspect was the individual one: your own isolation when you are down and depressed or have incredible anxiety and do not want to or are unable to interact with anyone. The struggle of maintaining friendships, as mentioned, and finding nurturing relationships tend to be difficult in these periods. Furthermore, another aspect was regarding the structural components: problems with money matters, how services were organized, and issues with contemporary society, namely individualism and ‘unsocial’ media.

Having problems in being able to sustain an occupation is a well-known challenge when we struggle with severe mental health challenges. This obviously interferes with personal economy. Almost all the focus groups discussed the challenge of having too little money and how this relates to having a social life in the context of mental health recovery. As these groups discussed, this can also create loneliness, because many popular activities today are expensive.

One tendency people may have, is to avoid social activities because it is too expensive to participate:

P2: “. . . it often happens that someone says ‘Sorry, I am sick,’ for example, if you need to spend some money. Going to the movies is expensive. And then you are going for a coffee later, and that too is expensive. Many don’t have the money. Everything is expensive and that’s difficult. . .” (FG, Service users 2).

It is obvious that having too little money can be a potential barrier for some, and thereby a potential barrier for building networks and boosting social support. Economic barriers in the services were also listed as a potential barrier when trying to support people and offer help. Accordingly, this varied in the different districts. The services that had a good money flow from the politicians in specific districts could offer better services. In one of the districts, the participants among volunteers stressed that:

P3: “. . . it’s all about money and resources. For instance, we don’t get money to offer television anymore, because we need to cut in our budget. We don’t have the resources and that is an obvious limitation. . .” (FG, Volunteers 1).

Among the professionals, there were also a lot of worries and negative experiences related to consequences for service users when cutting the service budget. In one district, a stable meeting point was closed down, and a lot of service users fell into crisis. The social rhythm and healing rituals that the place offered suddenly disappeared. As explained here, the numbers (evidently) decide:

P4: “. . . we who work on the ground experience the consequences of thinking numbers in favour of profession. And, unfortunately, here the numbers set the agenda. . .” (FG, Professionals 1).

Social Challenges in Contemporary Society

The challenges with social media, individualism, a ‘diagnostic culture,’ and collective egoism were discussed in several focus groups when asked to describe barriers for social support. The discussions were nuanced and pointed out some of the new and arising social problems we face in our time.

P3: “. . . in theory, social media can be a good thing, and help to connect, find stuff. But fuck, I don’t know. My experience is that SoMe can enforce the negative feelings when you struggle. . .”

P5: “. . . yeah, it’s so intense, you get so distracted. It is too much. . .” (FG, Service users 3).

Among the service users, there seemed to be an agreement that social media could offer some benefits, but simultaneously often had a negative impact on (their) mental health. Also, the short distance from having a thought to producing an actual tweet or a Facebook post could lead to regrettable updates and comments, which could lead to embarrassment and humiliation.

Another dimension the service user focus groups discussed was the challenges (and possibilities) with getting a diagnosis. Clearly, there still seems to be a lot of stigma related to severe mental health challenges. One said that:

P2: “. . . I try to explain to people sometimes that I struggle with paranoia and can be psychotic in periods, and. . . I don’t walk around with a poster, because society still tends to see us as potential killers or looneys. . .” (FG, Service users 2).

The participants discussed experiences connected to a ‘diagnostic culture’ and that to receive some diagnoses would pigeonhole you, while to receive others would be more beneficial. One of the participants put it like this:

P1: “. . . it is often as if you get defined by your diagnosis. A lot of the time I feel like I can talk but not be listened too. That I am being filtered through the diagnosis, in a way. That makes me feel powerless. . .” (FG Service users 1).

Furthermore, there was agreement among the service users that receiving or having a diagnosis mostly was helpful to receive social benefits and to fit into programs that could offer some treatment:

P3: “. . . The only advantage with a diagnosis is that it can lead to getting the help that you desperately need. . .”

P1: “. . . yeah, and what society accepts in the mix of diagnosis and suffering is something I have experienced as crucial for social support. It was allowed to come and be depressed, but to have that other diagnosis was like: ‘Oh, she is a difficult person and we don’t want those kinds of people here’. . .”

P3: “. . . that’s a barrier. Some diagnoses stick with you and work as barriers . . .” (FG Service users 1).

Almost all the focus groups mentioned contemporary society as challenging in different ways. The most common phrases and topics in the conversations/discussions were the challenges connected to individualism and the experiences of egoism, stigma, and maintaining a façade.

P3: “. . . To be honest, the whole thing, it’s just a façade. Sometimes I think we are a bit lucky that we are at the bottom of the social

ladder, because at least we don't need to pretend all the time. . ."
(FG, Volunteers 1)

P2: ". . . we are ego-oriented, the whole bunch. . . we are all just
egoists. . ." (FG Volunteers 2).

It seemed as if contemporary society and the society that we are a part of was something a lot of the participants wanted to talk about when discussing social support and mental health recovery. All the focus groups discussed the challenges of being social in our time and the barriers they face when trying to connect with other people. This is not unique for only the participants in this study.

Commonalities and Differences Between the Groups: A Short Summary

We merged the discussions to create a lively description between the groups, and our analyses showed us that it might be more commonalities than differences when talking about how one understands social support, and in the description of barriers and facilitators for social support. What is special for the different groups? A) Service users describe more specifically how to live with the stigma and diagnosis and how this can work as potential barriers for social support. All groups point out the importance of addressing this. Meeting professionals with lived experiences combined with professional competence can potentially boost the different layers of social support: emotional, instrumental, and informational. The importance of having meeting places that offer social rhythm over time is crucial. These places need to develop the room for diversity (and more importantly: they need to exist). Maintaining friendship is difficult when struggling with long-term mental health challenges, and service users point out that some diagnoses work as barriers; others do not. The SU participants also discussed the barrier of shame related to struggle with mental health. Shortage of money potentially creates more loneliness, something discussed by SU participants. B) Professionals describe how to collaborate with social support and feelings of stigma, and that having the possibility to offer stable environments is crucial in doing so. Structural challenges such as poor leadership and lack of resources to keep meeting places open work as barriers when working with social support. C) Volunteers describe that they can play a different role in offering meeting places and work against stigma. What is distinct for the role of a volunteer worker is that they don't get paid, something they describe as a potential boost for the trust in their relationships with service users, thereby offering a different type of emotional support. They work as volunteers more or less solely because they want to and often have lived experience with mental health challenges, and some of the volunteers' meeting places offer what traditional services often cannot: time and continuity. As one of them said beautifully: ". . . I guess the secret is relationships over time. Many service users have been here for a long time. We are in a way each other's network. We know each other's histories."

The baseline seems to be a common agreement of the potential of meeting places and their healing (or not) possessions. If meeting places in local communities either thrive and develop to boost social support or dissolve and disappear, this idea is related to socio-ecological matters on different levels, and the way they are organized. In all, the groups' topics related to contemporary society were discussed in the attempt to describe potential barriers for social support.

Discussion

As the findings in this study, together with others, show, the quality of social support is deeply connected with how the service users, professionals, and volunteers experience how they can collaborate with practical and emotional matters in daily life. All this can build a bridge to and open up the different layers of social support and a sense of community, and obviously provide a better foundation for mental health recovery. In relational, political, and societal interactions, there always lie many possibilities and barriers. Our findings contribute to new knowledge about how these possibilities and barriers are experienced, discussed, and described in the field. It is especially interesting to see the levels of reflection the participants had on contemporary society. This leads our discussion toward finding a connection between the domain discussions and the socio-cultural events we believe play a crucial role in how we work with social support.

We want to lift and expand the discussion into three main topics that regard socio-ecological/cultural conditions in relation to the focus groups discussion: I) The diagnostic dilemma in a culture of diagnosis II) How do we build mutual social support? And III) Relational recovery: and so what? We also reflect on our study concerning the ongoing pandemic.

The Diagnostic Dilemma in a Culture of Diagnosis

Some of the service users and professionals experienced that psychiatric diagnosis sometimes can be a helpful tool. At the same time, psychiatric diagnosis can follow you your whole life and potentially create different barriers, as the participants in this study discussed. As some of the participants pointed out, we still tend to categorize and stigmatize in our contemporary diagnostic culture. Several participants highlighted that diagnosis mainly worked as an opportunity when it came to social welfare benefits, but it stopped there. Some experienced being “filtered through the psychiatric diagnosis” they had received. To be able to create an equalizer between somatic and psychiatric diagnosis is still a utopia. At the same time, as service user participants in this study listed, social media and the digital boom also come with a sacrifice and risk. It can potentially enforce the networks’ understanding of one as ‘crazy’ or ill, and it is easy to regret posting something. The ‘digital journal’ with screenshots and other possibilities makes all of our online/social media activity exposed.

Our ability to support one another and to be attentive toward other people’s needs is challenged by the individualistic, hyper-digital, and competition-oriented society that we have built.³² This is said while acknowledging that our progress, which often can be experienced as a paradox when we look at all the mess, in many ways has made life better for the majority of human beings in some aspects.³³ On the other hand, we believe that this progress comes with a sacrifice. Despite our improvements, we also believe that we are destroying some of the foundation for community, to talk with each other face to face, and that our need to put people in psychiatric boxes sometimes can work as barriers for social support. As some participants discussed, specific psychiatric diagnoses almost serve as a positive status symbol, and others work as barriers for support. This adds to the experience shown in other studies.

Researchers from many fields are challenging the problem with a diagnostic culture, and how it potentially creates more illness than facilitates support.³⁴

It is remarkable how several participants in this study contextualized contemporary society within the topic of social support and the ability to experience quality of life. Accordingly, it seemed like several participants in the different groups felt that something just was not right, that the social rhythm in their communities and the potential of building relationships in some ways were broken. The consequences of witnessing the pace of instability and an ever-shifting community with fragile relations might be increased loneliness, stress, poor mental health and frustration—something that might be even more exposed in the time of COVID-19.³⁵

How Do We Build Mutual Support?

In our universal need for social support, one of the most important aspects is to be able to give something back. This is highlighted by the participants in this study. As we know, it is crucial to feel that we are connected in our community, and that the things we do in some way or another matter. This study shows that building stable environments with the possibility for social rhythm, lived experience, mutual support, and what we have called healing rituals, potentially can boost mutual support and feelings of togetherness. Places that represent something as the ‘stayer-ability,’ which one of the focus groups discussed, are not only transferable to relations on the micro-level but are also transferable to the macro level. As shown in the domain discussions, the participants in this study underline that we need places that we know will be present; a place to find comfort, a place to meet people that you like to meet, a place where you can get/receive and where you can give. We need to build places and community where support can arise. In this process, we need both a variety of creative social work and an active social policy because we know social policy matters in the process of facilitation.³⁶ However, this is, of course, easier said than done. Can we force friendships? Is there no such thing as difficult persons and social environments which, rather than build us up, break us down? Loneliness and relationships are complex. We are aware of this and that human beings have the potential of evil and power abuse, and further that collective evildoing may always be a risk that we need to live with.³⁷ On the other hand, as several participants described in this study, the idealism, altruism, and love people have for one another are dimensions that can be nourished with the right stimulus.

Relational Recovery: And So What?

This study, among others, shows that there still is a need to focus on how to reclaim community and social work in the process of both building public health and facilitating mental health recovery.^{11,38,39,40} What is particularly interesting in this study is the hands-on discussions on what the barriers in doing so can be and that they are relatable to ongoing debates. This invites us to understand even better how we need to go forward and build the relationships that are crucial in the process of recovery. To be able to do so, we need to investigate what is breaking community and relations so that we can reclaim it, and understand the very nature of hope and recovery as relational.⁴¹ In the ongoing pandemic, which already has had a devastating impact on many people around the world, and where social inequality in health in many aspects again arises as brutal injustice, there are also present some

possibilities in rebuilding how we see the world, how we make services more available (or not), and how we measure quality of life, that everything is relational and that different layers of social support play a crucial role.^{42, 43} Can the crisis help us reclaim community and altruism, or will it make things even worse, especially for people with poor health and little money?

On the road to reclaiming community and reducing inequality in health, we need an active social policy that includes many voices and experiences. Building supportive communities, and thereby potentially boosting social support, has been discussed for a long time, and is now sometimes presented as something 'radical' and 'new' in mental health research, for instance, in presenting scenarios for future mental health care in a social perspective.^{13,44,45} Social hope seems to be more important to embrace than ever, with reference to our contemporary circumstances.⁴⁶ We believe that our collective consciousness needs to be opened up toward the ongoing and future political scenarios, both considering public health in general, and when we are experiencing mental health challenges and crisis specifically. This means that our role in democracy needs to be even more engaging and politically vigorous.

Wilkinson and Pickett argue that the battle for status and competition has been ever more intense since the 70s, and that diagnosis and social problems such as depression, psychosis, schizophrenia, and narcissism might have increased related to an overall general level of stress.⁴⁷ The division between the richest and the poorest is increasing, not only globally, but also in countries such as Norway, where inequality between citizens has been and still is, compared to other countries, at very low rates. If relational recovery means trust and support between citizens, we need to look at how to engage people in vulnerable situations even more into politics. Inequality in mental health is discussed as a rising problem in, for instance, Norway.⁴⁸ If we want to achieve good mental health for all and facilitate mental health recovery, politics is indeed something personal that needs more attention when developing services and supportive communities. This requires participation. One aspect that surprised us, both in the sampling and in the field work, was the lack of diversity regarding ethnicity and cultural background. We believe that there is a need for more in-depth research and knowledge when it comes to understanding other cultures' perspectives of social support and mental health.

Conclusion

This study shows facilitators and barriers in building social support as viewed from seven focus group interviews among service users, mental health professionals, and volunteers. In our analysis, we found that stable environments, social rhythm, and healing rituals were important facilitators for boosting different layers of social support and mental health recovery. The different perspectives show us the commonalities and differences when working with social support. However, there was an agreement that the quality of social support can increase if communities are able to offer stable meeting places with room for diversity. We also found that crucial barriers for social support were connected to poor economy, the socio-economic factors the services face, and different challenges in contemporary society, such as disruption of social relationships through social media. Feelings of shame related to mental health challenges can also still work as a barrier and the diagnostic culture can work as a barrier for support. In our discussion, we invite our readers to regard the socio-

cultural aspects in our time that are reflected upon in the focus groups' discussions. From our perspective, this affects the way we can work with social support and facilitate mental health recovery for people experiencing long-term mental health challenges.

Implications

- The mental health field needs to revisit the meaning of relational recovery and design stable meeting places with room for diversity and lived experience in local communities. That requires close collaboration with volunteers and policy makers.
- The diagnostic culture still needs to be challenged by lived experiences because it can work as a barrier toward social support in both civil society and mental health services.
- Mental health workers need to engage more in socio-political matters and facilitate broader democratic engagement, inclusion, and collaboration with service users.
- Socio-economic inequality creates inequality in health and instrumental social support regarding economy is crucial toward participation and increased quality of life. Several participants report that scarcity works as barriers in social life and thereby social support.
- More research is needed regarding multi-cultural aspects of social support and how this may affect the need for diversity in building more inclusive and supportive local communities.
- The ongoing pandemic makes it even more crucial to work with social support in local communities, to evaluate accessibility adjustments, and to work toward a progressive social policy that concretely helps people living with mental health challenges.

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Limitations

This study is a value-oriented study. This might affect the result and create biases. Another limitation is that the focus groups cannot capture all the different opinions and might result in some people's perspectives having more weight/emphasis than others. We could also have benefited from collecting a broader sample regarding ethnicity/cultural aspects.

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