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When Young Adulthood Presents a Double Challenge: Mental Illness, Disconnected Activities and Relational Agency

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Introduction

Young adulthood is often imbued with fundamental existential questions of 'Who am I?' and 'Who am I supposed to be?'. This existential uncertainty is accentuated when everyday life is burdened by massive psychosocial or psychiatric problems and lived in an institutional setting within the frame of social-psychiatry. Young people living with severe psychiatric problems such as paranoid schizophrenia or personality disorders have to face not only general developmental tasks and challenges but also severe and bothersome symptoms, considerable side effects of medicine, and, not least, the social isolation in the wake of living with mental illness.

These young adults are thus faced with a continuous double challenge: they find themselves in the midst of the general challenge of building and mastering what we call young adulthood, developing an independent stance in life, building competences to meet the demands of this increasingly independent lifestyle, starting or completing an education or making the transition to adult work life, all the while building lasting relationships outside a family setting. At the same time, these young adults must cope with the extraordinary challenges that follow from dealing with severe mental illness. Often these challenges are so pervasive that a life outside the institutional setting appears impossible to participate in. This implies that the activities that are shared by their peers are often perceived as out of reach, which in turn may lead to further isolation or the feeling of living life on the edge of normality. In addition, self-understanding, along with

the motive orientation, is often shaped by a strong psychiatric discourse and an everyday life within various institutional settings, which in turn may hinder the very development that is being sought.

Treatment options are primarily organized within the realm of psychiatry and are often highly individualized. Despite this being helpful to a majority of young adults who are able to organize and manage their everyday life with mental illness with the help of a traditional psychiatric approach, it is not sufficient (or relevant) for others. It is this group of 'others' that this chapter concerns.

At a private social-psychiatric living facility in Copenhagen, a different approach is taken to life with mental illness with an emphasis on community, meaningfulness and what we could call reconnecting with others via joint activities. Treatment focus is turned upside down in the sense that what would be the focus in the psychiatric system, namely managing symptoms, taking medication on time and so on, is deemed less relevant and not put to the fore. Rather, everyday life is lived – and built – around *doing* things together and developing new motives for participation and engagements with and in the world. This approach draws heavily on cultural-historical activity theory and implies an alternative conceptualization of mental illness, as well as emphasizing the importance of building 'relational agency', as termed by Edwards (2005).

This chapter will propose an understanding of the young adults' problems as *disconnected activities* rather than mental illness and discuss the difference this conceptualization entails in relation to the concrete social-psychiatric practice. The ambition is to present a practical example of how to concurrently co-explore what matters to the young adults and co-create a mutually meaningful community through which motive orientations and capabilities to meet the demands of young adulthood can be developed.

Social-psychiatry: An institutional setting of developmental possibilities and impediments

To frame the social-psychiatric practice in question, I shall briefly give an account of the structure of the Danish psychiatric system. The system comprises three independent organizational units that are all part of the public welfare system, albeit with different organizational anchorage. Psychiatric hospitals and outpatient psychiatry are part of the health care system and organizationally connected. In addition, we have social-psychiatry, which is organized under the

social system. Social-psychiatry grew out of a tradition of social work and hence has a focus on building competences for everyday life, outside of a hospital setting. Social-psychiatric living and treatment facilities may be public or private but all adhere to the same regulations for the area, and residency is financially covered by the municipality, as part of the social welfare system.

Social-psychiatric work centres around the challenges of everyday life with mental illness. This implies that the work effort is concurrently aimed at the residents' managing of symptoms of mental illness, as well as supporting them in building a meaningful everyday life for themselves – with the inbuilt imperative of moving towards an increasingly independent lifestyle. This is especially emphasized in the case of young adults, which this chapter will specifically discuss. In many ways, the fundamental imperative behind social-psychiatric institutions is thus developmental; people are assigned a stay with the specific goal of developing skills and competences for an increasingly independent life. In this way, we can consider the social-psychiatric living and treatment facility a developmental possibility in its own right.

At the same time, however, the way the institutional practice is organized means that it may also become an impediment for the very same development that it is supposed to support and facilitate. Allow me to briefly clarify this point: Because of the financial dependency on the social system, young adults are only granted a stay at a social-psychiatric living facility for six months at a time, which may then be prolonged. However, measures of progress and development are mandatory, which means that the social work carried out needs to be translated into concrete measurements of improvement. As a practical consequence, mental illness symptoms frequently become the pivotal point of conversations or work effort, as these are easily measured, and they become a conspicuous part of the institutional culture. Though repeated conversations about mental illness may be an important part of recovering or regaining a sense of control over one's life situation, it may at the same time foster an activity structure around having a mental illness, which in turn implies a possible self-understanding tied to seeing oneself as mentally ill.

A stay at a social-psychiatric living facility is often preceded by encounters with the psychiatric hospitals, and often the young adults have already had what we could refer to as a considerable psychiatric career. This is strongly reflected in the young adults' self-understandings and therefore also in their motive orientation and their perspectives for life. Few are able to formulate what they are directed towards or what they dream of – instead, they rely heavily on their

psychiatric diagnosis as both an explanation for their current life situation and predictor of their future. In addition, they experience the demands that they are faced with, if they want to participate in life outside the institutional setting, as too complex or out of reach. The result of this is a tendency to be resigned to or maintain a motive orientation that does not foster much newness.

Psychiatric diagnoses are often brought up as one of the first things, as a concurrent attempt to explain their current situation and an expression of a deep desire to be understood – or maybe even a way of disclaiming responsibility. As an illustration, one of the residents, Andrew, has adopted a self-understanding of being bipolar, which to him implies a life with certain restrictions, in the sense that all kinds of bodily arousal should be avoided. This implies alcohol and drugs, but also intimate connections with the opposite sex, especially if this involves strong feelings such as falling in love. His motive orientation is therefore deeply imbedded in a psychiatric self-understanding related to the avoidance of future manic episodes. As understandable as this may be, it may simultaneously prevent the development of a meaningful everyday life. We shall return to Andrew later.

The strong psychiatric discourse, the illness-framed self-understandings, the resignation and social isolation, along with motive orientations not meeting the general societal demands for an independent lifestyle, are among the core challenges we encounter in social-psychiatry. In addition, problems are individualized, both by the young adults and by the case workers with whom we collaborate, leaving limited space for reconfiguring the life trajectory of the young adult.

Reformulating the problem: From individualized to relational problem conceptualizations

The young adults we encounter in social-psychiatry often carry with them experiences of being labelled or even stigmatized, as problematic, difficult or mentally ill. This entails a rather unfortunate misconception: that the problem, in whatever shape it may appear, belongs to the individual. In turn, this conveys a deep insecurity in relation to their own sense of direction, of motives and basically of ontology: who am I and where am I going? Often previous meetings with the psychiatric system have led to augmented psychiatrically informed self-understandings, which may have the advantage of supporting a

compliant collaboration with the psychiatric system. Concurrently, however, this augmented psychiatric self-understanding often carries the disadvantage, in terms of development, of projecting a life in psychiatric terms – needless to say that this is neither inspirational nor stimulating for the motive orientation of the young adults.

To account for how we work to circumvent this challenge of individualized problem attributions, there are two issues that need to be addressed: the first pertains to the relational dimension of mental illness and the second to the role of motives.

The relational aspect of mental illness

I have no intention of providing an account of the history of mental illness, nor the diagnostic understanding of specific illnesses. Rather I will discuss the need to rethink our understanding and conceptualization of mental illness, in the light of a cultural-historical approach. The emphasis will therefore be on the possibilities offered by embracing this theoretical stance and the criticism that could be conveyed towards more traditional perspectives on mental illness will not be directly addressed. General conceptualizations of mental illness imply that it is *the person* (in the singular) who requires treatment, and the social or relational aspect that is inevitably inherent is most often obscured. By emphasizing a *relational aspect* as inherent, I simply wish to point to the fact that human lives are lived interdependently, as dialectically entwined, and mental illness must be comprehended accordingly. The idea of mental illness as a relational matter is not new and draws references to the work of Ronald Laing (2010), and more explicitly that of Erik Wulff (2013); Wulff theorized that schizophrenia was not an illness residing *within* the person but rather a manifestation of defective social relations (for an elaboration, see Holmboe and Risdorf, 2013).

Mental illness as disconnected activity: An attempt at reconceptualization

The idea of mental illness as a relational problem resonates with the work of Karpatschof (1989), who proposes to understand mental illness as *disconnected activities*. I shall briefly present his work as it provides a conceptualization of mental illness that has proved productive in relation to working with the young

adults. Drawing on Leontjev's notion of activities (Leontjev, 2002), Karpatschof argues that mental illness can be understood as *disconnection* from the activities that constitute personality: personality is anchored in the ontogenetically developed activity structure, thereby reflecting participation in a myriad of practices and intersubjective relations. Here, Karpatschof employs the concept of *integrated activities* to reflect the embeddedness of people's activities in a shared social meaningfulness, thus emphasizing the inherent intersubjectivity of the human lifeworld.

An integrated activity structure is neither a given nor a permanent condition, but rather something that must continuously be created and recreated – and its meaning renegotiated – in relation to the concrete challenges and dilemmas that life inevitably presents. The notion of *disconnected activities* describes the situation where the psychological pressure on the person has become so intense that it is no longer possible to maintain the activity structure in a personally meaningful way. Here, ontogenetic differences become evident as some people have less well-established social networks to draw on in times of adversity. A well-integrated activity structure allows for being momentarily thrown off-course by life events; however, for some people this may not be the case for two reasons: (a) the strength of the potentially traumatic life event may be too hard to handle based on the current activity structure and (b) the activity structure may be grounded in intersubjective relations and practices that may in themselves have been challenging, for example, growing up with sexual or physical abuse, severe bullying, poverty or parents' substance abuse. The people we encounter in social-psychiatry often present an unfortunate but very understandable combination of both, thus presenting ontogenetic histories of violence, abuse or emotional neglect, combined with social exclusion, drug abuse and futile friendships. This in itself does not *cause* mental illness, but it presents a risk, in the sense of contributing to a potentially fragile foundation for the personality.

To follow Karpatschof's argument, it is paramount to emphasize the foundational intentional or motive-driven aspect of the human lifeworld (see also Engelsted, 1995; Hedegaard, 2003, 2012); people are always being directed towards something in the world – towards building some sort of meaningfulness. In situations where that *something* can no longer be achieved (as the direction of the former integrated activities), new actions and activities are sought out to replace the meaningfulness that is no longer available. To exemplify, these could be attempts to cope with emotional fluctuations through various kinds of self-harm, such as cutting, self-induced vomiting, bashing one's head against the wall repeatedly or via the development of a large consumption of alcohol or drugs

(exceeding recreational use), just as it may manifest as obsessive or paranoid thoughts and actions, auditory hallucinations or a distorted sense of reality. This is what Karpatschof terms *disconnection*. Thus, he uses the same psychological dynamic – the foundational human directedness – to explain both the process of establishing integrated and disconnected activities.

Paradoxically, the process of disconnection is an attempt to *maintain* a connection to something meaningful and recognizable – an attempt to maintain the foundation for the personality. The dissolution of the personality structure equals a psychotic state of mind, where the grounding in a shared reality is left behind, and where disintegration of the self is ubiquitous.

Karpatschof's proposition to regard mental illness as disconnection is constructive in the sense that it does not reduce mental illness to either childhood trauma or unbalanced neurotransmitters, but instead insists on explaining mental illness with the same psychological dynamics as are involved in life in general and, thus, not as something qualitative different. A normative reading, however, may suggest that there is a sharp divide between a connected and a disconnected activity, which poses the question of who is to judge the quality or status of an activity – here I see an inherent risk of introducing a normativity in categorizing activities as either or.

To circumvent this potential issue, rather than adopting Karpatschof's terminology, I would propose the more dynamic formulation of *disconnecting* – thus replacing the adjective *disconnected* with the present participle *disconnecting* – to emphasize the active and dynamic process that is referred to. A *process of disconnection* serves to explain the manner in which the young adults describe *processes of disengaging* in shared meaningful activities, the *lack of motives* and a *general loss of meaningfulness* in their lives. So as to not lose their sense of self, and because they were unable to reconnect or re-establish their sense of connection with prior engagements, alternative actions arose that over time turned into activities, such as intensive (and perhaps excessive) marijuana use, obsessive-compulsive thought patterns or self-mutilating behaviour. It is neither pivotal nor therapeutically interesting to establish at what point in time these actions turned into activities and became all-encompassing in terms of the person's motive orientation. Rather, we need a terminology by which to understand this process in a way that opens up to ways of *reconnecting*. The notion of *disconnecting* presents a potential as it allows for a processual grip on a person's trajectory, without normative categorization.

Adopting Karpatschof's understanding of mental illness as a process of disconnecting thus creates openings in terms of treatment that transcends the

focus on merely alleviating or removing symptoms or changing behaviour, by emphasizing the need for developing new directedness or motive orientation for connecting with the world.

Motive development and co-creative processes in psychosocial work

The pertinent question of *who one is* and desires to become is central to working with young adults with psychosocial problems. This is so not because they have problems, but rather because this is a *general* question that many young adults are struggling with – and it thus presents a productive vantage point for collaboration. What are the motives for participation in different kinds of practices, or perhaps even the motives for the future? And if these are unclear, fickle or futile, as they often appear to be, then how can the development of motives be supported and nurtured through shared processes of co-creation?

Commencing collaboration with questions relating to interests, hopes and dreams transgresses the normative evaluation of the person and creates a space of possibilities for potential new actions, activities and, most importantly, meaningfulness. It allows us to emphasize the importance of creating or building something with one another – more so than engaging in mutually objectifying processes by making the other person the object of our work effort. Here, I draw references to psychosocial practices established by, for example, Vianna and Stetsenko (2011), Nissen (2006, 2012), Mørch and Nissen (2001), as well as Minken (2002). I will briefly touch upon a few examples, the first being Minken's work in Norway. Minken (2002) established a successful intervention project, where he organized therapeutic work around a joint interest in motorsports. This entailed an open-ended process perspective where the overall goal was to develop new motives for participation and, through this new activity, structures. Minken's approach emphasized psychosocial treatment as a goal-oriented activity *contributing to change* in a person's life; this implies that the person seeking treatment was not rendered an object for the professional's work effort, but rather that the person was *invited to participate* in activities that were continuously co-created and co-developed by the person, other young people and the professionals in relation to a shared interest in motorsport. Thereby, the young person could concurrently maintain and build agency and could thus become (or remain) the central agent in his or her own life. Through joint collaborations on fixing bikes, practising driving skills and cleaning bike

engines, the young people not only acquired isolated technical skills but also became engaged in friendships and mutual dependencies in teamwork; learnt (meaningful) discipline; and developed new zones of proximal development by continuously expanding their skills and developing new motive structures. A shared interest in motorsport was thus made the catalyst for a collaborative project that opened up new possibilities for action and participation through which the participants could negotiate and develop new meaning sets – in relation to themselves, to others and to the world. To draw on Schutz's (2005) distinction between different kinds of motives, Minken's project facilitated motives that were *forward-directed* (rather than directed by the past) and thus aimed at building (and achieving) goals for the future.

Minken's approach underlines the need to co-construct new joint activities through which the young people can develop new motives, activity structures and self-understandings. Similar points are found in Stetsenko's proposition for adopting what she terms a 'transformative activist stance' in psychosocial work which emphasizes the co-creative, emancipatory and relational aspect of human development (2008, 2012; concrete examples are provided by, for example, Vianna and Stetsenko, 2011).

Another example originates in my own prior work (Borup and Pedersen, 2010a, b), where the co-creation of a joint home became the collaborative project in a social-psychiatric living facility for young adults. Here, the gradual transformative processes of changing what to some residents felt like a waiting room into a place they could call home implied new ways of relating to one another along with new ways of participating. This in turn altered the ways in which the residents perceived not only each other but also themselves, and it gave way to new needs and motives that were impossible for either of the involved parties to conceive before we started out these transformative processes of co-constructing a home.

There are two important points here that resonate well with the work carried out with the young adults in Copenhagen: the first relates to an emphasis on the process itself more so than the end goal or result; it is through processes of co-creating something and relating to one another that new needs and motives arise, new activities are formed, and thus, in the longer perspective, new ways of being in the world and understanding oneself emerge. The second point is that to obtain good therapeutic results, one need not engage in ambitious activities, such as running a marathon or climbing Mt Everest. On the contrary, the transformative processes can be meaningfully found and co-created in everyday life settings, as I will now try to describe when turning to the concrete social-psychiatric practice in Copenhagen.

Supporting processes of *re-connection*

Young adulthood is full of contradictory invitations, demands and possibilities of whom to become and what to make of oneself, and carries an implicit expectation of individual responsibility for creating a meaningful path in life – especially in a time with a strong discourse of possibilities being endless (see also Pedersen, 2015). A majority of the challenges that young adults are facing relates to *how* to approach and act in such a space of possibilities and contradictions. Their future lies somewhere outside the institutional setting, which requires for them to develop both a motive orientation and the capabilities to handle a more independent lifeform and the inherent demands. Therefore, we need to support and create a zone of proximal development (Vygotsky, 1978) that allow for a young adult to relate to and approach the demands of the world outside the institutional setting. For some this implies developing a motive orientation enabling them to actually recognize and relate to these demands in a sensible manner, and for others it becomes a matter of developing specific capabilities to address the needs and demands they are experiencing. Should the social-psychiatric institution fail in relating to more general societal demands for young adulthood, the institutional setting in itself risks becoming an impediment for further development in that it creates a likelihood for the young adults to linger in what we could call a parallel society – a point also voiced by Bauman (2005).

Our work with the young adults is grounded in the conceptualization of mental illness as presented by Karpatschof, which implies an emphasis on supporting *processes of re-connection*: Re-connection to meaningful practices in which they can expand or build new self-understandings that allows for them to be *young adults*, and not primarily mentally ill. This endeavour is first and foremost facilitated and supported through the co-creation of a strong *sense of community* at the living facility, which theoretically reflects our grounding in CHAT and thus emphasizes the importance of the collective or the social in relation to facilitating individual development (see Vygotsky, 1978; Makarenko, 1974). On a practical level, establishing a sense of community is an attempt to model an ordinary shared housing arrangement among young adults, which implies having to coordinate and share the responsibility for indispensable everyday life tasks such as grocery shopping, cooking and cleaning. These activities are coordinated on the weekly house meeting, where the week is planned, and other joint activities are discussed and coordinated, such as trips, concerts, going to the movies or organizing a joint bicycle repair day. Besides

these practical coordinating tasks, the house meeting also serves as the venue to handle conflicts and to share and align hopes and dreams for what a shared future looks like; this is where the young adults, assisted by the staff, build *common knowledge* (Edwards, 2011, 2017, and Chapter 1 of this volume) of what matters in what we are doing with one another and how this micro-community is or becomes meaningful to all. I here take common knowledge as something to not only develop among professionals but also among the young adults and members of the staff – eventually also including the municipal case worker assigned to the case. Evidently, this is an ongoing and demanding task that is continuously challenged by the various backgrounds and experiences that the young adults bring to the table, and the fact that occasionally new people move in (and others out). Despite the difficulties that our insisting on a community in the house may bring, we recognize how the young adults share a directedness and desire to be part of a community, to feel at home and to have a place and a group of people to contribute to. A desire that is often disregarded when trying to understand the motives of people in social-psychiatry or other marginalized positions.

In our experience, the weekly house meetings serve as grounds for establishing relations between the young adults and even relational agency. The relational agency (Edwards, 2005) among the participants arises when they experience how it is possible to discuss and solve conflicts on a collective level, by sharing their perspectives and hopes with one another and in realizing that they may have more in common than what separates them. Or, in Edwards's words, it is the 'capacity to align one's thoughts and actions with those of others in order to interpret problems of practice and to respond to those interpretations' (Edwards, 2005, pp. 169–70). This fosters an enormous sense of belonging and a capability that not only adds positively to the individual self-understanding but at the same time supports relations *between* the young adults and helps form social connectivity.

In addition to the continuous focus on building and supporting the social connections through the emphasis on community in relation to a shared housing arrangement, there is a myriad of individual challenges and interests to meet. I will exemplify in the following pages.

Cheesecake therapy as means of building relations

When Karen moved into the house she had a hard time relating to the other residents; she preferred close and rather exclusive relations with members of the

staff, which was partly good in that it allowed for some relations to form and partly presented an enormous challenge in that the relations were so exclusive. At the same time, Karen had a very strong narrative of being severely personality disturbed, and she could explain all her actions by this reference. It so happened that Karen enjoyed baking cakes, which was a passion she and I shared. We therefore started spending quite a lot of time planning which cakes to make, baking them and serving them to the rest of the residents. It was thus a shared interest that could be used as a starting point for building relations – not only Karen's and mine but also relations between Karen and the other residents (who loved cakes and the fact that someone was willing to bake them). On top of this, our shared interest in baking was a way to co-develop our skills; I learnt a lot about experimenting with cheesecake flavours from Karen, whereas she learnt that a big part of baking cakes was the feeling of joy from contributing to the small community in the house. For her, our shared baking practice came to serve as a way into the house, as a way of becoming a member of the community as it granted her a position from where she could participate. Participation presented an immense challenge for her and was something where she needed to develop some skills in relating to others if she were to meet the demands of being part of the community. The interesting point here is that this development was possible because it built on Karen's already-existing motive orientation (baking cakes and relating to members of the staff), which meant that it did not feel like either an imperative or a criticism of her actions or lack of interest in the other residents. For some time, it was therefore more constructive, in a therapeutic sense, to spend my time with Karen collaborating on cake production in the kitchen, rather than having exclusive therapy sessions in the office.

Running shoes versus resignation

The experience of being faced with imperatives, criticism or demands that were difficult to meet were David's (one of the other residents) biggest challenges. Over time, this had led to an immense reluctance to do anything, a resistance towards what he experienced as an imperative to *change* and leave his self-understanding behind. David had long periods of time where he basically gave up on things, spent all of his time playing online games or programming stuff on the computer, as a repetitive action pattern that did not appear to lead anywhere. Various attempts to get him back to school had proved fruitless, and for every attempt he seemed even more resigned and often tried to sleep his day away – mostly to be out of the way of the staff, whom he felt were nagging him. David had

two main interests, one being computers and programming and the other being parkour. Parkour is an outdoor training discipline where movement in urban spaces is expanded to include running, climbing, swinging, vaulting, jumping, rolling, quadrupedal movement and so on, depending on what the situation or the environment allows for. It is a rather physically demanding sport, and David had thus refrained from actively practising it for quite some time, although he would often refer to it as something he longed to resume.

Over time, we managed to engage David in going running once a week, in a small running club consisting of him and me (or another member of the staff). He was in rather bad shape, but motivation could be found in relating it to his desire to pick up parkour practice again, for which he needed to be a bit more fit. The running sessions turned out to be excellent occasions for deep and meaningful conversations – about life, challenges, the meaninglessness of his current situation and how far away he felt from living the life he wanted. There was something about both of us wearing running clothes and being physically challenged that made an interesting break with the therapeutic set-up we were able to master back at the house. At the house we were always locked in our formal positions of psychologist and resident, whereas, when out running together these positions were not important; it was more important who could first make it to the next lightning pole or who could challenge the other person to run faster. During our runs, we would not so much talk about formal stuff, but more about music, concerts and dreams for the future. At times, we would walk rather than run because there was so much to talk about, or because one of us was out of breath. Eventually it evolved into a walking practice, where we would do long walks and reflect on life and the challenges that David was facing. The turn to the walking practice coincided with David starting an internship at a computer repair shop where he soon thrived and started perceiving himself as a valuable worker. This led to him regaining enough confidence to restart an education and stick with it. Our conversations then served as a joint reflection space of the challenges that were inevitably part of engaging in new practices, such as education, which was something we could both relate to.

As the brief examples with Karen and David demonstrate, it is not necessarily the bigger questions in life that need to be addressed in order to engage the young adults in developing their motive orientations, but more so it is often the minor aspects of everyday life that may serve as generative starting points for collaboration and the development of relational agency. It is in these small pockets of everyday life where we manage to find space for personal interests that motives for participation exceeding the current situation arise, and where

the foundation for new needs and motives can be built. In such relational encounters, agency is developed contributing productively to the activity structure, by ways of constructing or expanding it. Over time, this leads to new ways of participating, new relational embeddedness and meaningfulness, in other words, *re-connection*. This re-connection served to resolve the prior state of dis-connectedness that constituted the mental illness. For various reasons, Karen and David did not display explicit motives to participate in the social community at the house or to pursue an education. However, when their hobby-like interests enabled their building relations so that new ways of participating became possible, new motives for further participation emerged. And though this may seem banal, it targets the tendency to expect young adults in the social-psychiatric system to have clear motives for recovery, an education, a job – in other words, a normative lifestyle. And when they do not display clear motives there is a tendency to find them unwilling to cooperate, or impossible to work with *as* they do not present as *motivated* for development. We tend to forget that the societal demands required to handle an independent lifestyle outside the institutional setting may appear too enormous or out of reach – and the motive orientation to meet them needs to grow, at its own pace, from interests or joyful activities that are already present, in order to be meaningful.

Regaining a grip on youth life: New activities and self-understandings

A developmental challenge that presents itself when living with mental illness is tied to the prevalent psychiatric discourse. Evidently, the psychiatric discourse in itself is not the most prominent problem; however, it is an unanticipated developmental challenge that often proves difficult to overcome. The case of Andrew serves to illustrate this point.

Andrew had lived at the social-psychiatric living facility for a few years. In his late teens and early twenties, he had extensively used marijuana and he had been involved in various sorts of petty crime. Following an arrest and a trial, this lifestyle stopped abruptly. Andrew received a treatment sentence and was admitted to a psychiatric hospital. Here he was diagnosed with bipolar disorder, and over the course of two years at the psychiatric hospital he learnt to perceive himself as *vulnerable*. The logical consequence being that any kind of excitement or arousal should be avoided to avoid future manic episodes. Passivity and a general hesitant attitude followed and became Andrew's prominent mode of

being. This led to an array of existential questions for him in relation to the quality and form of life that he could envision for himself.

An intense search for new possibilities began and Andrew's passion for photography became the lever to engage in new activities: He started an internship as a photographer's assistant, which slowly allowed him to develop a motivation of his own to get up in the morning. Over time, the internship developed into an actual job, and gradually Andrew's self-understanding changed into seeing himself as more and other than mentally ill. However, the mental illness narrative, reflecting a strong psychiatric discourse, persisted in relation to a specific part of his life: that pertaining to intimacy and relationships. Andrew was determined not to become manic again so the idea of falling in love was a very remote dream and something that he had accepted was not in the cards for him, given his illness. Over time, as he regained a grip on his everyday life, this idea grew into a contradiction for him as he felt a growing desire to relate to the opposite sex. But he was scared, mainly because he was doing so well and did not want to jeopardize the sense of control that he had.

Instead of having our weekly session in the office, Andrew and I developed a practice of taking long walks and visiting different coffee shops in the city, while exploring the city by foot. It allowed Andrew to smoke without annoying me, and it allowed for the conversation to flow freely between us. We found that this sort of fluid reflection space afforded a more relaxed setting for reflecting on life's challenges together, than a traditional therapeutic session could have. Concurrently, it permitted an approximation of more general ways of talking about problems, thus, moving away from a psychiatric discourse and framework for life in general. In addition, it served to transgress a tendency to objectify each other as fixed positions (as therapist and client) and allowed for us to be two people sharing thoughts on life, albeit from different perspectives.

To return to Andrew's challenges in relation to relating to the opposite sex, it so happened that I was also dating at the time, and I used this as an opening for Andrew to relate to a world that he felt very disconnected from, by sharing some of my own observations and experiences. Gradually, he became motivated for actively engaging in dating, installing a dating app on his phone and relating to the girls with whom he connected. As with other challenges he met in his everyday life, Andrew would share his concerns and insecurities with me, and in relation to his newfound dating activity we would discuss the wording of concrete messages and answers. When messages consecutively turned into dates, we would discuss good venues, things to do and how to work around the fact that he was still living at a social-psychiatric living facility. As for most people,

the world of dating is full of ups and downs, and so it was for both Andrew and me; this we were able to share and use each other's input constructively in a joint exploration of and reflection on being part of the dating world.

What the case of Andrew serves to illustrate is that through our continuous walking and coffee-drinking sessions, Andrew and I developed a relational agency that allowed for Andrew to act on a motive orientation that before had appeared impossible to meet, given his rigid self-understanding as bipolar. In this gradual approximation of new activities, Andrew developed his motive orientation further and was able to leave behind what he referred to as a *disabled youth life*. The conversational space that was created between us offered a place for reflection and joint exploration of the challenges that Andrew – and to some extent I – was facing in the course of conducting our everyday life, in relation to work, establishing friendships and potential relationships, and also emancipating the barrier that a mental illness narrative had resulted in for Andrew. The example illustrates that putting an emphasis on rebuilding strong connections with other people and regaining a firm grip on everyday life is a very effective response to not only dealing with mental illness but also how a mental illness discourse may linger on and serve to prevent further engagements in young adulthood. It points to the requirements of the presence of other people to engage in relations with – relations through which concrete spaces for developing new stances in life are co-created that ultimately give way to new self-understandings. Concurrently, it underlines the importance of co-creating meaningfulness and content in life; this cannot be dictated from a position of superiority or knowing-better. Rather, it must be developed as a shared knowledge through the joint exploration of life's opportunities, conditions and demands, and through shared openness and a genuine interest in the other person.

Meeting the double challenge of young adulthood

The young adults we encounter in social-psychiatry are struggling to build a meaningful everyday life in liminal positions in between the challenges and opportunities of young adulthood, on the one hand, and a formal social system, on the other hand, that tend to narrowly label them as mentally ill, or primarily see their *functional* needs and abilities. This presents a challenge of how to best support their development, and ultimately their transition, from a life of narrow institutional dependency to a life of increased social participation and interdependency, and psychological well-being.

I would argue that there are no simple solutions to this, but that we need to emphasize the *processual aspect* of co-creating new possibilities for becoming as open-ended movements and not the implementation of a one-size-fits-all model. The human psyche is dynamic, closely related to the practices in which we participate, and our concrete and situated possibilities for action. Therefore, we need to co-create spaces for participation with one another, to facilitate the development of meaningfulness and agency. In dealing with mental illness, we need to assume a wholeness perspective rather than single out the aspects pertaining to mental illness, detached from everyday life practices. When succeeding in this endeavour, we see how young people (e.g. Andrew and David) manage to develop new ways of integrating their activities and establish new meaningfulness and purpose in life.

Narrowly focusing on mental illness symptoms, for example, by attempting to make the young adults discontinue their self-mutilating behaviour, doing drugs or repeatedly telling them that what they are thinking or experiencing is wrong, may very well spur resistance to collaborate, as these well-intended attempts to help are often experienced as attempts to remove or undermine a person's self-understanding – such attempts are thus often ineffective. When one feels under attack, a considerable effort may be exerted to maintain a recognizable image of oneself and the world however dysfunctional this may be. This was one of the predominant dynamics displayed by Karen when she first moved in. Building a new self-understanding is a long process of trials, negotiations and consolidation – it takes time to recognize yourself anew. The resistance and the conflicts that may arise are not dangerous or to be avoided; rather they should be seen as the main generators of development, because this is where new spaces for becoming arise. This is in line with key understandings of developmental dynamics within the cultural-historical framework (see, for example, Riegel, 1975; Hedegaard, 2003, 2009, 2012).

At the social-psychiatric living facility in Copenhagen, we try to support these developmental processes in relation to motive orientation, new activity structures and self-understandings that reflect being a young adult rather than mentally ill. In our concrete practice, these processes are facilitated and supported mainly by way of two central and interrelated agendas: (1) the continuous focus on building a sense of community and (2) building relational agency around motives or interests that are already present and using these as starting points from which to develop directedness towards and engagement with the world, and more specifically in relation to the demands that the young adults are facing in handling young adulthood.

Processes of re-connection are not an individual matter; they require the presence of other people, of concrete activities to connect to and engage with and a general feeling of belonging somewhere. The joint reflections with Andrew or David, or the cheesecake baking with Karen, would not matter in terms of individual development if taken out of the context of the community. And although the community that we co-create at the living facility may appear unambitious in its focus on basic reproductive tasks, it provides an important arena for developing social relations and acquiring some of the capabilities that are needed to handle general demands for young adulthood. This analysis underlines how developing individual agency in double-challenged young adulthood can be supported and accomplished through the building of shared or relational agency. Furthermore, it is worth remembering that a fair share of the young adults come with personal histories of emotional neglect or abuse and have a hard time relating to other people; acquiring such capabilities is certainly important groundwork for further development and is difficult to achieve without a community to relate to. In that sense, it is the *relational meeting* that is the essence of our work, and building meaningful everyday lives is our shared point of interest, addressing general challenges of young adulthood and its transitions together.

Mental illness may, in clinical terms, linger as a travel companion throughout life but it need not be an obstacle for building and living a full and meaningful life. What we find to be productive in embarking on this process of *reconnecting* with the young adults is for mental illness to lose its status as the primary descriptor of *who the young people are* and *what they can do* in life. Through joint processes of reflection on what constitutes community and what everyday life *could* and *should* look like for us, that very same community is developed and common knowledge of how to understand the concrete struggles, stories and symptoms of the young adults is co-created, contributing to a development of both individual agency and our shared practice.

Through engagements in shared activities and the building of relational agency, it is possible to overcome severe manifestations of mental illness. Methodologically, this points towards increased therapeutic emphasis on collective everyday tasks and on building relations around shared interests, questions and challenges. To employ a theoretical stance of regarding psychological difficulties as disconnecting activities rather than mental illness creates a space of possibilities; both therapeutically and practically. However, there is an inherent and continuous ethical challenge when working with development and motive orientations as it includes the risk of construing a

forced motivational project. This accentuates the need to engage in continuous and open co-explorations and reflections with the young adults on *what matters* and how to best ensure that our time together is meaningful.

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