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Residents' experiences of relationships with nurses in community-based supported housing – a qualitative study based on Giorgi's method of analysis and self psychology

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Abstract: One of the prioritizations in the World Health Organization's (WHO) Mental Health Action Plan 2013–2020 is the provision of community mental health and social care services, such as supported housing. The ongoing process of such deinstitutionalization has raised issues concerning the impact on users' quality of life. The purpose of this study was to explore how residents in supported housing experience receiving professional help and how they perceived their relationships with nurses. The second aim was to investigate the relevance of Giorgi's method of analysis and self psychology in analyzing these experiences. Four residents were interviewed individually. The interviews were based on a semi-structured interview guide and analyzed by Giorgi's method of analysis. Relations were interpreted within self psychology. The residents reported that they not only felt safe in the community but also felt a greater awareness of wanting to appear normal. They seemed to have an easier daily life and felt that the personnel met their selfobject needs when routines allowed for it. Professional awareness of empathic attunement and selfobject roles might enhance residents' self-cohesiveness. The interviews were analyzed by Giorgi's method of analysis, and the use of clinical concepts from self psychology was chosen to achieve a more dynamic understanding of the participants' relational experiences and needs in supported housing.

Keywords: mental health, nursing relationship, self psychology, supported housing, experiences

Introduction

This paper describes a qualitative study of residents in supported housing for people with mental illness. The aim was to identify residents' experiences of living in supported housing and, in particular, how they perceived their relationships with nurses in this new context of living. Supported housing is accommodation with 24/7 staff in private apartments for people with mental illness. In Norway, nurses in supported housing are employed as milieu therapists, even though they do other nursing tasks as well.

Giorgi's method of analysis was used to analyze and condense the actual text of the qualitative interviews. The method consists of five structured steps to analyze the meaning of a phenomenon experienced by the participants of a study.[1] We applied self psychology to analyze users' perceptions of this relationship and the therapeutic role of the nurses in milieu therapeutic settings located in supported housing. Self psychology is a theory that includes both a model of development and a model of clinical consultation and therapy[2] and is mostly used in individual and group therapy. It emphasizes the self as the crucial part of the personality and its dependence on

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relations with significant others that we experience as part of our self.[3] As both self psychology and qualitative research focus on subjects' experiences and interpretations from phenomenological perspectives, it was natural to combine these approaches in this study.

Literature on research and clinical application of self psychology in this context is scarce. Our hope is that this study may introduce self psychology as a useful means for understanding and creating awareness of the changing and dynamic role expectations that emerge in residents of supported housing.

Background

One major goal of the World Health Organization's (WHO) Mental Health Action Plan 2013–2020[4] is to provide care, improve quality of recovery and reduce disability for people with mental disorders. Toward this end, one option of the comprehensive Mental Health Action Plan is to provide complete, integrated and responsive mental health and social care services in community-based settings. This would include shifting the site of care away from long-term mental hospitals to community-based mental health care services such as supported housing.[4] Deinstitutionalization of mental health services has been taking place over the last 50 years. The last couple of decades have seen a marked increase in the creation of supported housing in the Western world, which suggests the importance of doing research on residents' experiences and the content of supported housing when it comes to the helping relationships.

Previous research

A recent literature search in the following databases: PsycINFO, ScienceDirect, MEDLINE, Google Scholar, CINAHL and ProQuest showed that the main foci of the international research were housing for homeless, physical activity in supported housing, supported housing schemes, recovery in supported housing and the effects and cost effect of supported housing and housing first. We failed to find any studies on the use of self psychology to inform therapeutic communication in supported housing. In fact, we found few investigations that focused directly on human interactions and communication in providing mental health services in this context. Neither did we find any studies that combined the use of self psychology and Giorgi's method of analysis to investigate experiences of helping relationships.

Relationships

Andersson[5] investigated the relationships between professionals and 17 residents living in supported housing in Sweden. The aim was to understand the impact of the helping relationship on perceptions of social support in supported housing. Data were collected by means of participant observation and interviews. Supportive relationships were defined to comprise a social climate that included a true interest in the individual, care, concern and respect. Supportive relationships were also described as "like friends" relationship. In unsatisfying relationships, the participants experienced being objectified and treated condescendingly. The author emphasized the importance for professionals to be aware and identify unsatisfying relationships and to replace the professional helper if needed.

Experiences

In two Norwegian studies,[6,7] clients interviewed other clients about living in supported housing. In the study of Westerlund and Bjorgen,[6] residents expressed feeling safer in the supported house than in mental health institutions. Despite this, they did not want to live in the supported house, because they wanted to be independent. They explained that rules and routines in the house made it difficult for them to be as independent as they wanted. Blaestervold et al[7] found that residents of a supported house reported that they were less frequently admitted to hospital, got more help in the home and felt safer there than in mental health institutions. The main reason given for feeling safer was that they felt they could ask staff for help at any time. Still, they experienced that rules and routines made it hard for them to feel truly independent.

Another Norwegian study conducted by Roos et al[8] explored how people with severe mental illnesses experienced living in sheltered housing. Fourteen residents participated in individual interviews (n=6) or group interviews (n=8). The main finding was that the participants experienced a high degree of safety and satisfaction because professionals were easily available, open for socialization and secured the users' right to withdraw. However, short tenancy agreements made some participants feel insecure. Nearly all socialized with other residents, but few outside the sheltered housing. Roos et al[8] advised service providers to be aware of what makes residents feel safe without developing a too dependent relationship with the staff.

In Sweden, Bengtsson-Tops et al[9] interviewed 29 residents concerning user experiences of living in supported housing. The results showed that the residents appreciated a place to withdraw and rest. They had mixed emotions about being brought together as a group against their will. On the one hand, they found that it was a sign of not being normal and forced togetherness; on the other hand, it was easier to be accepted by resident neighbors, because they shared mental

problems. Being part of a group also meant fellowship and belonging. They also described a limited life characterized by questioning one's identity, the feeling of inequality and leading a dull life with lack of stimulation. In sum, the residents experienced not only a sense of fellowship, safety, trust, privacy, relaxation and feeling well but also a sense of failure, relational addiction, being lost, dullness and bitterness. Bengtsson-Tops et al[9] suggested increased awareness of group processes in supported housing and that the staff should evaluate and respond to the residents' social and emotional needs.

Satisfaction

A Swedish study[10] investigated the degree of satisfaction with housing support in ordinary housing and supported housing with a sample of 370 residents. They found a high degree of overall satisfaction. However, the participants in ordinary housing were less satisfied with their social life compared to those living in supported housing, perhaps because the staff were the only social contact the residents had, compared to supported housing where the residents had daily interactions with staff and other residents. The study also showed that security, privacy and the residents' right to choose, where and how to live, were important in terms of satisfaction. Recently, Brolin et al[11] interviewed 20 residents of supported housing to develop a grounded theory of people with psychiatric disabilities, living in supported housing. The research question was: What is the main concern for people with psychiatric disabilities living in supported housing, and how do they resolve this concern? The main concern was being deprived of self-determination resulting in a subsequent process of striving for meaning. The authors concluded that similar experiences have been expressed by people living in psychiatric settings for a long time, and it still needs to be addressed to achieve the main goals of this sociopolitical reform.

Like the majority of research on supported housing, these studies were not observational studies that scrutinized human interactions and communication in this context of providing mental health services. This indicates a need for research on the experiences of users of mental health care services in supported housing with a specific focus on exploring the positive and negative aspects of this context for therapeutic processes.

The study

Aim

The principal aim of this study was to explore residents' experiences of living in supported housing, with an emphasis on their perceptions of the user–nurse relationship. A secondary aim was to investigate the relevance of Giorgi's method of analysis and self psychology in analyzing and understanding the users' experiences of nurses' roles in this relationship.

Design

Qualitative research is designed to study, describe and explain human experience, and interviews are used primarily to produce qualitative data.[12] The interviews in this study were based on a semi-structured interview guide and analyzed by Giorgi's method[1] of analysis. This method was chosen in advance before doing the interviews but did not influence the creation of the interview guide. The use of self psychology was used to further analyze the results generated by Giorgi's method.

The topics were decided prior to the interviews, but the actual interviews were informal and adjusted to each participant. This made it possible for the participants to share their experiences without interruptions. The interviewer intervened only if the participant needed help to continue. Before the end of the interviews, the interviewer ensured that all topics of the interview guide were covered. The main topics were receiving help in their own home, their influence on the service they received and possible differences between living in supported housing and an institution. They also reflected on the significance of their hobbies and social network. The topics were developed based on the subject of the research; the resident's experience. Since both the research question and the methodological approaches of the study focus on subjective experiences, other topics such as diagnostic information were not covered unless they were introduced by the participants in the interviews. Each interview lasted for 1–1.5 hours and was conducted and transcribed in Norwegian.

Participants

In this study, supported housing was assisted living facilities for people with mental illness. The houses had personnel on duty 24/7, and the participants had lived in them for at least 5 years prior to the interviews. As a first step, personnel in supported houses in five municipalities were contacted and given a brief description of the study. Next, residents were informed about the interview and asked whether they would participate. Since the residents lived in supported housing because of mental illness, it could be presumed that quite a few were too vulnerable to participate in the study. On that account, we were happy that four residents from two supported houses in two municipalities were willing to participate. They represented 20% out of a total of 20 possible respondents in these municipalities. Next, they received

detailed information about the study, confidentiality and how the information they provided would be used. Finally, they signed a written informed consent to take part in the study.

Two male and two female residents between the ages of 25 and 60 years were interviewed once, individually. None of the participants were married or had children, and none had ever participated in regular work life. Three of them had lived independently on their own during their adult life. One of them had lived in other supported houses, as well.

Ethical considerations

The Regional Committee for Medical and Health Research Ethics (REK) in Norway approved the project. Participation was voluntary, and each person was given understandable information about the project and its confidentiality on two occasions before the interview. They were informed that information or quotes that could be recognizable would be slightly changed to safeguard confidentiality and that they could withdraw their consent and withdraw from the study at any time during the project. The participants were advised to postpone or withdraw from the project and the interview if it began to cause them high emotional distress.

Data collection

The main subject in the interview was the subjective experience of living in supported housing. The principal topics were to investigate perceptions of the user–nurse relationship and to explore the relevance of self psychology in understanding the users' experiences. More specifically, we focused on residents' perceptions of receiving help in their own home, their influence on the service they received and possible differences between living in supported housing and an institution. They also reflected on the significance of their hobbies and social network. The residents were interviewed in their apartments to make the situation more comfortable. The first author, a mental health nurse, conducted the interviews as part of a master's degree project in August and September of 2013. Three of the interviews were recorded on tape. The last interview was not recorded completely because the participant felt stressed about the recorder. Instead, notes were taken. Each interview was rounded up by presenting a brief summary of the obtained information to the participants for comments and changes. The four respondents confirmed that the summary concurred with their view.

Data analysis

The first author analyzed the interviews by Giorgi's five-step method. It was chosen because it is a recognized and established approach and a structured method for analysis of qualitative data.[1] The first step was to transcribe the interviews from the audio files. Next, a short summary of each interview was made to get a holistic view of the data. To complete step two, the units of meanings were identified by re-reading the complete transcripts. In the third step, a densification of the meanings was created to refine the content. Next, the meanings that were similar were grouped together, and finally, all of them were assembled under several main topics. Self psychology was applied by both authors to analyze users' perceptions of their relationships and the therapeutic role of nurses.

Self psychology

Heinz Kohut introduced self psychology in the mid-1970s as a further development of psychoanalysis, and it is widely accepted as one of the central psychoanalytic theories.[13] It is a comprehensive theory that includes both a model of development and a model of clinical consultation and therapy.[2]

The self

The self, described as the central part of the personality, is an important part of the theory.[3] It consists of a person's feelings, thoughts, sensations and attitudes toward the world and himself.[14–16] Kohut described the self as a dynamic system consisting of three axes (the tripolar self). The function of the grandiose axis is to sustain a positive and stable sense of self-esteem. In normal development, this will emerge as the person's sense of self-worth, ambitions, commitment, self-assurance and accomplishment.[17] The twinship-seeking axis is described as the person's ability to communicate feelings to significant others, form affectionate relationships and become a part of a fellowship based on similarity.[16] The idealizing axis is referred to as a person's ability to create and keep a solid system of goal-setting ideals.[14]

Selfobject relations

Selfobjects are significant others or objects we experience as parts of our self.[3] Kohut[16] described how the axes of the self develop by interaction in selfobject relations to meet the idealizing, mirroring and twinship/alter-ego needs.

The selfobject needs for mirroring are the need to be valued by others and to be admired as well as to be confirmed by others.[3,14] The selfobject needs for idealization are the urge to create idealized images of significant others and to merge with idealized selfobjects.[13] The selfobject needs for twinship/alter-ego are the need to feel likeness to others and to be included in their fellowship.[16] Selfobject relations nourish the self's capacity to become or remain stable, so that a person can more easily achieve or maintain self-cohesion.[15]

Self-cohesion

Kohut[16] described the experience of a cohesive self as being a result of adequate development of the tripolar self.[13] Self-cohesion is described as a self that is stable and continuous. A feeling of confusion, imbalance, meaninglessness and vulnerability may be a sign of weakened or loss of self-cohesion. If a person's self is imbalanced or weakened, that person will more often experience weakened self-cohesion.[3] These people will have to use more energy to self-regulate to maintain a sense of a cohesive self.[13]

Affect attunement

Affect attunement is the first step in empathic processes. It means attuning to someone emotionally, trying to understand the subject of another's behavior rather than just the actual behavior. Attunement is a link between two individuals' inner worlds, and it involves adapting and sharing emotional states.[18] In self psychology, pathology is seen as a rejection of affect attunement from selfobjects, signifying that a person's emotional needs have not been recognized or met. A simple example is a person being sad, but having no one there to comfort him or her.[13]

Validity, reliability and rigor

Data from the interviews were influenced both by the researchers' views prior to the interviews and the perceptions they developed during the interviews. There is always a risk that preconceptions and even prejudice may bias interviews. One of the researchers in this study had worked in supported houses before. This may have influenced the interview, even though the researcher was aware that it could be an issue. We did not find any research on resident–nurse interactions that used a combination of Giorgi's method and self psychology. In spite of this lack of research to support our methodology, we believe that three factors counteracted this potential bias: 1) the rigor of the steps in the qualitative method, 2) the use of self psychology to better understand the users' perceptions of relational aspects, and 3) having two researchers in the selection of user perceptions and thoughts, as well as in their interpretation. Finally, the use of only one interviewer may have enhanced consistency across the four interviews.

One of the methodical limitations in this study is the low number of participants. The low number of participants in the study could be a disadvantage. A small number of perceptions or voices may lead to a biased and insufficient understanding of a phenomenon. Regarding participants' recruitment, the authors did not know exactly how staff asked the participants to join the study and did not take any measures to prevent staff pressure in the recruitment process. However, there were no signs of involuntary participation during the interviews, and we are convinced this would have surfaced if pressure had been exerted. The fact that only two supported houses are represented in the study could also be an issue. In addition to this, as the residents' experiences were not directly observable, data depend on the participants' ability to reflect on their experiences and to communicate about them during the interview.[12]

Findings

It appears that most of the residents were satisfied with their living situations. The context of supported housing encouraged the residents to take independent decisions concerning their lives. The staff helped them cope with challenging situations in the community, and participants described staff as what could be interpreted as idealizing selfobjects. The main topics that emerged from the interviews were easier life, safety versus freedom, and being, or not being, common or like ordinary people. The latter appeared to be the most important theme.

Safety versus freedom

Kohut[16] described the cohesive self as stable and continuous, characteristics that would contribute to better self-regulation. The participants reported that everyday living was easier in the supported house. They emphasized that they received better help than in institutions because it was provided in the context of everyday community living.

All the participants had fewer hospitalizations after moving to the supported house. One reason was their easy access to professionals there. One participant elaborated on this by explaining how the context of the supported house made it possible for the professionals to provide immediate assistance in more normal settings, compared to in a hospital. Another participant said that having personnel there all the time, and an outreach crisis team from the specialist health services as a backup, was the reason for fewer hospitalizations. This may indicate that they all experienced better self-regulation in the supported house because they had available significant others, idealized selfobjects, to help them cope in difficult times. They also said they were able to get out more:

> I am able to get out more now that I live in the house. I have been anxious all the time, so it has been difficult to get out among others on my own. If someone is with me, they can help me if I am stuck in a situation, such as at social services, or so. [Annie]

This suggests that the individual's need for idealized selfobjects was met to help her cope when anxiety appeared to be unmanageable. Having staff present as a supportive idealized selfobject may have helped the resident to self-regulate in other stressful situations, as well.

In the supported houses, the residents got help coping with daily living. The service seemed to be flexible when the residents had plans for the day that were threatened by high emotional distress. In phases where the resident did not need as much assistance, that would be accepted by the staff at the supported house. Getting assistance in their own home to cope with their symptoms and practical issues seemed to enhance strategies to self-regulate in daily living. All the participants agreed that the supported house made life easier:

> If you get help at an institution, you will get help right there. Then you go home, and it will not work anyway. So, you will have to go back to the institution again, instead of getting help at home right there and then. Help that will work in everyday life. [Sarah]

However, it seems like staff's impact on patients' self-regulation functioned well primarily because of their close presence:

> You know, when you live in a staffed residential, you know that you can get a hold of someone quite quickly if something comes up, compared to living some place where you would not have the staff […] where you like […] if you are not doing good […] you do not always know […] and if it happens at night there might not be anyone to contact […] so […] then it can really spin off and get worse during the night. [George]

Easier life

The youngest woman experienced that there were different and even conflicting aspects of receiving help:

> In the residential you might get too much help. I noticed that when I first moved here […] the way the staff talked to me. Like they felt sorry for me. There are no reasons to feel sorry for me. [Annie]

The way the staff talked to her made her think they felt sorry for her. It might have been that the staff actually did talk to her differently. On the other hand, maybe she already felt like an outsider and expected them to treat her like one. This might have affected how she could experience the staff's attunement. The staff could have tried to meet what they thought was her selfobject need as an idealized selfobject, while perhaps what she actually needed was a mirroring selfobject or an alter-ego selfobject, someone who could recognize her or someone she could feel similar to.

One of the male participants talked about some situations where he got upset and angry with the staff and commanded them to leave his apartment. Despite this, the staff always came back. The participant was smiling as he talked about this. He said it felt safe knowing they would come back anyway. He also described the staff as being like a mother taking care of him. This may be interpreted as the staff having served the role of idealized selfobjects.

It seemed like the goal of the supported houses was to allow residents to master their lives within the supported house context. None of the participants said that the staff had any plans for them to master their own lives in an ordinary house; one without staff. This indicates that the context of the supported house could be an obstacle to eventually living a normal life as there seemed to be no goals for such a future. One of the female residents, who had lived in several different types of supported houses, said that her goal was to move to a place on her own. She added that she missed a type of assisted living facility that is in between the supported house, where the staff is there 24/7, and living alone. That gap could make moving out hard to manage. She was the only participant who said anything that hinted at a desire for total recovery. This is different from the findings in the research of Westerlund and Bjorgen[6] where participants reported that they did not want to live in the supported house because they wanted to be independent.

The results of the interviews from this study may indicate that the personnel worked to make the residents stable in this context by, for instance, helping them with daily tasks. It did not seem like there were any goals for the residents to move on to a lower level of care in order to achieve independent lives. This may explain why the residents reported examples that illustrated idealizing selfobject roles in the staff. The users got aid and support to cope in difficult situations, but not help to manage independently, like, for example, a mirroring selfobject could have provided through acknowledgment and confirmation.

All the participants made it clear that since they lived in their own apartment, they could decide who could visit them, whom to spend time with and what to do at what time. The participants said that the staff accepted that. Still, they felt like there was a delimitation since staff controlled who visited the house.

> Freedom to me is to have girlfriends over and live the life that I want. To marry whom I want. [John]

The need to decide what was important in their own lives could be understood as a need to be met on their grandiose axis of the self, the person's sense of self-worth, ambitions,

commitment, self-assurance and accomplishment. If the staff met them on this by being a mirroring selfobject who could give them acknowledgment and confirmation, it could perhaps ease their way to becoming freer and more independent. On the other hand, the residents might also need staff to be in an alter-ego selfobject position, someone to be like, or an idealized selfobject, someone to lean on, to achieve the same independence. For residents to have a good experience in the supported house, it seemed important that the staff were able to meet different selfobject needs. Depending on the states and interactions residents were in, they needed different relational support in order to strengthen the axis of the self to become cohesive and independent.

The participants were satisfied with the help they received with their daily chores and needs. This could mean these residents' needs were met and supported in these situations by nurses whom they perceived to be idealized selfobjects. However, whether the participants' needs concerning happiness, hopes and dreams were met remains unanswered.

Being ordinary

The participants used phrases such as "us" versus "common people". All the participants agreed they wanted to appear common, but what it meant to be common differed with each individual. So, what does it mean to be common? Can this be considered as a selfobject need? One of the participants described being common as equal to being healthy, as being like people with regular lives, as being people who are not mentally ill. It seemed like the participants categorized themselves as being slightly different from everyone else. They described not having much of a social network. For two of them, family and staff were their only social network; for one, staff was the only social network. The remaining one had a few friends and the staff, but no family nearby.

Participants' repeated comments about being neither common nor normal, but wanting to appear to be, could be understood as a weakness of the twin-seeking axis of the self, as weak on the self's need for fellowship and search for social acceptance, despite possibly also fearing it. Some people with mental illness might experience a lack of fellowship because they think they are different, rather than actually being treated as different. Still, the participants said they felt common in certain situations. One individual, for example, said that she wanted to go on a trip where no one knew her. It seemed that this was an example to her of a situation where she would feel common because of her "no one knows me there" perception. Can analysis of residents' selfobject needs provide an answer to why they felt uncommon?

The residents could not look at the staff as friends because of the rules regulating their relationship. These are issues the residents would not have living in ordinary homes, socializing with people who did not work there. One of the female participants said this:

> Before I got ill, I used to have friends. Here I can consider some as friends, but there are rules that make it not possible for us to be friends. We are not allowed to be friends with people who work here. When it comes to the other residents, we have got nothing to talk about with each other. [Sarah]

From a self psychology perspective, this may mean she wanted staff as alter-ego selfobjects, as friends or someone to be like, but they could not attune to that. So what difference would it make for her twin-seeking axis of the self if they met her as an alter-ego selfobject? One might assume it could have contributed to a more cohesive self and given her a feeling of being more common. Furthermore, this could potentially positively influence the grandiose axis of the self, by perhaps increasing the individual's sense of self-worth or self-commitment. Maybe this would have made it easier to cope in challenging situations. How, then, can professionals help someone with a fragmented self, if rules prevent them from attuning to the resident's selfobject need? Of course, we have very little information from this resident on the exact nature of her expectations of a closer relationship with "the people who work here". Neither do we know enough about the rules that she thought blocked closer relationships with the nurses. Nonetheless, in general, there is already a gap between the staff and the residents, because staff know a lot about the residents but residents know little about staff. In addition to this, if staff cannot meet a wide spectrum of residents' needs because of certain rules, then distance between staff and residents may be increased. In some cases, this may make empathic attunement difficult, if not impossible. Lack of positive attunement for someone with already fragmented self-experience may make the self even more fragmented. Knowing this, how can staff keep their professional distance and, at the same time, be the selfobject the others need in order to achieve a cohesive self?

In another case, one of the female participants said that she needed social skill training with a focus on making small talk to manage the new living context:

> Like, what do you talk about meeting people in the store? How do you answer if someone you do not know comes up talking to you? I think that I have to reach for a healthy life. Everyone should have this focus. [Annie]

This comment reflects a lack of self-confidence and a need for idealized selfobjects to help her cope with unpredictable social situations.

According to the participants, they took part in activities that were important to them. This might be interpreted as a perception of having a possibility of being a part of the society, as described in the WHO's Mental Health Action Plan.[4] Increased participation in activities could be good for them. On the other hand, if the feeling of not being normal or like other people prevails, they might choose activities based on that feeling rather than on what they actually would have chosen if they had considered themselves as common.

Discussion

The aim of this study was to investigate the relevance of Giorgi's method of analysis and self psychology in analyzing user's experiences of the helping relationship in supported housing and to explore residents' experiences concerning living in supported houses with a specific focus on therapeutic interpretation of the helping relationship. As in previous studies,[6–10] participants said that they felt safer knowing they could ask staff for help in challenging situations and they considered their life as easier. At the same time, they were worried about being different from ordinary people, as also appeared in the study of Bengtsson-Tops et al.[9] So, is life safer and easier in supported houses because residents do not have to deal with certain difficult situations or is it because they get help finding their own strategies of coping with challenging situations? Do the residents worry about appearing uncommon because they live in supported houses? Andersson[5] described supportive relationships. In self psychology, this is understood as a presumption to meet selfobject needs. In this study, the resident's selfobject needs were analyzed on the basis of their total experience of living in supported housing. It seemed like some of the residents' selfobject needs, as described earlier, were met as long as these fitted into the routines of the supported house; yet, it looks like they were primarily met at their need for idealized selfobjects. However, it is very likely that the needs for mirroring and alter-ego selfobjects are just as important if residents learn to cope with challenging situations and build a cohesive self.

Brolin et al[11] described the importance of self-determination for living in supported housing. In self psychology, self-determination is understood as relational communication that helps building a cohesive self. Kohut[16] described the experience of a cohesive self as being a result of sufficient development of the tripolar self. If staff can contribute to the development of the cohesive self, residents may then be able to use their resources in a better way. This could affect all three axes of the self and contribute to residents' better self-regulation and self-cohesion. In our view, self psychology represents a significant frame of knowledge by focusing on attunement and selfobject needs in the recovery process. It has the potential of providing a dynamic understanding and enhancement of cooperation between residents and service providers in order to help residents achieve their life goals. Our findings suggest that the participants shared some of the same life experiences and major goals for their lives but that their individual needs for achieving these goals were different. They all wanted to appear common or normal, but what they needed to feel that way appeared to differ.

Since qualitative methods and the use of semi structured interview guides are somewhat flexible, it is relevant to discuss whether the chosen method gives the most reliable results of the investigation. In this study, the interview guide covered relevant topics for the study. However, topics that could expand the understanding of the participants' experiences may have been missed. Still, by using Giorgi's method of analysis, we found interesting and specific findings about the residents' experiences of the helping relationship that became clearer by further analysis in the perspective of self psychology. The final results emphasized that Giorgi's methods of analysis and self psychology can complement each other to get reliable results about experiences of the helping relationships.

Limitations

Even though the participants were informed about the confidentiality of their conversations with the researchers, they may have left out some information about their experiences. Despite this possibility, given that there are few studies on residents' experiences in supported houses and that the number of supported houses seems to be increasing internationally, the study is helpful in providing a tentative insight into relational aspects of staff–user relationships in supported houses.

Another challenge in doing qualitative research is that insufficient information from the participants could render an interviewer's voice dominant and could influence conclusions. In this study, one of the participants asked for the recorder to be turned off during the interview. This might have led to lost information. Another participant did not say much unless asked and did not elaborate much on the answers. This could also affect conclusions. Still, one of the assets of qualitative

research is that a small number of participants allows for in-depth and thorough information about their experiences.

Conclusion

The participants said that they had easier everyday lives after moving into their supported houses and that they, to some extent, perceived their selfobject needs being met. However, they experienced this mostly when it fitted in with the personnel routines in the supported houses. A greater professional awareness of empathic attunement and selfobject roles and how these may enhance the cohesiveness of the resident's self might enhance the helping relationship.

Giorgi's method of analysis, which was used to get the essence of the participants' experiences, made it easier to structure the process of analyzing the interviews and to stay focused on what experiences participants actually emphasized. After sorting the information into different themes and topics, we found the use of clinical concepts from self psychology useful for developing a more comprehensive understanding of the participants' relational experiences and needs in the supported houses. We suggest that the combination of Giorgi's method of analysis and self psychology can improve such an analysis and expand the meaning of participants' experiences in qualitative research on milieu therapy and helping relationships.

This study focused on residents' experiences. It would be interesting to do further research on a larger number of residents or people who used to live in supported housing. What was life like after moving out? How were their needs met while living in the supported house? It would also be interesting to do research on supported housings' personnel to find out how they consider the resident's selfobject needs are met.

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Author contributions

Both authors contributed toward data analysis, drafting and critically revising the paper and agree to be accountable for all aspects of the work.

Disclosure

The authors report no conflicts of interest in this work.

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