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research article

Recovery: indications for the practice of social work oriented to human needs

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The research focus of the article – based on Aaron Antonovsky's sense of coherence – is the analysis of recovery from the perspective of clinical social work. The methodological approach adopted in the study is based on the co-creation of knowledge together with 29 people experienced in deep mental health problems who agreed to participate in the process of intersubjectively defining mental crises, the possibilities of overcoming these and thus the ways of understanding recovery. The results of the study show that the basis of the recovery process is meeting a set of five needs: (1) effectiveness, (2) emotionality, (3) connectedness, (4) coherent identity and (5) affirmation of the past. A certain pool of individual experiences acquired during this process is a source of the formation of internalised beliefs that can be linked by a sense of 'manageability' (resulting from the satisfaction of the first three of the aforementioned needs), 'comprehensibility' (related to the need for 'coherent identity') and 'meaningfulness' (related to the need to 'affirm the past').

Key words recovery • sense of coherence • service users' involvement • participatory research

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Introduction

The article focuses on analysing the specificity of recovery from the perspective of clinical social work. The clinical approach is understood here not so much as related to the diagnosis and practice developed in psychiatry, but as embedded in the broader tradition of Martin Buber's philosophy of dialogue, Carl R. Rogers' humanistic psychology and contemporary analyses of applied sociology. Being clinical hinges on dialogue, thanks to which the original distance, sense of otherness and caution characterising the contact between social workers and persons seeking help can transform into a common ground of understanding and cooperation. The value of the dialogical perspective is substantiated not only from the perspective of therapeutic practice but also from the perspective of research (Seikkula and Arnkil, 2006).

Remarkably, the participatory research presented in the article was conducted in Poland, where the asylum model (based on treatment in large psychiatric hospitals) is still dominant, which significantly limits both the field of research on recovery and the development of clinical social work. Environmental forms of social assistance and rehabilitation for people with mental illness created in Poland over the past 30 years have not been reflected by symmetrical changes in the area of healthcare.

The first decade after the introduction of the Mental Health Protection Act 1990 in Poland resulted in an avalanche of new forms of community therapy and rehabilitation. These were created chiefly by people employed in social assistance, including social workers. The second decade began with the process of Poland's accession to the European Union and was associated with combating drastically high unemployment (in 2004, the unemployment rate was 19 per cent). It consisted in adapting active social policy solutions, promoting the employment of people with disabilities (including mental disorders) and implementing the idea of social entrepreneurship. These activities involved primarily civic organisations cooperating with social assistance institutions. In the recent decade, a gradual increase in the activity of people experiencing a mental crisis can be noticed – mainly related to the reduction of social stigmatisation. In Poland, new forms of their social activity are sought, which may be based on seeing the experience of the crisis as a resource. In recent years, people with experience have appeared in the public space as: advocates for patients' rights; conference participants; people educating about illness and mental health; and, finally, participants of training courses designed to prepare for a new professional role called 'recovery advisor' (Kaszyński, 2010). It should be emphasised that part of the psychiatric community consistently strives to form a culture of treatment based on local communities. However, singular environmental treatment projects are still pilot solutions financed mainly from European funds.

What is important is that, remarkably, over 20 per cent of children and adolescents whose parents use social assistance suffer from mental disorders. Among families with children that do not use social assistance, the figure is 13 per cent (Moskalewicz and Wciórka, 2021). The burden for social workers will gradually increase due to the social consequences of the COVID-19 pandemic and the mass migration of Ukrainian citizens due to war. In this context, studies on social work with people experiencing mental crises, and especially those based on the perspective of service users' involvement, which is scarcely represented in Poland, are particularly important from the perspective of reflection on the potential directions of development for professional practice.

Background

Recovery is commonly defined as a deep personal process of reforming: (1) professed values, life goals and ways of achieving them; (2) the importance of individual experiences and related emotions and feelings; and (3) the ways of fulfilling key social roles, as well as acquiring and employing necessary social competences (Anthony, 1993). According to Leamy et al (2011), detailed issues related to recovery that are relevant to clinical research and practice are as follows:

- connectedness (for example, peer support and support groups, positive relationships, experiencing support from others, and the feeling of being part of the community);
- hope and optimism about the future (for example, belief in the possibility of recovery, motivation to change, hope-inspiring relationships, positive thinking and valuing own success, and having dreams and aspirations);
- identity development (for example, identity enrichment, rebuilding/redefining a positive sense of identity and overcoming stigma);
- meaning in life (for example, valuing mental illness experience, development/enrichment of one's own spirituality, improvement of the quality of life, discovering the possibilities and meaningfulness of social roles and goals, and a sense of life rebuilding); and
- empowerment (for example, a sense of personal responsibility, control over life and focus upon one's own strengths).

It is worth paying attention to the elements considered particularly important for the recovery process. Above all, hope is one of them. It appears very often in definitions of the recovery process, especially those that were created autonomously by people who have experienced mental illness (Lysaker et al, 2005). Experienced persons also emphasise that in this process, it is also important to distance oneself from psychiatric etiquette and rebuild one's own independent identity (Deegan, 1997).

From an individual point of view, the issue of 'small successes' and small joys of everyday life appears more and more often in the accounts of people with the experience of a mental illness. It is about small steps on the way to life satisfaction and a sense of being the actor. These can be called 'micro-affirmations'. They are an important element positively influencing the effectiveness of the healing process. It is important to notice them and appreciate these seemingly unimportant and unnoticed elements (Topor et al, 2018).

To sum up the preceding remarks, it should be emphasised that the concept of 'recovery', despite the fact that it has been popular for a long time, still remains somewhat indefinite. Currently, based on many analyses of existing interpretations of this term, we can conclude that the most important elements included refer to the feeling of independence, hope, valuable interpersonal relationships, social support and empowerment (Doğan et al, 2020).

The theoretical framework adopted in the study for research on recovery is the concept of the sense of coherence by Aaron Antonovsky (1987). It can be understood as a relatively permanent, specific property belonging to an individual, being a global, complex, individual life orientation or otherwise a set of certain internalised beliefs of a given person. These beliefs include a sense of 'comprehensibility', 'manageability' and 'meaningfulness'. The former is responsible for perceiving reality as elaborate and explainable; the second is responsible for believing that we have effective ways to cope with the world; and the third relates to the belief that life – no matter what the circumstances – is always worth our emotional involvement. Aaron Antonovsky emphasised the key importance of meaningfulness, arguing that people with a strong sense of meaningfulness will be very interested in understanding what surrounds them and finding the right resources.

It should also be emphasised that the broader theoretical reflection on salutogenesis (Mittelmark et al, 2022), including mental health issues, is essentially convergent with the understanding of recovery. First, a common element for mental health/recovery is emphasising the positive meaning of broadly understood human spirituality: the belief in the meaningfulness of reality, having hope and faith, and formulating positive beliefs. Second, mental health/recovery is a dynamic, processual and complex phenomenon that encompasses experiences lived through and valued as positive (happiness, profit, well-being and wholeness) and negative (unhappiness, loss, lack of well-being and emptiness). The third aspect concerns the salutogenic orientation, which is the foundation of Aaron Antonovsky's theory, as well as of reflection on recovery.

Previous research conducted on the topic of study can be divided into three groups. The first includes studies that emphasise the importance of taking biomedical factors into account when analysing recovery. The fact of illness symptoms and treatment (and the conditions in which it is carried out) are key variables determining recovery (Jacobsen and Greenley, 2001; Wood et al, 2010). In the second group, studies refer to the cognitive-behavioural perspective, according to which recovery should be seen as an intersubjective activity of positively defining/redefining everyday life, despite the presence of illness symptoms and treatment (Leonhardt et al, 2017; Barbic et al, 2018; Pahwa et al, 2020). Finally, the third group – which is part of the dialogical approach – places issues of making sense of past life experiences and life as a whole at the centre (Anthony, 1993; Huguelet et al, 2007; Topor et al, 2018). The search for factors enabling and strengthening health despite the state of illness, unfavourable circumstances and social barriers remains the axis of activity of experienced people and social workers, regardless of whether it concerns preventive healthcare, broadly understood therapy, scientific research, education or health policy.

Method

Research problem

The article offers an analysis of understandings of recovery in a group of people diagnosed with schizophrenia and the determination of what actions responding to the needs of experienced people should be undertaken by social workers in specialised support institutions to strengthen the individual pursuance of recovery.

Research context

The study was undertaken as part of the training programme conducted by the Maria Grzegorzewska University in Warsaw during 2019–21 entitled, 'Advisors for recovery. Support for the process of recovery and social activation of people experiencing mental crisis', co-financed by the European Social Fund under the Operational Program Knowledge, Education and Development 2014–20. The aim of the project – the first such in Poland based on the concept of recovery and carried out by a university beyond institutions related to psychiatric treatment and social assistance – was to improve the skills of experienced (mentally ill) people in supporting other patients. The course included 100 teaching hours during five weekend meetings. It was run by academic teachers, and after the test, the participants received the 'Certificate of Recovery Advisor'.

Research group

Out of 180 people participating in five sessions of the training, 29 people diagnosed with schizophrenia who participated in the first two stationary sessions were enrolled in the study. The next three sessions were conducted in remote or hybrid mode due to the restrictions related to the threat of the COVID-19 pandemic.

The group consisted of 15 men and 14 women aged 20 to 65, without a clearly defined prevalence in terms of age or education. The participants had little professional experience. They were hospitalised many times in inpatient psychiatric wards – the vast majority of them were hospitalised for the first time between the ages of 20 and 30.

In terms of categories used in medical diagnostics, the mental crisis experience by the project participants was most often described as 'schizophrenia'. Such a diagnosis was made in 21 people, among which 12 were diagnosed with the paranoid form. Two people were diagnosed with a medical condition, the basis of which was a periodic dominant experience of severe anxiety and depression. The picture of the disease in six people had not been clearly defined, with the diagnosis of schizophrenia being uncertain. It was accompanied by descriptions of personality difficulties, which formed a background for individual experiences typical of schizophrenia, anxiety and states of depressed mood.

Research method

The qualitative method of participatory research was used (Askheim, 2022), which constituted an important element of the training activities carried out under one of the training programme modules entitled, 'Empowerment and Recovery', which lasted 20 hours and was led by a social worker and research coordinator. Two techniques were used: (1) projection, which consisted in preparing written materials, including photos; and (2), based on individual experiences, the group searching for the essence of understanding recovery.

In the first, introductory part of the 'Empowerment and Recovery' module, which lasted seven hours and was conducted in the form of a moderated discussion, participants of the training defined the key terms they selected that, according to them, describe the essence of recovery. During their work, they relied on their own experience of illness and recovery, as well as the experiences of co-participants of the training.

After the introductory part, participants of the training were asked to perform a task consisting in preparing individual, synthetic descriptions based on their experiences, focusing on four issues. The first was about the essence of the mental crisis. Another was an attempt to identify how others can help the affected person. The third related to mental health recovery strategies. In this area, the request to the participants of the training concerned not only the preparation of a short, written statement but also the taking of a photograph of an object that is a personal symbol of recovery for them. The chosen item was supposed to be emotionally important, accompany the person in their life and be part of their environment. The final issue that was to be the subject of contemplation by the project participants concerned grasping the meaning of institutional forms of support. The participants had up to three weeks to complete the task.

The second part of the module, which lasted 13 hours and was prepared and presented by the person conducting the classes, was focused on the

generalised (anonymised) presentation of the results of the completed task and group re-discussion on individual areas. In the course of discussions and group arrangements, the dominant semantic lines outlined in the analysed statements and the semiotic focal points relating to the depiction of the issues of recovery were distinguished. After an introductory lecture on the main assumptions of the theory of salutogenesis, the results of the work were related to the conceptual framework defined by three key concepts for the sense of coherence: 'comprehensibility', 'manageability' and 'meaningfulness'.

The training programme started in 2019. Participants in the 'Empowerment and Recovery' module participated in the study from April to June 2019. The individual parts of the training module took place in subsequent months (the first part of seven hours in April; the second part of 13 hours in June) so that the schedule allowed participants to be introduced to the study and to prepare and develop written/photographic materials for further analysis.

Data analysis method

The data analysis relied on the use of focus-group interviewing as a technique supporting teaching-based research (Linhorst, 2002; George, 2012), which enabled the optimal use of the competences and knowledge of the experienced persons participating in the study. The data analysis was carried out during the second part of the 'Empowerment and Recovery' training module.

The written material (including the photos) obtained from 29 study participants was anonymised by the social worker coordinating the study and developed into a unified and legible graphic form. The developed material was sent by email to the participants of the study with a request to read it and pay attention to those elements that were crucial for defining the essence of recovery in their opinion.

The written material was analysed in four focus groups composed of study participants. These groups were supported by a social worker and a participating psychologist. Each group consisted of seven to eight people. The selection of participants for the groups was random. The introduction to the work of the focus groups included: (1) a synthetic outline of Antonovsky's three categories of the concept of a sense of coherence ('manageability', 'comprehensibility' and 'meaningfulness'); and (2) the presentation of the group task, which consisted in:

- assigning written research materials to one of the categories of coherence;
- assigning original names to the categories, which made them more detailed and/or more precise; and
- preparing a ten-minute presentation summarising the group work, the aim of which was a synthetic description of recovery.

Each of the four focus groups (working in parallel) received one of the two previously prepared sets of 14 and 15 different written materials (including photographs) for analysis. Thus, each set was analysed independently by two groups.

The results of the work of individual groups, presented to all of the participants of the study, were again discussed and agreed upon by all participants. The course of the discussion was moderated and recorded (in the form of mind maps) by the research coordinator.

During summary discussion, for each of the indicated categories of the sense of coherence, the participants of the study chose the most appropriate original name and photograph illustrating it by reaching a consensus. Participants also had the opportunity to submit additional reflections on the recovery process, supplementing the analysed written material. Importantly, the participants of the study expanded the originally assumed analysis of the recovery process, referring to three categories of the sense of coherence in the course of the discussion. The modification – worked out through the systematic condensation of meaning (Malterud, 2012) – pertained to the 'manageability' category, which was operationalised in three separate thematic blocks, named 'action', 'calming' and 'relationship'. The other two categories – 'comprehensibility' and 'meaningfulness' (named 'passion' and 'memory', respectively) – were not further differentiated.

Ethics of the study

The participants of the training were invited to the study and – after presenting its purpose and its connection with the training – asked for their consent to participate in it. The refusal to participate in the study did not require resignation from the training. It was possible to participate as an observer, commentator, participant in the discussion and so on. The research process was supervised by a psychologist present at all group training meetings. We would like to emphasise the role of the social worker as a person who not only coordinated the research but also took care of compliance with ethical standards for participatory research. The adopted methodological decisions were analysed from an ethical point of view, specifically, that the course of the research should not contradict the assumption of the subjectivity of the people involved in it. Efforts were made to involve respondents in the research process as much as possible. In this regard, we highlight the discussion of the structure of the individual research assignment, the choice of focus groups as a key element of data analysis and the joint discussion and formulation of the first results of the study.

Results

When presenting the results of the joint discourse of all the research participants, which was focused on individual written materials, including photographic works, it should be stated that there are many ways to recover, as well as different ways of understanding its specificity. In the course of the analysis of individual photographic works and related descriptions, five categories were defined that most fully reflect their specificity: (1) 'action', (2) 'calming', (3) 'relationship', (4) 'passions' and (5) 'memory'. Differentiating the categories was a group process of searching for an 'existential foothold', which enabled experienced people to gradually regain control over their life and enter the path of recovery.

Action

The first issue, which corresponds with the subjects from the 'action' category and definitely dominates others with its pragmatism, concerns the discovery and consistent use by patients of a safe method that enables establishing and maintaining relationships with others. The author of one of the works presented a computer that is ready to

work. The photo is coloured. When the computer is turned on, it stands on a tidy, almost empty, desk with only speakers and a lamp. It can be assumed that this is the ill person's workplace. The icons displayed on the desktop are not organised; rather, they are arranged quite freely in the screen space. In the description of the work, its author stated: "I started becoming ill at the beginning of the computerisation era. At that time, I was already aware of the rapid development of computer science and of my deepening deficits in this area." For this man, noticing this fact was the beginning of consistent and long-lasting learning to work with a computer. The computer has not only become a tool for accessing people ("Despite their general sympathy, my colleagues were surprised at my questions, which resulted from ignorance combined with illness anxiety") but also made economic activity possible, resulting in greater social independence. Increasing information technology (IT) competences had another important function: it was a clear and operationalisable criterion of a gradual recovery of health. The computer was a tool of direct access to people, or, more precisely, it created a conversation about everything related to the field of computer science. The man consistently created a common narrative space, enabling what is extremely difficult for experienced people: taking up and maintaining daily conversations. It should be emphasised once again that it is of fundamental importance for the recovery of health that the patient defines an individual way of being with others, the basis of which is personal commitment to what is important to them, gradually experiencing a positive change in self-image and acquiring a belief in the ability to establish non-threatening relationships with others, that is, the right choice of 'the right point of view and moment'.

Calming

Another issue of getting out of the crisis and recovering is related to the patient's need to recognise their own emotional space, which was often beyond their control as a result of experienced harm, social stigma or a borderline sense of loneliness. Violent, unexpected and surprising experiences leave wounds that take a long time to heal and can be reopened by a seemingly trivial event. Hence, the presence of others is perceived by patients as a source of potential pain, is associated with a fear of closeness and is infused with a persistent distrust. The search for ways to rebuild social ties – the aforementioned method that should guarantee the patient's safety – becomes particularly important in this situation. It is a personal laboratory in which a person after a crisis looks for an answer to the question of whether they are able to control emotions, which are an inherent feature of every relationship with another person, and whether they have effective mechanisms of emotional self-control. One of the photographed objects (from the 'silence' category) – illustrating the challenge of regaining emotional certainty – is the cover of a notebook, which described everyday feelings during therapy for the patient: "In it, I described what happened to me during the six months of therapy, as well as after meetings. When I often feel sad or bad, I reach for this notebook and read more interesting descriptions. Then I feel much better."

Keeping notes, which can be called an 'emotional journal', is an example of consistent self-reflection for the patient in the therapeutic group – recognition, naming and the ability to be in the world of other people emotionally – which he identified as an important aspect of recovery. Therefore, it can be assumed that returning to

events from the past by recalling the entries made has a healing effect on the patient: it allows them to overcome difficulties and experience a sense of control over the emotions that appear.

The issue of patients shaping their own emotional space can be synthetically described as experiencing the ability to control one's own instincts, searching for a personal emotional order and learning the rhythm of experiences shared with others.

Relationship

The self-giving gesture seems to be the most desirable attitude towards people experiencing mental crisis. Attempts to unravel the mystery of recovery, including, first of all, capturing the turning point at which the gradual process of regaining internal control and influence on reality begins, are often associated with the seemingly banal conclusion that the presence of another person is the most important thing. Patients emphasise that the key is the ability to establish a 'careful relationship' with them, revealing what is special and unique about them, as well as a 'small gesture', which is an expression of the authenticity of others. The third distinguished category of objects (defined by the word 'relationship') illustrates the phenomenon of meeting another human as not only a breakthrough fact in the history of the crisis but also giving hope for the future. An example is a photograph of a drawing showing "two hands, one helps the other to get out from behind the wall" between tightly adhering bricks. The picture raises some anxiety, which is related to the layout of the hands, clearly indicating the search for contact, a call for help – rescue – with the simultaneous inability to reach for it:

> 'That's how I was sitting, behind the wall. Closed in fear of the world of people, other people and the tasks of the future. I tried to get out of it, work on it myself. I have met many valuable people, but they, while helping, were losing patience with my problems and behaviour.'

Only accepting the presence of co-patients brings a significant relief: "We accept you as you are, whether you are a closed or open person." The wall began to crumble. The woman met others seeking understanding and made friendships that "continue to this day". Allegorically, this transformation can be compared to being born again and experiencing unconditional love on the part of significant others, as well as to the subsequent learning that the gift received requires reciprocity.

Patients take up the challenge of opening themselves up to others, despite the risk of being wounded again; they see that they are (also) the architects of the walls that separate them from their surroundings and they may question the necessity of living cornered and the fear of undefined human attack. They often idealise the attitudes of significant others (especially healthy people) who accompany them in their recovery, ascribing the features of 'readiness to unconditional sacrifice' and 'maternal protection'. The challenge is then to look for a balance between the patient's unconscious aspirations for symbiotic closeness with another human and a simultaneous sudden need to break all relations with them. The patient's longing for a state of perfect safety, in which the boundaries of 'self' are unnecessary, is connected with the memory of being deeply wounded by relatives.

Passions

The fourth issue that was distinguished on the basis of the analysis of written/photographic material by the participants in the project (this time included in the 'passions' category) concerns the rebuilding of an individual sense of identity, the coherence of which has been damaged to a varying degree by the mental crisis. Incredibly often, the history of life is described by experienced people in a dichotomous way. What happened before the crisis is sealed off from life after it happened. The symbolic turning points are usually a visit to a psychiatrist with pharmacotherapeutic recommendations, psychiatric hospitalisation or sudden and unexpected changes in everyday behaviour. Moreover, thoughts about oneself become dominated by facts relating primarily to various aspects of being a 'psychiatric patient', which gradually become the only available narrative of one's own life history, permanently displacing other aspects of it. Sometimes, the ill try to free themselves from its hegemony. The essence of these efforts is to find a line between the pre-crisis and post-crisis self, the glue that will turn two stories into one. Sometimes, it is a passion for creating:

> 'As long as I have good eyesight, I will paint. I have painted all my life. There were times when I had a hiatus, but I kept going back to painting. In illness, other things ceased to be important. I couldn't go back to them anymore because they were too difficult, and painting and drawing have stood the test of time. I have always had the courage to create something new, to mix colours. Better or worse works were created, but they were. Now I have the feeling that I have not wasted my time. I have my style.'

This quoted description, accompanying a photograph showing artworks and painting utensils in an expressive way, is a testimony to the coherence of the self, where the love of creation is opposed to the destructive power of the crisis. The crisis did not touch what the ill person loved most about herself. It did not hit the source of self-love and self-esteem: the need to leave something behind for others. Manifestations of self-love, intertwined with expressing it towards others, are part of a creative attitude that allows not only overcoming a mental crisis and feeling the continuity of one's own life history, but also transcending oneself as a mortal being, or believing that 'I shall not all die'.

Memory

The last of the distinguished ways of presenting the issue of health recovery concerns the need of the patients to positively recognise their own past. Undoubtedly, the most difficult issue here is the ability to eliminate the sense of being hurt, which has often been strengthened over the years. On the one hand, that can be understood as the only available and stable point of reference for the patient's assessment of their life so far and for planning the foreseeable future as a substantial element of their identity. However, on the other hand, 'harm' can be a significant barrier preventing or significantly limiting personal development, for the core self draws from the memory of being hurt, which becomes an imperative of endless returns to the moments when another person became a source of suffering. Nevertheless, this issue can be viewed from a different angle. A symbolic recalling of past events in a crisis may be

perceived as opening a specific dialogical space that will allow us to consider not so much the moral responsibility of others for hurting the ill but, above all, the patients' responsibility or potential to forgive: "Am I to wait for my father's repentance to forgive him? He won't change, and even if he does, it'll take him forever! I can change. I can learn to forgive and eventually do it."

The willingness of experienced people to work morally on the responsibility to forgive those who have hurt them seems to be a sine qua non condition for them to gradually extract positive elements from their life history and use them as a resource that enables them to regain their mental health. The past is then no longer a statuesque monolith of experiencing harm; rather, it gradually begins to change with a tangle of individual episodes, small facts and flickering emotions that make it possible to affirm the past.

Recalling the past by the ill, remembering it, relating to what is happening in the tangible present and trying to make memories coherent is a process that strengthens human identity and thus opens it to the future. The ability of patients to recognise the past positively – as a period in which despite being marked by suffering, they were engaged in meaningful activity, had the opportunity to influence the course of events and were able to organise reality – makes them capable of waiting, caring and hoping for the future.

Summary

Based on the analysis of objects symbolising the path of recovery and their short descriptions, five specific categories were distinguished to include various meanings ascribed to the process of mental health recovery. The first category – predefined by the term 'action' – includes the possibility for people who experience a crisis to experience themselves as having effective ways of interacting with other people.

The second category – described as 'calm' – concerns experiencing the ability to control one's own emotional space, organising it by naming experiences and understanding the rhythm of their appearance and disappearance. A sense of emotional self-control and control is essential for them to open more intentionally towards other people and to experience relationships of trust, acceptance, friendship and love.

Willingness to accept another person and experiencing the pleasure of their presence is the third category – described by the word 'relationship' – which corresponds to recovering mental health. Its essence is for the ill person to experience themselves as related to others.

The ability of experienced people to shape and maintain volitional bonds with people is also important for the next of the distinguished categories, described by the word 'passions'. Its essence can be reduced to understanding mental health as regaining the coherence of the 'self', which was damaged or broken during a crisis. This is possible thanks to discovering those emanations of one's own identity that would be able to connect two worlds: the one before the crisis and the one after its occurrence. Discovering clear lines connecting the hitherto history of life by an experienced person is fundamental to feeling that their existence has been, and still is, coherent and meaningful.

Discovering a balanced 'remembrance of oneself' (the last category) as a person periodically active and passive, and committed and withdrawn, realising their own

passions and plans, and resigning from them is healthy and gives hope for achieving a similar state in the future. This is not to return to the past – patients are aware of the changes that have occurred and are taking place in them as a result of the crisis – but to achieve a new quality of life.

In order to generalise the conducted analysis, the focus of which was to capture the phenomenon of recovering mental health by experienced people, it should be pointed out that its essence is experiencing oneself as a person who is:

- effective in establishing and maintaining relationships with others;
- emotional, that is, capable of controlled emotional openness;
- related to others in a 'close distance' manner;
- identical, that is, perceiving the story of their life as a coherent whole in which the mental crisis was an important, but not a key, event; and
- affirming the past, which is the basis for initiating dialogues regarding responsibility for the possible forgiveness of suffering inflicted by others.

Ultimately, the basis of recovery is satisfying a specific category of five needs: (1) effectiveness, (2) emotionality, (3) connectedness, (4) coherent identity and (5) affirmation of the past. A certain pool of personal experiences gained over the course of this process is the source of the formation of internalised beliefs that – again referring to the findings of Aaron Antonovsky – can be described as a sense of 'manageability' (resulting from satisfying the first three of the aforementioned needs), 'comprehensibility' (relating to the need of 'identity') and 'meaningfulness' (relating to the need to 'affirm the past').

The results obtained can be the basis for further research into the possibility of the development of clinical social work embedded in the theoretical model of Antonovsky. This model is a potential basis for the implementation of social work aimed at meeting the specified category of needs. We are talking about a spectrum of influences, from those that allow patients to survive despite unpleasant experiences and not naming them, through building relationships focused on experiencing oneself in a safe social context, to those that allow them to work through past and present difficult experiences and the emotions associated with them. On the one hand, experienced people appreciate the opportunity to engage in a variety of activities related to daily life, but on the other hand, they also need deeper conversations about past events and their impact on the present. This study based on a small and homogeneous group – which is a key limitation of research – tries to contribute to the possible creation of a wider model in the future, which could then contain wider theoretical approaches and greater research attempts.

Discussion

Relating the results of the research to the three groups of studies conducted in this topic (as previously distinguished in this article), the following should be emphasised: (1) the biomedical component is practically irrelevant for recovery (the fact of the occurrence of disease symptoms, treatment and so on), which is quite common in studies undertaken from a 'non-medical' perspective; (2) the component relating to everyday life is important but only when 'ordinary everyday activity' leads to the implementation of autotelic values, which is especially essential (this corresponds

to the findings of Torgalsbøen and Rund, 2002; Griffiths, 2008; Doğan et al, 2020); and (3) recovery is a dialogic process, and at its centre are the issues of the meaning of previous life experiences – usually, those related to the fact of harm – and the possibility of 'positively' inscribing them in individual biography (this corresponds to the findings of Leamy et al, 2011; Slade et al, 2019; Cripps and Hood, 2020). It should be added that the conducted research emphasises the special importance of 'work on forgiving experienced hurt' for the recovery process, and this aspect is a new perspective in recovery studies.

The outlined perspective of mental health recovery can be understood as a possible basis for the development of clinical social work practice focused on conducting group dialogues with the experienced around recovery based on salutogenic talk therapy (Langeland and Vinje, 2022). They should equally concern the history of the person (experienced suffering and harm by non-recognition), hope for awakening (experiencing meaningfulness and turning to the future) and active adaptation aimed at using external resources of social support (Langeland et al, 2007).

It should be emphasised, however, that recovery can be defined from a different perspective (Wood et al, 2010), according to which the constellation of factors important to recovery also includes the expectation of having an influence on the medically recognised mental state (a reduction of the severity of disease symptoms and regaining emotional stability). Thus, recovery-oriented practice should include enabling access to environmental forms of psychiatric treatment and social support, which, in turn, strengthens the sense of coherence of the person with mental health challenges.

Rethinking the clinical practice of social work is needed in the context of one more and final remark regarding the results of the study. In most of the analysed photographic works and the descriptions attached to them, there is a specific common element that illustrates the phenomenon of health recovery: the practically total absence of therapists. Of course, many times, patients pay attention to them, emphasising their role as having medical knowledge and competence, and appreciating the impact they have had on their lives. Professionals are the kind of background that allows the definition of the place of action, that is, the starting social context in which the crisis unfolded, and allows the journey towards health to begin. A question should be asked as to whether such a state is the essence of recovery, which proves the subjectivity of experienced people, or the disturbing inability of professionals to adequately support the recovery process in line with the needs of patients. The second hypothesis seems to be more likely.

One reason is the constant willingness of social workers to activate paternalistic attitudes contrary to the idea of empowerment (Linhorst et al, 2002), which effectively excludes the impact of experience-based knowledge. On the other hand, we should not forget the barriers created in the academic environment where social workers are trained for the profession (Hodgson and Canvin, 2005). Suffice it to mention researchers' doubts about the extent to which 'individual stories of suffering' can be generalised and institutionalised to become the basis for functioning therapeutic solutions in mental health. Finally, the most important thing is whether, and to what extent, researchers and practitioners are ready to accept that professional social work – especially clinically oriented work – is equally based on evidence, values and knowledge derived from individual human experience. From a social work perspective, traditionally viewed academic knowledge is seen no longer as the only valid one but

as only a small piece of a much larger puzzle. Taking this perspective into account, the service users' involvement (Driessens and Lyssens-Danneboom, 2022) approach, including in the area of scientific research, has serious substantiation.

Conclusion

It is of key importance for social work carried out in cooperation with experienced people to detect, co-create and strengthen through conversation and cooperation all those situations in which the recovering person will be able to experience themselves as a person: (1) effective in establishing relationships with others; (2) capable of controlled emotional involvement; (3) connected in some way with others, the specificity of which is reflected in the phrase 'close distance'; (4) perceiving their life history as coherent, in which the mental crisis was an important, but not crucial, event; and (5) capable of affirming the past, which is the basis for rebuilding a sense of the meaning of life. Ultimately, in line with the postulates of the salutogenic model, an interview with experienced people about mental health challenges should focus attention on their adaptive abilities and, at the same time, the ability to activate environmental adaptations fit for those needs.

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