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Engagement in activities and occupations by people who have experienced psychosis: a metasynthesis of lived experience

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Purpose: The purpose of this study was to answer the question 'How do people who have experienced psychosis describe their engagement in activities of daily living and occupations?'

Procedures: A qualitative metasynthesis was undertaken on nine studies (encompassing 73 participants) published in occupational therapy literature. Only studies that had used individual qualitative interviews were included to highlight lived experience on a personal level. The quality of the evidence was assessed across all studies and found to be generally high.

Findings: Four overarching themes across the nine studies were identified: my emotions and identity; my own health and wellbeing; my relationships with family, friends and community; and my activities and occupations. The overarching themes are not intended to be considered categorically, as they all influence and interact with each other.

Conclusion and relevance: There is considerable synchronicity between the experiences of people who have experienced psychosis and the values of the profession. A client's meaningful engagement in activities and occupation is evidence towards how therapists provide authentic, respectful and effective support to these clients, in a manner that meets their needs as individuals.

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Introduction

Psychosis occurs when a person loses touch with reality in a manner that cannot be understood or empathised with by those around him or her (Treasaden 2010). Psychosis can occur in the context of many forms of mental illness, but it is considered a hallmark of schizophrenia. Schizophrenia is a syndrome characterised by delusions, hallucinations, speech disturbances, affective restrictions and cognitive impairments (Buckley and Jones 2010). Although psychosis is not a common mental illness, it is in some ways more visible due to its severity and generally chronic course, with an estimated 24 million people living with it worldwide (World Health Organization 2011). The development of psychosis can have a profound and devastating effect on a person's ability to participate in activities of daily living, particularly in the acute phase. This paper contributes to the evidence for the practice of occupational therapy in mental health by presenting a metasynthesis of how clients with psychosis perceive their recovery through engagement in activities of daily living and occupation. Before the metasynthesis and findings are presented, a clarification of terms is given for participation, activity, occupation and engagement.

Participation has been defined as 'taking part', and comes from the Latin *participare* meaning 'share in' (Hawker et al 2001). Law (2002) concurred with this, stating that the fundamental concept underlying participation is involvement in or sharing of an activity. However, an activity does not have to be personally meaningful to attract someone's participation – some are based

purely on perceived cultural expectations. For example, someone may iron the clothes they wear in public, but not bother ironing those they wear at home.

Activities involve a structured series of actions, which group together to form occupations (Creek and Lawson-Porter 2010). Occupations are considered to be meaningful both personally and socioculturally, are named within a culture and support participation (Creek and Lawson-Porter 2010). As stated by Kielfhofner et al (2007, p124):

> An engaging occupation is a coherent and meaningful set of occupational forms that cohere and evoke deep feeling, a sense of duty, commitment and perseverance leading to regular involvement over time in relation to a community of people who share the engaging occupation.

Participation does not automatically confer meaning to an activity or occupation, but a focus on meaningful activities of daily living and occupations is an explicit target of occupational therapy. Therefore, the term 'engagement' seems more appropriate when specifically addressing the activities and occupations that invariably have meaning or significance in the daily life of a client. Definitions of engagement specifically conceptualise it as to attract someone's interest or attention, and the word itself comes from the French *gage* meaning 'a valued object' (Hawker et al 2001). Thus, engagement is more than involvement in or sharing of an activity.

The recovery model in mental health is complementary to occupational therapy values, such as client-centredness and the achievement of personally meaningful goals (C Brown 2002). As recovery is a 'self-directed process of healing and transformation' (Deegan 2002, p6), the activities and occupations used to support recovery need to be meaningful or important to the individual. The aim of occupational therapy is to enable engagement in these activities and occupations, rather than simple participation. As such, occupational therapists listen closely to clients' experiences of engagement, affirming the importance of these experiences by valuing client-centred practice (Sumsion 2000).

In recent years, a series of research studies has been published in occupational therapy literature exploring engagement in activities of daily living and other occupations by clients with psychosis, using a range of qualitative methods. The aim of this paper is to present a metasynthesis of studies using a phenomenological approach, which describe the client's perceptions of engagement in activities of daily living and their related occupations, and their impact on recovery.

Method

Qualitative metasynthesis is a relatively new way of interrogating and presenting findings from multiple studies. Unlike the meta-analytic approach taken with quantitative research, the aim of metasynthesis is to provide new interpretations of the data, rather than aggregate results (Walsh and Downe 2005). A recent review has found this method to be an important tool for evidence that could benefit both occupational therapists and their clients (Gewurtz et al 2008).

While there are also studies about engagement in activities of daily living by people with psychosis that take a quantitative approach, only qualitative studies consciously preserve the clients' experiences in their own words. Metasynthesis is, therefore, an appropriate technique for exploring these qualitative studies. Although the authors of these studies explicitly state that they do not aim to provide generalisable results, there is value in exploring the areas of consonance and dissonance between the experiences of these individuals for the presence of overarching themes that may ultimately assist occupational therapists in supporting people with psychosis to engage in activities of daily living or other occupations. Consonance and dissonance were originally musical terms, but have now emerged in research to describe experiences of harmony or conformity (consonance) versus experiences of discord or incongruity (dissonance). The process outlined by Gewurtz et al (2008) was used to guide this study. This process uses the five main steps generally included in all approaches to metasynthesis: identification of a research question, specifying inclusion/exclusion criteria, identifying and collecting studies, assessing rigour for each study and synthesising findings to produce a novel interpretation. The metasynthesis is then presented under a series of overarching themes, which highlight areas of both consonance and dissonance between the studies.

The research question that guided this study was 'How do people who have experienced psychosis describe their engagement in activities of daily living, both singly and when grouped into occupations?' To ensure that the study took an appropriate focus, the following inclusion criteria were specified: (1) the study was published in an occupational therapy journal, (2) the study used only a phenomenological approach through individual interviews and (3) participants had been diagnosed with schizophrenia or had experienced psychosis as part of their mental illness. The inclusion criteria are justified on the basis that studies published in occupational therapy journals have a focus on activity and occupation, which is fundamental to the profession's core concepts and practice. The decision to focus only on qualitative interviews with a phenomenological/ personal narrative approach was taken to highlight lived experience at an individual level, and to increase the likelihood of rich data being collected for each person who had experienced psychosis. Psychosis and schizophrenia were included in the study, as most studies were linked to the diagnosis rather than the symptom. Although it is legitimate to integrate studies using different methodologies in metasynthesis (Walsh and Downe 2005), it was concluded that sufficient data existed in these studies to provide a detailed synthesis.

Exclusion criteria were (1) data that had been analysed using pre-existing models or themes and (2) studies that used other methods alongside individual interviews. Basing qualitative analysis on pre-existing models or themes is a valid way of conducting qualitative research, and using more than one method often leads to more robust analysis and results. However, the present study wanted to investigate themes that emerged directly from the client's own experiences

Table 1. Included studies with sample and location

Study	Method	Male	Female	Age	Location	Receiving occupational therapy
JA Brown (2011)	Phenomenology and occupational life history	2	3	20s	Canada	Yes
Chugg and Craik (2002)	Not specified – semi-structured interviews	4	4	23-49	UK	Yes
Cook and Chambers (2009)	Not specified – semi-structured interviews	18	8	Unspecified	UK	Yes
Deegan (2002)	First person account		1	Unspecified	USA	Yes
Eklund et al (2012)	Phenomenology	5	5	36-60	Sweden	Not stated
Emerson et al (1998)	Not specified – semi-structured interviews	6	3	20s 3	Canada	Not stated
				30s 3		
				40s 1		
				50s 2		
Hitch (2009)	Interpretive phenomenological analysis	5		20s 1	UK	Some
				30s 2		
				40s 1		
				60s 1		
Legault and Rebeiro (2001)	Single case design	1		20s	Canada	Yes
Woodside et al (2006)	Not specified – semi-structured interviews	4	4	20s 4	Canada	Not stated
				30s 2		
				40s 1		
				50s 1		
Total		45	28	20s 14	Canada 4	
				30s 7	UK 3	
				40s 3	USA 1	
				50s 1	Sweden 1	
				60s 1		
				Unspecified 47		

rather than those that originated with the researcher or were collected by other methods.

Potential studies were initially found by searching OTDBASE, using the terms 'psychosis' and 'schizophrenia'. OTDBASE is a database specific to occupational therapy peer-reviewed journals. Therefore, it was appropriate to ensure that studies met the first inclusion criterion. The initial search identified 21 potential articles. After application of the inclusion and exclusion criteria, seven studies were selected.

To these studies, the first author added an eighth, which she had completed, that met the inclusion criteria but was not listed in OTDBASE. This may have been due to the omission of any diagnosis from the key words. This led to concerns that other relevant studies may have been missed, and additional searches using the same search terms were conducted in the following databases: Academic Search Complete, AMED – the Allied and Complementary Medicine Database, CINAHL with Full Text, Health Policy Reference Center, Health Source: Nursing/Academic Edition and PsycINFO. No time frame was specified, and it was found that all available evidence has been published in the past 15 years. This round identified three studies. One study did meet the criteria, bringing the total sample of studies to nine.

Findings

A summary of the methods, samples and location of the included studies is displayed in Table 1.

The Rosalind Franklin Qualitative Research Appraisal Instrument (RF-QRA) (Henderson and Rheault 2004) was used to evaluate the studies' level of evidence. It was chosen due to its relative user-friendliness, extensive coverage of the measures that attempt to ensure trustworthiness, and provision of an indicative level of evidence which is congruent with systems currently used for quantitative evidence. This instrument evaluates the study's standards of trustworthiness, as measured through credibility, transferability, dependability and confirmability. When applying the RF-QRA, each study is subjected to a series of key questions, with example strategies provided to highlight possible evidence. After this process is complete, a level is assigned to the evidence from I (all four aspects of trustworthiness addressed) to V (problems with all four aspects of trustworthiness). This method is dependent on whether the study authors have reported their efforts to increase trustworthiness in their publication. This reporting can be variable and recommendations have been made for its adoption as a standard feature of qualitative research reports in occupational therapy literature (Moretenson and Oliffe 2009). The rigour of the studies is shown in Table 2.

As seven studies were scored at Level I or II, the level of evidence was quite high. Given the aims of qualitative research, it is understandable that several authors stated they were not attempting to ensure transferability. However, the measures taken by Cook and Chambers (2009) demonstrate that it is possible to achieve this with a large and well-selected sample. For the current metasynthesis, measures had been adopted to ensure the highest possible standard of trustworthiness.

The first author endeavoured to promote credibility through reading each article thoroughly multiple times, to ensure that all aspects had been considered. Although the aim of metasynthesis is not to aggregate, the findings presented can make claims to some transferability due to the large and varied combined sample. From the description of the method used to complete this metasynthesis, other researchers could replicate this study and arrive at similar findings.

Finally, confirmability had been addressed through peer review between all three authors, and conscious attempts to uphold reflexive practice throughout the study. Peer review included regular face-to-face and email discussion, and several reviews of this manuscript as a representation of it.

Given that one of the included studies was written by the first author, this process particularly focused whether this influenced the subsequent analysis. The first author was conscious of her personal assumptions about the subject, but found that the variety of data enabled a new interpretation of the topic which did not rely heavily on her previous research. This author is an occupational therapist of over a decade's experience in mental health, while the other two authors are academics who supervised the study.

After analysing the trustworthiness of all studies, the themes emerging were drawn out and listed. This was achieved through several readings of each article, the identification of themes within these studies and the organisation of them

Table 2. Studies included and rigour

Study	Credibility	Transferability	Dependability	Confirmability	Limitations	LOE
JA Brown (2011)	Prolonged engagement Member checking of formulation	Stated there is no intention to generalise (Not achieved)	Extensive peer review	Reflexivity exercises	Substance use not addressed Not longitudinal Monocultural Single interviewer	II
Chugg and Craik (2002)	Inclusion of quotes Triangulation by multiple investigators	Unable to ascertain from description of sample (Not achieved)	Second researcher analysing data Peer examination	Triangulation by multiple investigators Bias acknowledged	Lack of description of sample No prolonged involvement	II
Cook and Chambers (2009)	Member checking Client as researcher Triangulation by multiple investigators Reviewed by client-steering group	Maximum variation sampling used Large and well described sample	Triangulation by multiple investigators Detailed description of method Peer examination	Reflective journal Bias acknowledged	Client research increased recruitment rate and trust Interpretive phenomenological analysis may have allowed more reflexivity	I
Deegan (2002)	Written in the first person as a direct account	No generalisation intended (Not achieved)	Client's own interpretation of experience	Not presented as an objective account (Not achieved)	Rich description	III
Eklund et al (2012)	Inclusion of quotes Triangulation by multiple investigators	Detailed description of sample and context but homogeneous sample (Not achieved)	Detailed description of method Second researcher analysing data Peer examination	Reflexivity apparent in discussion Audit trail	Little member checking Limited sample No prolonged involvement	II
Emerson et al (1998)	Field journal Member checking	Detailed description of sample and context but homogeneous sample (Not achieved)	Peer review Methods log	Methods log Bias acknowledged	Single interviewer No prolonged involvement	II
Hitch (2009)	Member checking Triangulation of coding	Detailed description of sample and context but homogeneous sample (Not achieved)	Detailed description of method Multiple coding Peer examination	Reflective journal Regular supervision	Sample very homogeneous (all male)	II
Legault and Rebeiro (2001)	Repeated member checking Prolonged engagement	No generalisation intended (Not achieved)	Independent judgement of results Detailed description of method and sample	Field journal External audit (Not achieved)	Single interviewer Focused on one particular intervention programme	II
Woodside et al (2006)	Member checking Triangulation by multiple investigators	No generalisation intended (Not achieved)	Practice interviews conducted Field notes and memos Triangulation by multiple investigators	Bias acknowledged Reflexivity practised	Interviews conducted by phone Saturation not achieved Focused on employment	II

LOE = Level of evidence. The measures were achieved unless otherwise stated.

into overall themes. If overarching themes had been nominated as part of the results in the original articles, they were disregarded, as they would only be relevant to those particular responses and data. Where no themes were explicitly stated, these were drawn out using the headings in the articles as a guide. For example, Deegan (2002) is written in a first person narrative style, but included headings such as 'the coke and smoke syndrome' and 'tolerant environments', which were themes within her story. A total of 55 themes was extracted from the nine studies.

The themes were then considered as a data set, and arranged into groups according to emerging themes. This resulted in four overarching themes being identified across the nine studies. They are (1) my emotions and identity, (2) my own health and wellbeing, (3) my relationships with family, friends and community and (4) my activities and occupations (see Appendix 1). For example, the overarching theme of 'My emotions and identity' includes subthemes such as 'Happiness is gone' (JA Brown 2011), 'Excitement' (Emerson et al 1998) and 'I am more than a schizophrenic' (Deegan 2002). The themes identified from each study and their organisation into the overarching themes are in Appendix 1. The overarching themes are not intended to be considered categorically but, rather, in an interrelated way. Each theme influences and interacts with the other, reflecting the sophisticated and complex nature of engagement in activities and occupations.

My emotions and identity

Engagement in activities and occupations evoked a range of emotional responses in clients, which were often positive. The experience of pleasure was raised in several studies, and was always related to qualitatively good engagement. Pleasure and happiness were regarded as reasons in themselves to engage in activities and occupations, although a good match between person and occupation was needed to evoke these emotions. Emerson et al (1998) noted the common assumption that the symptom of anhedonia dampens the potential for enjoyment and pleasure from activities for people with psychosis. However, this was not supported by the data in many studies listed under this theme (Legault and Rebeiro 2001, Chugg and Craik 2002, Deegan 2002, Cook and Chambers 2009, Hitch 2009).

Relaxation was another emotional response related to engagement in activities and occupations that met clients' needs most successfully. When engaging in these activities, clients reported being able to lose themselves and get respite from worries and anxieties in other parts of their lives. Positive memories of past engagement and a sense of safety was also experienced as an enabling factor, which consolidated a sense of self-efficacy and meaning.

Negative emotions when engaging in activities of daily living were related to emotions that things would never improve. The participants in JA Brown's (2011) study were worried that their capacity to enjoy life had been permanently damaged by their development of a psychotic illness. Deegan (2002) related her negative experiences to the dehumanising approach initially taken by medical staff, explaining

how she gradually internalised the stigma. Another participant described a pattern of monotony and passivity that led him to feel he was 'wasting his life away' (Legault and Rebeiro 2001, p92). These last two interviewees went on to report improvement in their emotional state when they found, and began to engage in, meaningful occupations that provided them with a greater sense of purpose and hope.

The experience of engaging in activities of daily living was also strongly related to a sense of self and identity. A sense of accomplishment and pride was engendered by good experiences, and this was again linked by some to relief from other worries and anxieties. Hitch (2009) used the term 'self-actualisation' to describe this and included references by clients to problem solving, recovery, learning and insight development. A belief in one's own abilities grew from these achievements and became part of many clients' coping and survival strategies. This stronger sense of self was often needed to withstand the effects of negative expectations and stereotyping from the broader community, as stated by Deegan (2002, p10): 'I am more than that, more than a schizophrenic.'

Engagement in activities and occupations, therefore, provides people with psychosis a path to experiencing positive emotional states such as pleasure and relaxation, which serve to offer respite from the more challenging aspects of their lived experience. When engagement is experienced negatively, it is usually in the context of feeling stagnant or without hope for the future. Positive experiences of engagement can contribute to the development of a positive sense of self, which has wide-reaching benefits for the client as an individual as well as in his or her relationship with others.

My own health and wellbeing

There was a strong sense of personal responsibility and self-management relating to their own health and wellbeing, with clients speaking of autonomy, taking control and doing things to manage their illness themselves. Many mentioned the benefits of having an individual approach to their own health and wellbeing needs, and had proactively developed self-help and self-monitoring strategies that worked for them. Taking care of physical health concerns was identified as an important and beneficial aspect of this, whereas drug and alcohol use were recognised as having a detrimental effect.

The negative impact of psychosis was also recognised by some clients, particularly in the acute phases in which opportunities, emotional expression, environmental accessibility and relationships were felt to become narrow or limited by symptoms. These factors also related to the idea of self-help and self-management, with clients describing having to learn about the personal impact of their psychosis, how to tolerate discomfort, anxiety and stress while maintaining engagement, and how to identify or create opportunities for benefiting from their experiences. The notion of 'coming to terms' with psychosis emerged as an important, and often hard-won, step to recovery.

Owing to the narrative nature of experience re-telling, there was a strong sense of time and temporality in the clients'

Table 3. Cumulative list of factors that help or hinder engagement in activities and occupations

Factors that help	Factors that hinder
■ Adequate challenge (Emerson et al 1998)	■ Carer burden (Cook and Chambers 2009)
■ Assistance with self-care/domestic tasks (Cook and Chambers 2009)	■ Fear of exacerbating mental health problems (Cook and Chambers 2009)
■ Employment or other productive activity (Chugg and Craik 2002, Cook and Chambers 2009, JA Brown 2011)	■ Lack of employment and leisure opportunities (Cook and Chambers 2009)
■ Environment/location of the activity (Deegan 2002, Hitch 2009)	■ Lack of knowledge about psychosis (JA Brown 2011)
■ Fulfilling hobbies (Cook and Chambers 2009)	■ Lack of stable or appropriate accommodation (Cook and Chambers 2009, Hitch 2009)
■ Interest (Emerson et al 1998)	■ Poor service delivery (Cook and Chambers 2009)
■ Maintenance of 'ordinary' activities of daily living (Chugg and Craik 2002)	■ Seasonal difficulties (Cook and Chambers 2009, Hitch 2009)
■ Making positive lifestyle changes (Woodside et al 2006)	■ Stigma, racism and lack of community understanding (Cook and Chambers 2009)
■ Presence of companion animals (Cook and Chambers 2009)	■ Traumatic past events (Cook and Chambers 2009)
■ Previous experience with that activity (JA Brown 2011)	
■ Religious practices and belonging (Cook and Chambers 2009)	
■ Sufficient resources – financial, transport (Cook and Chambers 2009, Hitch 2009)	

descriptions of their own health and wellbeing. 'Recovery' was the preferred term to describe their ongoing experience of living with psychosis, and there were two periods in which it was conceptualised. Some clients spoke of the 'reconstruction' that needs to take place following an acute episode – a broadening and revival of opportunities, emotions, environments and relationships (JA Brown 2011). Others took a lifespan view, seeing recovery as a process of ongoing growth and transformation.

Engagement in activities and occupations is, therefore, a tool that people with psychosis use proactively to cope with, and recover from, their illness. A longitudinal, temporal view of their own health and wellbeing was taken by most clients, with a lifetime of recovery interspersed with periods of acute illness and restricted opportunities. Individualised responses may be expected due to the research methodology being used, but clients recognised and highlighted the need for unique approaches and solutions that take into account their preferences, experiences and needs.

My relationships with family, friends and community

Across all studies, relationships were universally seen as crucial to the initiation, facilitation and enrichment of engagement in activities of daily living and meaningful occupations. Many of the clients had been able to maintain relationships with family members through their illness, but friendships and intimate relationships had been elusive although highly valued and crucial to the experience of meaningfulness. While family disconnectedness and social isolation were factors that could hinder engagement, it was also noted that restricting relationships to those within the family could prevent developmentally appropriate shifts towards friendships and other relationships. The maintenance of relationships over the long term presented many challenges, but was important to the success of a person's recovery.

Relationships with mental health professionals were also explored by clients, with the mixed impressions to be expected from a series of individual therapeutic dyads. These relationships were seen to be healthy and helpful when staff and

services demonstrated that they valued the client as a person and when interventions were tailored to meet their personal needs. Some clients reported feeling that they had to manage their relationships with mental health professionals, including being selective in what they discussed and what help they sought. The role of medication also elicited a range of responses, with some clients finding it very helpful and others considering it harmful. Within the natural variability of therapeutic relationships, an individualised and respectful approach to working with clients was best appreciated, along with an acknowledgement that power within those relationships is more balanced than traditionally thought.

The notion of doing with, in which engagement in meaningful activities of daily living and occupations was facilitated by having an informal partner in participation, was found in several studies. The term connectedness arose on several occasions, describing the feeling of being synchronised with the engagement of another and the satisfaction of working towards shared goals. The benefits of leaving their usual environment and interacting with others were recognised by many clients and were valued.

Engagement in meaningful activities of daily living and occupations and the relationships that the client has with his or her family, friends and the broader community are closely related. The clients in these studies reported positive family relationships. However, their social networks were limited, with the challenges posed by the episodic nature of psychosis making the formation of new long-term relationships outside the family difficult. Group and social activities were valued by these clients as a way of connecting with their community in positive and goal-directed ways.

My activities and occupations

Many studies identified a series of discrete factors that helped or hindered engagement in activities and occupations. A combined list of those not already covered under previous themes is in Table 3.

Employment was identified as being a highly meaningful occupation by many clients, to the point that its maintenance could mitigate the impact of psychosis more than maintaining

self-care or relationships. It was also an important part of maintaining a social context, and was a source of meaning and usefulness in life. The importance of self-care and domestic activities attracted varied responses. Some clients stated that they would like to have assistance with these activities at times of acute episodes, while others felt that routines and hobbies were essential to their ongoing recovery.

Clients stated that it was important that activities and occupations be appropriately challenging; that is, not too difficult or too easy. If they were too difficult, some clients reported that they worried engagement would worsen their mental state. Daily engagement that offered structure, routine and the opportunity to practise interests was a means to achieve this. While activities that had previously been engaged in were reported as offering the advantage of familiarity and potential pre-existing skill, clients also indicated that they would appreciate new challenges, as long as they were manageable.

Activities and occupations undertaken within physical and social environments were often cited as important external factors linked to accessibility and comfort. From a physical perspective, facilities and services that were easily accessible were more likely to invite engagement. Some seasonal fluctuations were also reported across two studies, where warmer or colder weather had a direct influence on which occupations the clients chose to engage in. Then, from a social perspective, a tolerant, accepting and inclusive environment free from stigma, racism or ignorance was required to optimise engagement. The presence or absence of resources such as finances, accommodation and transport options was a major external factor in engagement, most often in a detrimental way.

Positive lifestyle choices, pet ownership and religious observance were positive influences on engagement, whereas carer burden and traumatic past life events could hinder engagement in meaningful activities of daily living and occupations. Therefore, engagement is influenced by factors relating to the activities themselves. Activities and occupations must meet the skills, drives and needs of the individual client. External factors, such as physical and social environments and the availability of resources, can be crucial to successful engagement. Although these factors are sometimes beyond the control of the person with psychosis, they are not beyond the influence of an occupational therapist.

Discussion

People who have experienced psychosis described their engagement in meaningful activities of daily living and occupations as relating to one of four broad themes: my emotions and identity; my own health and wellbeing; my relationships with family, friends and community; and my activities and occupations. These areas are interrelated in ways that highlight the sophistication and complexity of human occupation, and also align with the philosophy and values of occupational therapy. For example, a strong sense of self (emotions and identity) enabled clients to be more

assertive in managing their psychosis (own health and wellbeing), to manage their relationships more successfully (my relationships with family, friends and community) and to choose actively which activities and occupations they wished to engage in. This metasynthesis has identified many areas of consonance across the reviewed studies, with a high degree of agreement around many of the overarching themes.

There are, however, also some areas of dissonance. While most clients took a lifespan perspective on their recovery, some focused more on recovery as a rebuilding process after a discrete episode. This episodic perspective may be more prevalent in younger clients, although the aggregate nature of the data makes this difficult to verify. Another area of dissonance was preference for assistance with self-care and domestic activities of daily living during acute episodes of psychosis. In common with responses around medication and relationships with therapists, disagreement around desired support at these times reflected individual preferences and experiences.

Despite the varied nature of lived experience for people with psychosis, this metasynthesis has highlighted some findings that have much to offer occupational therapists wishing to engage in an authentically client-centred therapeutic relationship and to reflect on their practice. In many ways, honouring the lived experience of people with psychosis when providing occupational therapy requires a consistent adherence to the fundamental values of our profession. In its philosophies around clients, therapists, occupations and health and illness, occupational therapy aligns closely with the values and beliefs expressed by the participants in the studies reviewed for this metasynthesis.

A commitment to tailoring therapy for each client requires an understanding and acceptance of his or her occupational being, respect for the diversity, both among clients and within larger groups, and an acknowledgement that purpose and meaning reside within the client (Creek 2003). This concept of knowing the person was found by Blank (2004) to be appreciated by clients in a community mental health setting, as they felt valued as individuals by therapists who worked in partnership with them. Enabling opportunities for pleasurable engagement is related to the client's quality of life (Aubin et al 1999). Cognitive sensory intervention strategies that show promise in overcoming the debilitating effects of anhedonia on engagement in activities of daily living are now becoming available, which offer new ways for occupational therapists to pursue these opportunities (Favrod et al 2010). Further, intrinsically motivating occupations are rightfully the concern of occupational therapists, who consider them equally valuable as those prioritised by the community and social conventions.

Having a sense of hope for the future – the outcome of meaningful engagement – engenders a strength in clients that they feel helps them to meet the challenges of their illness. There is some evidence that mental health professionals are less optimistic and future-oriented than clients with psychosis (Hitch 2009). Yerxa (1992) believed that occupational therapy tends to maintain an optimistic view of a client's potential, coming from the understanding that occupations foster devel-

opmental changes, competence, improved function and adaptation. Publications by occupational therapists on this topic, with reference to people with serious mental illness, support the view that occupational therapy is a champion for hope (C Brown 2002).

While occupations may be the medium of change, occupational therapists have recognised that the client is the agent of change. Therefore, enabling a strong sense of personal responsibility around self-management in clients, as identified in this synthesis, can be a valuable contribution to ongoing recovery. Occupational therapy can be instrumental in supporting the rights of clients to self-determination and the fulfilment of their potential (Creek 2003). Clients are able to recognise relapse and enact strategies regardless of their level of insight (Kennedy et al 2000). As demonstrated by Chafetz et al (2008), health promotion training in self-management can be effective for people with severe mental illness.

Given the often relapsing/remitting or chronic pattern of psychosis, a lifespan approach to assessment and treatment is appropriate. Occupational therapists can support the narrowing and widening of opportunities by providing input around maintaining a healthy balance of occupations, and emphasising the process of recovery rather than outcomes. Engagement that enables the maintenance of existing relationships and the positive development of new ones can be planned with the client. Occupational therapy in community settings has a positive effect on relationships for people with psychosis (Cook et al 2009), and group activities that encourage integration into the community are a focus of the profession.

Supporting people with psychosis to face challenges in the workplace is an established aspect of practice and has been addressed in a number of studies (for example, Rouleau et al 2009). The influence of the environment (both social and physical) on performance is also well recognised in the profession, although it is generally not as strongly emphasised in mental health practice as in other specialist areas such as physical disabilities and access design.

Limitations

Despite the rigour of method used there remain several limitations to the findings. The goal of this method is to provide an interpretation rather than an aggregation of findings. As a result, other researchers may arrive at different interpretations of these data due to different experiences, frames of reference and understandings. While such competing interpretations could appear confusing, they may provide opportunities for further interrogation and critique of the evidence. The studies reviewed included the experiences of a relatively large sample of people (n = 73), but the individual study samples varied considerably with several single subject case studies and one large study including 26 participants. The depth and influence of information from each participant therefore varies between studies, which could impact on the generalisability of the findings. An example is the variability as to whether the participants had been in receipt of occupational therapy (Table 2). This

is an important factor to consider, as their experiences of activities of daily living would be directly influenced through the receipt of occupational therapy.

The studies were also all located in Western countries, which limit the findings to that cultural context. There was also a preponderance of male participants, so gender differences might not have emerged as clearly as they would have done in a more even sample. Although psychosis and schizophrenia were both included as search terms in this metasynthesis, only one study focused on psychosis as a discrete symptom rather than schizophrenia as a syndrome. Therefore, the study might differ from the lived experience of those with non-schizophrenia related psychosis, such as those experiencing drug-induced psychosis or mood disorders with psychotic features. The study limited its search to occupational therapy journals. There are many other qualitative studies that focus on the lived experiences of people with psychosis from other disciplines. While they may not have an occupational focus or reflect occupational therapy's current concerns and practice, a synthesis of their findings would be instructive.

Future research

A further metasynthesis of data arising from studies that did not meet the inclusion criteria, or that used focus groups or other methods, could be undertaken, and the results could be compared with those reported here. During the search, there was a reasonably large number of studies that have used the time diary method to explore engagement in activities of daily living for people with schizophrenia. These data may be amenable to synthesis or meta-analysis. Regardless of the future direction taken by this line of inquiry, metasynthesis is a rigorous and valid method that could provide the profession with valuable insights into practice.

Conclusion

This study has answered the stated research question, 'How do people who have experienced psychosis describe their engagement in activities of daily living, both singly and when grouped into occupations?' Engagement in meaningful activities and occupations was described by the different participants and participant groups in reference to four main themes: their emotions and identity; their own health and wellbeing; their family, friends and community; and their activities and occupations. Although there was much consonance around the overarching themes across the studies, some areas of dissonance were evident in regard to the temporal perspective taken of recovery and the level of support desired for self-care and domestic activities of daily living during periods of acute psychosis.

The findings provide clear guidance for therapists around how to provide authentic, respectful and effective support to people with psychosis, in a manner that meets their needs as individuals. Tailoring therapy to each client's needs, enabling opportunities for pleasurable engagement and the valuing

of intrinsically motivating occupations should be priorities for occupational therapists working with people who have experienced psychosis. Providing and supporting a sense of hope for the future enables clients to act as their own agents for change throughout their lives. Occupational therapists should also focus on enabling clients to maintain existing relationships, and positively develop new ones in their community. The profession also has specific expertise in supporting clients to engage in employment and in understanding the effects of the environment, both of which this study has identified as essential to successful recovery.

The highlighted synchronicity between the experiences of people who have experienced psychosis and the values and philosophy of the profession shows that occupational therapists possess the knowledge and skill to deliver this high quality support.

Conflict of interest: None declared.

Key findings
- Confirmation that engagement in activities is fundamental to the lives of people with psychosis.
- Considerable synchronicity between the experiences of people with psychosis and the occupational therapy values.
- Occupational therapy can provide authentic, respectful and effective support to people with psychosis.

What the study has added
The study highlights the effectiveness of metasynthesis as a means of critiquing and synthesising research evidence that directly represents the occupational being of people with psychosis.

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Appendix 1. Themes from all included studies

My emotions and identity	My own health and wellbeing	My relationships with family, friends and community	My activities and occupations
Happiness is gone (JA Brown 2011)	No life before psychosis (JA Brown 2011)	Relationships with family okay, but no intimate relationships (JA Brown 2011)	Little effect on self-care, but developmental progress to independent living disrupted (JA Brown 2011)
Excitement (Emerson et al 1998)	Lack of knowledge about psychosis (JA Brown 2011)	Social connectedness (Emerson et al 1998)	Productivity important as other areas are lost (JA Brown 2011)
Accomplishment (Emerson et al 1998)	Everything narrows in acute phase (JA Brown 2011)	Importance of maintaining relationships (Deegan 2002)	Tolerant environments help (Deegan 2002)
Relaxation (Emerson et al 1998)	Finding a way forward (JA Brown 2011)	Feeling connected to others (Woodside et al 2006)	Help provided by community mental health services (Legault and Rebeiro 2001)
Being interested (Emerson et al 1998)	Self-care strategies that work for me (Deegan 2002)	Engagement as an interpersonal relationship (Hitch 2009)	Positive routines (Chugg and Craik 2002)
I am more than a schizophrenic (Deegan 2002)	Tolerating discomfort while engaging (Deegan 2002)	Important that staff and services show they value the person (Cook and Chambers 2009)	External factors (Chugg and Craik 2002)
Overcoming internalised stigma (Deegan 2002)	Recovery as a process of transformation (Deegan 2002)	Having contacts with others (Eklund et al 2012)	Engagement in and through time (Hitch 2009)
Wasting my life away (Legault and Rebeiro 2001)	Drug use to cope (Deegan 2002)	Being part of a social context (Eklund et al 2012)	Enabling and disabling factors (Hitch 2009)
Reasons for engagement (Legault and Rebeiro 2001)	Coping with schizophrenia (Legault and Rebeiro 2001)		Occupational engagement (Hitch 2009)
Internal factors (Chugg and Craik 2002)	Using drugs and alcohol (Legault and Rebeiro 2001)		Occupational therapy focus (Cook and Chambers 2009)
Engagement as a means to self-actualisation (Hitch 2009)	Individualised coping strategies (Legault and Rebeiro 2001)		Factors that helped – external (Cook and Chambers 2009)
Factors that helped – internal (Cook and Chambers 2009)	Health (Chugg and Craik 2002)		Factors that hindered – external (Cook and Chambers 2009)
Precious memories (Eklund et al 2012)	Self-assessing/self-monitoring mental health (Woodside et al 2006)		Challenge of pitching interventions to suit the individual (Cook and Chambers 2009)
Feeling safe (Eklund et al 2012)	Working to maintain and improve mental health (Woodside et al 2006)		Feeling accepted (Eklund et al 2012)
	Factors that hindered – internal (Cook and Chambers 2009)		Having an everyday life that functions well (Eklund et al 2012)
	Being in good physical health (Eklund et al 2012)		Practising interests (Eklund et al 2012)
	Having good mental health (Eklund et al 2012)		Envisioning work or other regular daily activities (Eklund et al 2012)
			Feeling needed (Eklund et al 2012)