ORIGINAL ARTICLE

Social processes of participation in everyday life among persons with schizophrenia

MARIA YILMAZ1 PhD Student, STAFFAN JOSEPHSSON2 PhD, BERTH DANERMARK1 Professor & ANN-BRITT IVARSSON1 PhD

1The Academy of Health and Medicine sciences, Örebro University, Örebro, Sweden, 2Karolinska Institutet, Stockholm, Sweden

Abstract

Schizophrenia has an impact on social functioning and participation in everyday life. However, there is limited research concerning what persons with schizophrenia actually do in their societal context and what characterize the social processes influencing participation. The aim of this study was to identify social processes of participation in performing activities of everyday life among persons with schizophrenia by looking at what characterizes the social processes that precede or aggravate participation. Repeated participant observation of four persons with schizophrenia, performing everyday activities, was conducted, followed by interviews. A narrative analysis was used to analyse the data. Three plots constitute the main result: (1) When I know that I am appreciated and not different from others I want to continue what I’m doing (2) When I trust the people around me and have the possibility to mean something to them I do meaningful things (3) When I know in advance what’s going to happen I take part in discussions and mutual decision-making. The findings of this study can be used as a heuristic tool to structure the understanding of how different components co-operate in the social process of participation and can as such be applied when assisting persons with schizophrenia into participation in everyday life.

Key words: Social processes, schizophrenia, narrative, everyday life

Introduction

Difficulties in social interaction in everyday life frequently accompany a diagnosis of schizophrenia (Erdner, Nyström, Severinsson, & Lützen, 2002; Hvalsoe & Josephsson, (2003; Ivarsson, Carlsson, & Sidenvall, 2004; Mueser & Gingerich, 1994; Nyström, Dahlberg, & Segesten, 2002; World Health Organisation, 1990) and limit the person’s ability to participate in the activities of everyday life. The concept of social interaction is defined as the ability to interplay with people in a contextually and socially appropriate manner (World Health Organisation, 2001), and as a skill used in a person’s everyday activities to communicate intentions and needs and to coordinate social behaviour in order to interact with others (Fisher & Kielhofner, 1995). Interpersonal interaction and relationships are listed among the domains of Activity and Participation in the International Classification of Functioning Disability and Health (ICF) (World Health Organisation, 2001). Participation is defined as “involvement in a life situation” and can be qualified by what people do in their current environment (performance). A persons’ current environment includes the societal context in which the individual lives and performs. Some definitions of “involvement” are given in the ICF; to take part, being included or engaged in an area of life and being accepted or having access to needed resources. The focus of participation in this study has a social dimension, including “social processes”, which is the interaction with others that takes place while performing activities in everyday life, and how that interaction changes or develops over time. Earlier studies (Bejerholm & Eklund, 2004; Jansson, Sonnander, & Wiesel, 2003), indicate that the societal context of persons with schizophrenia often lacks opportunities for social interaction and activity performance. Jansson et al. (2003) and Bejerholm and Eklund (2004) indicate in their studies that there is a link between performing activities together with others and improved social interaction skills and enhanced self-esteem, but that these positive occasions are rare since persons with schizophrenia
spend most of their time alone in their homes. In order to target the difficulties with social interaction in everyday life among persons with schizophrenia or severe mental illness, several social skill approaches have been developed. However, research studies (Mairs & Bradshaw, 2004; Wallace, 1998) show difficulties in developing social skill training programs that result in increased social functioning for persons with schizophrenia. Wallace (1998) discussed the complexity of life and the difficulties to incorporate all aspects in a social skill training program and recommended the development of more precise assessments of individuals and roles, standardising training, presenting it in self-directed formats and increasing environmental supports. Brunt and Hansson (2002) also addressed environmental support when they investigated the characteristics of the social environment of small group homes for individuals with severe mental illness. Their findings showed that the most important characteristic according to the residents was social interaction, which mainly included aspects of interpersonal relations and companionship. This is in line with earlier studies (Halford & Hayes, 1995; Marley, 1998) where social support and meaningful relationships were found to be important to the improvement process of persons with severe mental disorders. Thus, these earlier studies imply that environmental support including social interactions and relationships is important to increase social functioning among persons with schizophrenia or severe mental illness. However, this could create a dilemma since social interaction in itself is a problem for persons with schizophrenia or severe mental illness (Erdner et al., 2002; Hvalsoe & Josephsson, 2003; Nyström, et al., 2002). A recent study (Yılmaz, Josephsson, Danermark, & Ivarsson, 2008) ascertained that persons with schizophrenia interact in complex ways when performing daily activities together with others since the participants both facilitated and hindered interaction depending on contextual factors. The contextual factors that were identified as influencing the interaction in a facilitating way were meaningful activities, trusting social attitudes and locations outside the home. The authors argued that if these facilitating factors were considered for each participant when planning or performing everyday activities it could lead to participation in everyday life. These findings could be compared to similar findings of factors associated to participation found in a study by Law (2002) where the nature and outcome of participation were described. Law (2002) found that there was a strong association between interests and participation. Further, she found that the social environment, in particular attitudes and the availability of social support was important in facilitating participation. Finally, experience in a wide variety of settings was essential for the development of participation patterns and the social interaction with others encountered while performing routines of everyday life.

A deeper understanding of how or why certain contextual factors can facilitate participation and how they unfold could give mental health professionals extended knowledge and a larger variety of tools in assisting persons with schizophrenia into participation in the activities of everyday life. Therefore, further research is needed to identify what persons with schizophrenia actually do in their societal context and what characterizes the social processes of participation. Consequently, the aim of the study was to identify social processes of participation in performing activities of everyday life among persons with schizophrenia.

Research questions

- What characterizes the processes that precede participation in performing activities of everyday life?
- What characterizes the processes that precede aggravation of participation in performing activities of everyday life?

Method

Design

To identify social processes of participation in performing activities of everyday life among persons with schizophrenia a narrative approach inspired by Polkinghorne (1995) was used since the data in a narrative approach contains descriptions of when significant events occurred and the effect the significant events had on subsequent happenings, which are configured and described in plots. The function of narrative analysis is to answer the questions how and why a particular outcome came about by asking, “How is it that this outcome came about; what events and actions contributed to this solution” (Polkinghorne, 1995). The data gathered in this study are diachronic (Polkinghorne, 1995), that is they contain temporal information about the sequential relationship of significant events connected to social processes when performing activities of everyday life. According to Polkinghorne (1995) segments of time can be considered in a lifetime perspective but also in daily or hourly episodes. By specifying the outcome (in this study; participation or aggravation of participation) the researcher locates a viewpoint from which to select significant events in the data necessary for producing the conclusion. Narrative analysis relates significant events and actions to one another by configuring them as contributors to the advancement of a plot. The findings must match the data while simultaneously giving it an order and
meaningfulness that is not apparent in the data themselves. Thus, narrative analysis is a synthesizing of the data rather than a separation of it into its constituent parts. When happenings are configured they take on narrative meaning.

**Participants**

A purposeful sampling was performed to select informative participants (Patton, 2002). The participants were recruited from a psychiatric ward in a county council in central Sweden. The selection criteria were: that the participants had been diagnosed with schizophrenia at least two years previously according to the International Statistical Classification of Diseases and Related Health Problems—Tenth Revision (World Health Organisation, 1990); that they were not in an acute psychotic mood; that they had been discharged from institutional care but were outpatients and had regular contact with the community-based mental health service and that they performed one or more daily activity together with other persons on a regular basis.

The staff at the psychiatric ward identified potential participants, introduced the study to them and asked if they would be willing to participate. Those who agreed received a letter to sign thereby giving their written consent. On receipt of their written consent to participate the first author made contact for an initial meeting. All participants were guaranteed confidentiality and were informed that they could withdraw from the study at any time, without it affecting their rehabilitation or care.

Four persons with schizophrenia, two men and two women, participated in the study. One woman was in her forties and the rest of the participants were in their fifties. None of the participants were married or had any children; they all lived alone with different forms of social support and their living conditions varied from living in their own apartments to living in supportive housing. All the participants had been diagnosed with schizophrenia more than four years previously.

**Data collection method**

The data collection consisted of participant observation, informal talks during the observation and qualitative interviews based on guidelines described by Patton (2002). The participant observation was conducted on three occasions for each participant; the second and third instances were followed by an interview concerning the participant’s experience of the recent activity performance and interaction. In one case only one interview was conducted since the participant had difficulties to concentrate. However, the data from the two occasions for observation and the one interview were deemed as rich enough to be included in the study. The observation took place in the participants’ environment and the observed activities and interactions were chosen jointly by the participant and his/her primary therapist (PT)\(^1\) from the participants’ daily routines. The activities were performed together with one or more persons with a certain amount of regularity in the participant’s everyday life. The observations focused on interactions that took place during the activity performance and lasted for one to two hours. All observation was overt: both staff and participants were informed of the study and knew why the observer was there. Further the observer was partly participant in the settings observed hence not exclusively taking the position of spectator (Patton, 2002). During the observation, detailed field notes were taken (Patton, 2002). The informal talks that took place intermittently were included in the field notes, and were separated from the rest of the text by quotation marks. The interviews were tape-recorded. The interviews took place in the participants’ homes or privately at the community mental health rehabilitation centres in accordance with the preferences of the participants. The interviews took between 15 and 30 min. A general interview guide approach was used combined with informal conversational interviews according to Patton (2002). That is, the researcher had before the interview took place outlined an interview guide with the same opening question used in every interview; “Tell me about how you experienced performing this activity/these activities together with NN?”, followed by questions such as “how did you feel when this happened …”, “tell me more about what happened at that time”. The interviews were informal and conversational since the participants were free to associate to other situations where he/she had had the experience of performing activities together with others. To let the participants talk about other situations connected to activities of everyday life and participation gave the researcher access to experiences and situations that were not covered in the observation and thereby also to a broader picture of the phenomenon in question (participation). Soon after the participant observation and interviews were completed the field notes were organized to create a more comprehensive text and the interviews were transcribed verbatim.

**Data analysis**

The data analysis was guided by Polkinghorne’s description of “Narrative analysis for eventful data” (Polkinghorne, 1995). In a narrative analysis, the researcher draws on disciplinary experience to interpret
and make sense of responses and actions. The interpretation of the data in this study was made from the perspective of the author, an occupational therapist with several years of clinical experience in the field of psychiatry. The analysis was made in the following seven steps resulting in the identification of three common plots, a plot could be described as a sequence of events forming a logical pattern and achieving an intended effect.

1. An initial reading was made to obtain an overall sense of the data through repeated examination of the transcribed interviews and field notes.
2. Significant events connected to social processes when performing activities of everyday life were searched for in each interview.
3. Marginal notes were then made in the transcribed interviews connected to each significant event about its possible narrative meaning in relation to participation.
4. Steps 2 and 3 were then repeated when analyzing the field notes to complete the transcribed interviews with significant events that had not occurred there or to support or expand the ones that did occur.
5. Related significant events and their narrative meaning for each participant were organized into individual plots, rendering meaningful connections between the significant events.
6. The individual plots for all participants were compared to one another to find similarities and differences and to see how they made sense outside of the data elements. Through this recursive movement process common plots were identified.
7. Analytic explanations were then made by the first author, which contributed to the construction of the plots.

Examples of the different steps in the narrative analysis are given in Table I.

During the data analysis narrative smoothing (Polkinghorne, 1995) was used to exclude the data elements that were not necessary for the analysis. These data elements did not contradict the plots, but were not pertinent to their development, for example, significant events that lasted for a very short period of time and/or were very similar to other significant events. In the common plots the social processes of participation in the activities of everyday life of the participants in this study as well as the social processes preceding aggravation of participation were identified. The plots describe how and why different social processes led to participation or aggravated participation in performing the activities of everyday life. These processes could be seen in the everyday life of all participants (Adam, Bo, Cissi and Diana). The circumstances differed for each participant but similarities in actions and significant events leading to or aggravating participation in the activities of everyday life were found. The richest descriptions of significant events creating a plot were used to illustrate the social processes behind the outcome. These descriptions derive from the data from one or two of the participants’ stories representing similar events that also occurred in the data of other participants. In order not to reveal the identity of the participants, the circumstances in which the significant events took place have been altered when presenting the findings, still keeping the focus on social processes of participation in the activities of everyday life. The main result addresses social processes that led to participation in performing everyday activities. The social processes that aggravated participation in everyday activities are given in connection to each plot to put the main findings in perspective.

**Ethical considerations**

An application for ethical approval to conduct this study was sent to the Regional Research Ethics Committee in Uppsala, Sweden, which decided that the study could be performed without any ethical scrutiny (Dnr 2005:242).

**Findings**

The result of this study is presented in three common plots giving possible explanations to how social processes precede or aggravate participation in performing everyday activities. The first plot consists of significant events that were characterized in the analysis as *when I know that I am appreciated and not different from others I continue what I'm doing*. The second plot consists of significant events characterized as *when I trust the people around me and have the possibility to mean something to them I do meaningful things*. Finally, the third plot consists of significant events characterized as *when I know in advance what's going to happen I take part in discussions and mutual decision-making*. The plots include data from all four participants although illustrated by one or two representative cases. The analytic explanations made are also included, contributing to the construction of the plots.

*When I know that I am appreciated and not different from others I continue what I'm doing*

At the time of the data collection Cissi worked at a sheltered workshop where she got on well with her
### Table 1. Examples of the different steps in the narrative analysis.

| Step | Interpretation of narrative meaning | Individual plots for each participant | Common plots step 6 |
|------|-------------------------------------|---------------------------------------|--------------------|
| 2    | Significant events found in the interviews and/or field notes | C. Talks about her PT as a person that can put her foot down and is honest, she likes that because that is the way she is too. Her PT supports her in different ways depending on how she feels. | To be seen, heard and listened to lead to participation in activities of everyday life. |
| 3    | Interpreted narrative meaning      | D. Arriving at the sheltered workshop, everyone she meets greets her and she feels appreciated. She feels appreciated and receives attention from her coworkers and because of that she likes going to work. | To be met by respect, to receive attention from others and to have straightforward communication lead to participation in activities of everyday life. |
| 4    |                              | D. Talks about her best friends who live in different cities. She calls them on the phone sometimes. They are going to meet in the summer and go on a trip together. She plans her trips herself together with her friends. | To have friends, to take the initiative to and to plan meaningful activities lead to participation in activities of everyday life. |
| 5    |                              | A. The bus connections are bad. He cannot find the short-cut to the bus station. It is far away and he does not know how to get there. He only leaves his home twice a week and he would like to walk around town more often. He doesn’t want to leave his accommodation more but because of insecurity and difficulties to express himself stays at home. The staff only has the opportunity to go with him twice a week. To have the desire to be able to do other things than what he does now but not the opportunity to do so lead to aggravation of participation in activities of everyday life. |
| 6    |                              | B. Previously worked at the Fountain house. It was fun. He was kept from a job he had liked. He was disconnected from the job. One day he couldn’t find the bus home. He then has to ask his PT to help him home. He only lives on the home once a week and he would like to walk around town more often. | A lack of attention (respect), to have difficulties in expressing himself lead to aggravation of participation in activities of everyday life. |
work-leaders and co-workers. When she arrived at the sheltered workshop everyone she met greeted her by her name. Cissi expressed that, “It is fun, it makes you feel appreciated”. Cissi demonstrated good knowledge of her job-tasks. She knew what to do, where to do it and at what time each task was supposed to be done. When she and one of the work-leaders were about to finish a job they had worked on together Cissi pointed out that they needed to leave to be in time for their next job. To begin with the work-leader said that they had plenty of time, but Cissi insisted and the work-leader trusted her to be right and told her to go first and that he would follow soon after. When she arrived at the bus that would transport the group to their next job the others had been waiting for her and seemed happy that she had arrived. At the next job Cissi commenced and completed each task with the same confidence as before and was praised by the work-leader for doing a good job. Cissi stated that she did not have the feeling that some made more decisions than others and that she felt appreciated by her co-workers and work leaders.

This could be understood to mean that the appreciation, trust and acceptance Cissi received from the people at the sheltered workshop made her feel included and because of that continued to perform her tasks together with the others at the sheltered workshop. She also expressed confidence in her boss:

“... he is always willing to help if one ever has problems ... he looked at me and saw that I didn’t feel good and found out what the problem was ...”

The boss was sensitive to the workers needs, which seemed to contribute to the supporting atmosphere at the sheltered workshop.

Cissi also had support at home. Her PT visited her regularly to support her in performing different activities at home. Cissi expressed the variation of support she got from her PT. “No, she supports me in everything, sometimes she does nothing, she just sits there and is a support to me ...”. An example of how the PT supported Cissi was when the PT asked her what they should do that day. Cissi made a suggestion but the PT answered that the activity that she had suggested was something she could handle herself without support from her. Cissi agreed and made a new suggestion, which the PT accepted as something she needed support with. A quote from Cissi shows how much she appreciated the way she and her PT communicated with each other:

“... I think it is more effective with NN (the primary therapist) ... and she ... she can put her foot down ... she is straightforward and honest just like me and then it works fine I think”.

Occasionally there could be disagreements between Cissi and the PT but because of their ability to communicate and the respect they had for one another, in these situations they were able to either compromise or give in to the will of the other. Cissi expressed it succinctly: “It is either her or me that gives in, or we reach a compromise”.

To have straightforward communication with the primary therapist was found to be a significant event that led to participation in the activities of everyday life for Cissi. This communication gave the PT information about Cissi’s need for support. They could then together discuss and plan what the support should consist of. Because of the way the PT involved Cissi in the planning of the tasks to be done as well as giving an honest answer to her first suggestion Cissi participated both in the planning and in the performance of the activity. This could be understood as the PT considering Cissi her equal.

This plot addressed the process through which receiving attention and respect from others and benefiting from straightforward communication led to participation in activities of everyday life. Of importance within this process were significant events related to appreciation, acceptance and trust. A short reflection on the opposite, which is social processes that aggravated participation in the activities of everyday life of the participants, will render some perspective to the plot above.

Cissi once talked about earlier situations when she had had primary therapists that showed a lack of respect by not being on time for their planned meetings, which made the resources she needed for participating unobtainable. Another example of aggravating social processes in the activities of the participants’ everyday life happened during a shopping tour with Bo. When he started a conversation with the cashier at the counter, the cashier just ignored him and he left the counter quietly. At another occasion he got tired during an activity performed in his apartment. He tried to express this to his PT by complaining that his back was hurting. The PT didn’t seem to take the hint since he just told Bo to take it a little easier. Later, during the interview, Bo stated:

“Well, I think the best way is that one can work as much as one is capable of and that the staff do the rest, that they have a sense of how much one is capable of ...”.

Because of the communication problems between Bo and the PT he was not participating in the planning of the activity performance, he did what the PT told him to, but finished the task quickly and carelessly. Included in the processes preceding aggravation
of participation were events related to communication difficulties, lack of respect and/or attention, which led to withdrawal from participation.

*When I trust the people around me and have the possibility to mean something to them I do meaningful things*

Bo put across during the interview that he would like to find some meaning in what he did. He had read in magazines that it was important to find the meaning of life. Still he found it difficult to take part in different activities. However, at the time of the interview Bo went regularly to church services, he stated that it was a way to find this meaning of life:

“Well, it’s very difficult [to take part in different activities] … the little time I spend outside the home is when I go to church services … it’s good to seek God as the meaning of life”.

Bo recounted that at the church he first sat together with the other church visitors and talked to the minister. After the service he either stayed to listen to a Bible seminar held by the minister or he moved on to another church to join their meeting. Even though some of the other church visitors accompanied each other to the other church, Bo never joined them. Still, he expressed that he thought it was fun at the church when there were a lot of people there and that he felt that he had something in common with those people:

“Well, I do [feel fellowship with the others at the church] of course, they are odd people that join the service, and still they have an intrinsic value.”

Even though Bo didn’t seem to interact with others when visiting the churches he obviously felt involved in the activity and because of that, and the feeling of fellowship with the others at the church he was motivated to participate regularly in this activity, which also necessitated planning and initiative.

Diana talked about her interest in making short trips and how that made her feel relaxed. During these trips she made new friends and met friends from earlier trips. She planned to go on two trips together with her friends in the summer. Sometimes Diana made the trips on her own but she preferred to have company:

“It’s always more fun to have company, because then you always have someone to talk to…. It’s important if you think socially … to come out and meet people and have someone to talk to.”

I asked her what she did during her trips and she told me that she usually ate good food, and drank some beers, danced and listened to music together with her friends. Diana had also got to know some of the orchestras at dance saloons. Some of them had played in her hometown and she told me that she went there to listen to them. She said, full of expectations:

One of the orchestras will come here for midsummer, then I will go there to serve them coffee … They usually let me help them, last time they were here was on a Tuesday and I went there early and then they let me help them unpack their equipment.

Diana’s other big interest was in performing art. Through her contact with the community mental health service she had the possibility to join a performing arts group once a week. She conveyed that taking part in this group was both fun and stimulating and that the other members of the group were nice people and easy to get on with; “… we have fun, yes we do …”. She also said that it was easier to go outside when she had something fun to do, such as joining the performing arts group:

…but sometimes it is easier to go outside it depends on what it is, if the weather is nice outside and I will take a walk if I need to go outside, then it’s very difficult but if I’m going somewhere to do something that I think is fun, that I think is good, then it’s easier to go outside.

One of the occasions for observation took place during one of the performing arts group’s rehearsals. During the rehearsal Diana was very actively engaged. This was exemplified by the way she expressed her own opinion about parts of the programme they were rehearsing, and how she discussed with the supervisor the different ways in which the program should be performed. During observation it also became evident that Diana was good at what she was doing since she was the main character of the programme. During the interview Diana told me that the performing arts group performed at different places for example at day-care centres for older people or other locations. She said that sometimes after the performances people came up to her and praised the work she had done and that she appreciated that very much and that she felt that her involvement in the group made it easier for her to meet and make contact with others. She expressed her feelings like this:

“Well, it is happiness. Happiness and one gets self-confidence when one notices that people like what one does and my art and so on … and that makes one feel that one can mean something to others …”.

Diana initiated and planned her trips by herself; she kept in contact with her friends in other cities by calling them on the phone now and then, and for
planning future trips. Diana gave the impression of a quite self-governed person who showed trust both in her private social environment and in the mental health setting. It could also be understood that Diana felt that she meant something to others when she helped the orchestras with their equipment or served them coffee. Because of her own motivation and trust in her social environment, for example in the performing arts group where mutual giving and taking took place, Diana could continue to participate in an activity that was interesting and meaningful for her. It was also stimulating to have the opportunity to perform for others, which sometimes led to new contacts and appreciation from others. This plot addressed how a process of having the opportunity to perform meaningful activities together with other people led to participation in the activity being performed. The social processes, addressed in this plot that led to participation in activities of everyday life were related to facets of taking initiative, expressing an interest that could be performed because of a trust in the social environment and/or because of intrinsic motivation. To mean something to others increased self-confidence, which could be assumed, stimulated further participation in the meaningful activity performed.

In the participants’ stories social processes that aggravated participation in the activities of everyday life were also found and could shed further light on this plot. These social processes were related to lack of initiative, difficulties in expressing interest or feelings of insecurity in the social environment, which in turn limited the possibilities to perform meaningful activities and impeded participation in the activities of everyday life. Adam talked about activities he wished to do or was interested in doing but did not do. He talked about places where he had lived before when he was young and that he would like to go there again. He wanted to do meaningful things, and dreamt of art exhibitions. Adam stated further that the few times he got out of his home weren’t enough. In order to go down town by himself, he had to take the bus but the bus connections where he lived were very bad, and he did not know his way to the bus stop; because of this he had to stay at home until someone could accompany him. He talked about a job he had had earlier that he liked very much at a Fountain House, but that he was now kept from going there. He was not sure but he thought that it was because his financial support person had said that he could not afford the bus fare.

When I know in advance what’s going to happen I take part in discussions and mutual decision-making

Two occasions for participant observation took place during shopping tours with Adam. Two different PTs accompanied him on those occasions. Before leaving Adam’s apartment, on the first occasion, he and the PT planned what groceries to buy. They helped one another to suggest different groceries to be bought while writing the shopping list. It did not necessarily mean that every suggestion should be bought but they were checked, if something was found in the larder it was not written down on the list. The interaction gave the impression that this was a routine where the same groceries were checked on every occasion. When the list was completed we left the apartment and went out to the car. Adam told us that three different shops were to be visited in a certain order for buying certain things at each shop. During the shopping tour Adam and the PT read the shopping list together and sometimes discussed, for example, prices of equally groceries between themselves. Sometimes Adam saw something in the store that he wanted to buy that was not on the list. He then discussed with his PT if he could afford it before he chose to buy it or not. On some occasions the PT reminded him that what he wanted to buy he either already had at home or were unnecessary things.

On the second shopping tour he went together with his other PT. The shopping list was already written and contained only four items. Adam then told the PT that they had to buy Coca Cola too, and the PT wrote it down on the list. In the car Adam said that he wanted to go to the three stores he visited during the last shopping tour. The PT was surprised and asked what he was going to do at one of the stores. Adam answered: “It’s cheaper there ... to buy soft drinks and fruit”. At the store we passed the bread department and the PT asked if Adam wanted to buy bread here or at the other store. Adam did not answer, just looked at the bread. Finally the PT chose the bread, which Adam accepted. We went on to the next store and Adam wanted to buy bread there too, which gave the impression that it was at this store where Adam usually bought bread. He stopped and looked at the bread counter, picked up two different kinds of bread and asked the PT for his opinion. The PT suggested one of the loaves but Adam hesitated. The PT finally chose the bread Adam usually bought and he was satisfied. During the second shopping tour Adam bought more things than where on the shopping list.

On the first occasion when Adam went shopping together with his PT a certain routine and structure was noted. This routine and structure described above led to enhanced participation in the activity being performed since Adam was more involved as he discussed and made decisions together with his PT. The well-prepared shopping list seemed to help structure the shopping tour so that not too many unnecessary things were bought and Adam saw for himself and discussed with his PT what was left to
buy. It could also be understood that following a routine helped Adam to know in advance what was going to happen and which shops to visit, which helped him to prepare himself for the activity. On the second occasion, however, the routine and structure was not as obvious as on the first occasion. It was often interrupted and because of that Adam seemed confused and put more of his energy on trying to recreate the routine than on discussion and mutual decision-making. The lack of a structured and thoroughly discussed shopping list probably resulted in him buying things he already had at home or that were unnecessary. The lack of structure and routine decreased the number of opportunities for discussion and mutual decision-making, which in turn aggravated participation in the everyday activity being performed.

During observation at Cissi’s home she conveyed that it was important for her that others were punctual and that she had the agreed amount of time together with her PT. Because of that she and her PT had made an agreement of “flexible time” which meant that if the PT was ten minutes late she consequently stayed ten minutes longer. Cissi also told me that she and her PT had made a schedule of their meeting times. Before her latest episode of hospitalisation the schedule also contained which activities that they should perform on each occasion. Cissi thought that the schedule containing activities worked very well and now when she felt stronger she said that she wanted them to start doing that again. Cissi expressed that she appreciated that her PT supported her in performing different activities when she needed it, and compared it to former PTs she had had, “…well, with the others it was just like I did the dishes and they vacuum-cleaned …”.

This could be understood to mean that the structure of a schedule helped Cissi to prepare herself before every session with her PT, which made it easier for her to participate in the planned activities. The way in which she described her former PTs gives the impression of a negative routine where the support was not adapted to Cissi’s needs of support in performing different activities but instead followed some kind of general routines not meeting neither her needs nor her abilities which could be seen as a decrease in the possibilities to participate in a variety of activities of everyday life. The same could be seen in the short story of Adam’s shopping tours when, on the second occasion, Adam’s need for routine and structure was disturbed and he became more unsure and less participatory.

This plot addressed the close connection between having routines and structure in everyday activities and social processes including significant events related to discussions before decision-making and help to foresee and prepare for coming activities and how this in turn led to participation in the activities of everyday life. However, it also shows examples of how a lack of routines and structure can impede the social processes of taking part in discussions, mutual decision-making and preparing oneself for different activities, which led to aggravation in participating in the activities of everyday life.

**Discussion**

The main findings of this study identified different social processes that led to participation in performing activities of everyday life among the participants. The content of these processes were described in three different plots, supported by events and short stories found in the data. The findings also identified social processes containing events that aggravated participation in everyday life, which in many ways were found to be the opposite of the processes leading to participation. Further, it can be noted how these three plots have fallen out, clustering events in accordance with the main categories that contribute to participation, according to the ICF (World Health Organisation, 2001): (1) environment; (2) personal factors; and (3) activity. To include evidence and arguments in support of the plausibility of the offered findings (Polkinghorne, 1995) the main findings of this study will be discussed in relation to perspectives of Recovery and Occupational therapy theory.

The findings in the first plot of this study indicate that social processes that included significant events where the participant was met by respect, received attention and took part in straightforward communication led to participation in everyday activities. This is in line with what has been found to be effective components in both the Recovery paradigm (Anthony, 1993; Borg & Kristiansen, 2004; Deegan, 2001; Happel, 2008; Mancini, Hardiman, & Lawson, 2005) and in client-centred practice for occupational therapy (Law & Mills, 1998; Sumison & Lencucha, 2007; Sumson, 2004; Townsend, 1997). Both in recovery research, including personal stories of people that have recovered from mental illness (Borg & Kristiansen, 2004; Deegan, 2001; Happel, 2008; Mancini et al., 2005), and in the principles (Law & Mills, 1998) and research of (Sumison & Lencucha, 2007; Sumson, 2004) client centred practice in occupational therapy, key values for a successful recovery or rehabilitation process have been identified. These features are almost identical in both perspectives. They both highlight the importance of supportive and therapeutic relationships including trust, respect for the choices and priorities of the client, active listening and empathy. Client centred practice in occupational therapy also emphasizes the importance of shared responsibility and mutual
respect for each other and to meet as equals, each with his or her own expertise (Law & Mills, 1998). According to these theoretical perspectives and research findings it is plausible that above mentioned key values or effective components could also be important elements in social processes leading to participation in everyday activities as the findings in this study indicate.

The findings in the second plot of this study imply that to take one’s own initiatives to perform meaningful activities together with others, to trust in one’s social environment and to mean something to others are significant events in the social processes that lead to participation in the activities of everyday life. To perform perceived meaningful activities was understood to be central in this plot leading to participation. It was the activity per se that motivated the participants to go outside and to meet others, which sometimes led to circumstances where the participants felt that they could mean something to others. Similar findings were addressed in a recent study (Leufstadius, Erlandsson, Björkman, & Eklund, 2008) describing how, for example, to talk to and to have contact with others, to keep up with the outside world, to feel needed and to help others, to have enjoyable and interesting occupations and to learn new skills were found meaningful in the daily activities among persons with mental illness. In a study by Deegan (2005) she reported that nearly half of the research participants mentioned that helping others in formal or informal ways had a reciprocal effect, that is by helping others they also found ways to help themselves.

The concept of perceived meaningful activities was also addressed in a study by Mancini et al. (2005) where all participants stated that a key factor facilitating recovery was having opportunities to grow and develop through meaningful activities. The engagement in meaningful activities allowed them to develop confidence and feel a connection with something “bigger than themselves”. Further, Deegan (2005) found that valued roles and activities gave life a sense of direction, meaning and purpose to persons with psychiatric disabilities, which raised their self-esteem and helped decrease symptoms. This can also be found in occupational therapy theory. Kielhofner (2008) talks about occupational roles and the way in which we see ourselves in different roles and act as someone that holds that role. Without sufficient roles, one lacks identity, purpose and structure in everyday life. Further Kielhofner (2008) states that disability may not only bar people from occupational roles but may also relegate them to sick and deviant roles. Activity is the core of occupational therapy practice (Creek, 2002) and purposeful activity is used in therapy to provide the opportunity for the individual to achieve mastery, thus gaining a sense of inner assurance and competence (Roberts, 2002) which also affects occupational roles. Intrinsic motivation, planning and to take one’s own initiatives comes from the person’s own abilities. Motivation, for example, is considered to be intrinsic and is facilitated by the client’s participation in identifying meaningful goals and occupational priorities (Cole & Tufano, 2008). This could also be seen in the findings of this study. When the participants had the opportunity to choose and perform activities that were meaningful and interesting to them, they also took initiatives and planned those activities.

According to recovery research (Farkas, Gagne, Anthony, & Chamberlin, 2005) growth potential is a key value for recovery with a focus on the inherent capacity of an individual such as special gifts and resources. Further, Farkas et al. (2005) point out that mental health professionals must explore these special gifts and resources and help the consumers to mobilize these in the service of recovery. The findings in this study indicate that when the participant trusted in the social environment they took initiative to perform perceived meaningful activities. The literature and theories discussed above support the result of this study and the assumption that to take one’s own initiatives to perform meaningful activities together with others, to trust in one’s social environment and to mean something to others are significant events in the social processes that contribute to participation in everyday activities.

Finally, the findings in the third plot of this study identified social processes where significant events such as mutual decision-making and to take part in discussions preceded participation in activities of everyday life, which has much in common with the first plot. However, what was interesting here was that the creation of routine and structure as strategies in connection to performing the activities seemed to increase the possibilities of participation. Routine and structure are concepts that connect to the recovery perspective and to occupational therapy. Leufstadius et al. (2008) found in their study that to have certain routines, including certain activities, during the day was perceived as meaningful among persons with persistent mental illness. Routines and habits are patterns of behaviour in people’s daily lives, consisting of activities that ensure the presence of and structure for the familiar in our daily life, thus offering stability and protection against chaos (Hasselkus, 2002). People with severe mental illness who spend most of their time at home with no regular occupation or activity (Bejerholm & Eklund, 2004) have to constantly struggle to maintain a normal circadian rhythm (Hvalsoe & Josephsson, 2003). In Deegan’s (2001) personal story of how she recovered
from mental illness she shares her own recovery strategies with the reader. One strategy was to have routines. She says:

Routines were important to me, especially in the early years of my recovery. Sometimes when everything was falling apart inside of me, it was good to be able to rely on routines that would give form and structure to the chaos I experienced (Deegan., 2001).

Methodological considerations

The purposeful sampling was made to reach informative participants who had experience of and could give information about the phenomena studied (Patton, 2002). The way the potential participants were asked by staff from the psychiatric ward if they were willing to participate in the study could be questioned because of the dependent position they had in relation to the staff. However, the reason for this procedure was the hope that the potential participants might feel more comfortable being asked by someone they knew rather than a stranger. Another questionable issue was that the first crucial oral information did not come directly from the researcher and, therefore, could have been changed to some extent even though information about the study had been given at several occasions to representatives from the staff. This could have influenced the number of participants that agreed to participate in the study.

Considering the aim and research questions of this study it was appropriate to use a narrative approach (Polkinghorne, 1995) since the narrative analysis identified significant events and actions in the participants' narratives and related them to each other over time, rendering an explanatory causal meaning to the outcome, that is, social processes of participation in performing activities in everyday life. A disadvantage of using narrative analysis with data from short episodes of everyday activities could be that the individuals’ stories become less prominent. However, it should be noted that with the identified plots we have made room for the variety and complexity of all four participants' stories. In accordance with Polkinghorne (1995) we have reasoned that plots mark off a segment of time in which events are linked together as contributors to a particular outcome. Segment of time can range from the boundless, to life-times, to daily or hourly episodes. In each case the plot establishes the beginning and end of the storied segment thereby creating the temporal boundaries for the narrative gestalt. In this study daily and hourly episodes that took place in the everyday life of the participants were studied and resulted in three separate common plots where social processes of participation were identified. To insure that the narratives were as rich as possible a combination of interviews and participant observation was used as the data collection method since narratives can be both verbal and enacted (Josephsson, Asaba, Jonsson, & Alsaker, 2006). The way everyday activities are performed may reflect skills and abilities as well as interests and joys (Alsaker & Josephsson, 2003). Participant observation (Patton, 2002) rendered the opportunity to capture and understand the context in which the social processes took place and to see things that may routinely escape the notice of the people within the setting. The interviews (Patton, 2002) were done to obtain the participant’s own view of the experience by using a general interview guide combined with an informal conversational approach. An advantage of using the informal conversational approach was that it gave access to activities that the participant had performed together with others at some previous point in time, which enriched the data. The trustworthiness of the study was ensured through a rigorous process of analysis, as described in the method section, and through constant discussion between the authors during that process (Miles & Huberman, 1994).

Conclusion

The identified social processes, described in the three common plots, which led to participation in the activities of everyday life in this study, included significant events that are in line with effective components found in the theoretical perspectives and empirical research of the recovery paradigm and occupational therapy theory. The findings in this study imply that what people with schizophrenia actually do in their societal context and how they contribute in the social processes that lead to participation is influenced by both individual factors such as the person’s unique intrinsic capacities or strength and meaningfulness of the daily activities they perform, and contextual factors such as the restrictions or possibilities in their social and physical environment. This is in agreement with the main categories in the ICF (World Health Organisation, 2001), environment, personal factors and activity. However, it is of importance to point out that in reality the social processes described in the three plots are interwoven and complex as an ongoing interaction between them takes place. Considering the findings in this study the point of departure for creating programs aiming at increasing social skills and participation should be individual with a balance between routines, structure and flexibility. This is a challenge since no standard programme can cover all effective components for all individuals, especially
since these components can change over time. Thus, the findings of this study do not give an unambiguous answer to what kind of significant events in the social processes lead to or aggravate participation in the activities of everyday life. However, it can be used as a heuristic tool to structure the understanding of how different components cooperate in the social process of participation and can, as such, be used in assisting persons with schizophrenia into participation in everyday life.

Acknowledgements

The authors are grateful to the informants for their participation in this study. They would also like to thank the staff of the community mental health services and the staff of the psychiatric ward for their help during data collection. Örebro University, Swedish Institute of Disability Research supported this study financially.

Declaration of interest: The authors report no conflicts of interest. The authors alone are responsible for the content and writing of the paper.

Note

1. Primary therapist is an assistant nurse in community mental health, assigned to support 5–10 specific clients in different areas of life.

References

Alsaker, S., & Josephsson, S. (2003). Negotiating occupational identities while living with chronic rheumatic disease. Scandinavian Journal of Occupational Therapy, 10, 167–176.

Anthony, W. A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. Psychosocial Rehabilitation Journal, 16, 11–24.

Bejerholm, U., & Eklund, M. (2004). Time use and occupational performance among persons with schizophrenia. Occupational Therapy and Mental Health, 20, 27–47.

Borg, M., & Kristiansen, K. (2004). Recovery-oriented professionals: Helping relationships in mental health services. Journal of Mental Health, 13, 493–505.

Brunt, D., & Hansson, M. (2002). Characteristics of the social environment of small group homes for individuals with severe mental illness. Nordic Journal of Psychiatry, 56, 39–46.

Cole, M. B., & Tufano, R. (2008). Applied Theories in Occupational Therapy. Thorofare: SLACK Incorporated.

Creeke J. (2002). Treatment planning and implementation. In J. Creeke (ed.), Occupational therapy and mental health (Third ed.). Edinburgh: Churchill Livingstone.

Deegan, P. E. (2001). Recovery as a self-directed process of healing and transformation. Occupational Therapy in Mental Health, 17, 5–21.

Deegan, P. E. (2005). The importance of personal medicine: A qualitative study of resilience in people with psychiatric disabilities. Scandinavian Journal of Public Health, 33, 29–35.

Erdner, A., Nyström, M., Severinson, E., & Lützén, K. (2002). Psychosocial disadvantages in the lives of persons with long-term mental illness living in a Swedish community. Journal of Psychiatric and Mental Health Nursing, 9, 457–463.

Farkas, M., Gagne, C., Anthony, W., & Chamberlin, J. (2005). Implementing recovery oriented evidence based programs: Identifying the critical dimensions. Community Mental Health Journal, 41, 141–158.

Fisher, A. G., & Kielhofner, G. (1995). Skills in occupational performance. A model of human occupation. Theory and application (Second ed.). Baltimore: Williams & Wilkins.

Halford, W. K., & Hayes, R. L. (1995). Social skills in schizophrenia: Assessing the relationship between social skills, psycho-pathology and community functioning. Social Psychiatry Psychiatric Epidemiology, 30,14–19.

Happel, B. (2008). Determining the effectiveness of mental health services from a consumer perspective: Part 1: Enhancing recovery. International Journal of Mental Health Nursing, 17, 116–122.

Hasselkus, B. R. (2002). The meaning of everyday occupation. Thorofare: SLACK Incorporated.

Hvalsoe, B., & Josephsson, S. (2003). Characteristics of meaningful occupations from the perspective of mentally ill people. Scandinavian Journal of Occupational Therapy, 10, 61–71.

Ivarsso, A., Carlsson, M., & Sidenwall B. (2004). Performance of occupations in daily life among individuals with severe mental disorders. Occupational Therapy and Mental Health, 20, 33–50.

Jansson, L., Sonnander, K., & Wiesel, F. A. (2002). Clients with long-term mental disabilities in a Swedish county—conditions of life, needs of support and unmet needs of service provided by the public health and social service sectors. European Psychiatry, 18, 296–305.

Josephsson, S., Asaba, E., Jonsson, H., & Alsaker S. (2002). Creativity and order in communication: Implications from philosophy to narrative research concerning human occupation. Scandinavian Journal of Occupational Therapy, 13, 86–93.

Kielhofner, G. (2008). Model of Human Occupation. Theory and application. (Fourth ed.). Baltimore and Philadelphia: Lip-pincott Williams & Wilkins.

Law, M. (2002). Participation in the occupations of everyday life. American Journal of Occupational Therapy, 56, 640–649.

Law, M., & Mills, J. (1998). Client Centred Occupational Therapy. In: Law, M, editors. Client Centred Occupational Therapy. Thorofare: Incorporated.

Leufstadius, C., Erlandsson, L. K., Bjorkman, T., & Eklund M. (2008). Meaningfulness in daily occupations among individuals with persistent mental illness. Journal of Occupational Science, 15, 27–35.

Mairs, H., & Bradshaw, T. (2004). Life skill training in schizophrenia. British Journal of Occupational Therapy, 67, 217–224.

Mancini, M. A., Hardiman, E. R., & Lawson, H. A. (2005). Making sense of it all: Consumer providers’ theories about factors facilitating and impeding from psychiatric disabili-ties. Psychiatric Rehabilitation Journal, 29, 48–55.

Marley, M. A. (1998). People matter: Client-reported interpersonal interaction and its impact on symptoms of schizophren-ia. Social Work, 43, 437–444.

Miles, M. B., & Huberman, A. M. (1994). Qualitative Data Analysis. Thousand Oaks, California: SAGE Publications Incorporated.

Mueser, T., & Gingerich, S. (1994). Coping with Schizophrenia. A guide for families. Oakland, CA: New Harbinger Publications Inc.

Nyström, M., Dahlberg, K., & Segesten, K. (2002). The enigma of severe mental illness: A Swedish perspective. Issues in Mental Health Nursing, 23, 121–134.

Parson, M. Q. (2002). Qualitative research & evaluation method (third ed.). California: Sage Publications, Inc.
Polkinghorne, D. E. (1995). Narrative configuration in qualitative analysis. *International Journal of Qualitative Studies in Education, 8*, 5–23.

Roberts, M. (2002). Life and social skills training. In: Creek J, editor. *Occupational therapy and mental health* (Third ed.). Edinburgh: Churchill Livingstone.

Sumison, T., & Lencucha, R. (2007). Balancing challenges and facilitating factors when implementing client-centred collaboration in a mental health setting. *British Journal of Occupational Therapy, 70*, 513–519.

Sumison, T. (2004). Pursuing the client’s goal really paid off. *British Journal of Occupational Therapy, 67*, 3–9.

Townsend, E. (1997). *Enabling occupation. An occupational therapy perspective*. Ottawa: CAOT publications ACE.

Wallace, C. J. (1998). Social skills training in psychiatric rehabilitation: recent findings. *International Review of Psychiatry, 10*, 9–19.

World Health Organisation (1990). *International Statistical Classification of Diseases and Related Health Problems—Tenth Revision*. Genève.

World Health Organisation (2001). *International classification of functioning, disability and health. Short version*. Geneva: World Health Organisation.

Yilmaz, M., Josephsson, S., Danermark, B., & Ivarsson, A.-B. (2008). Participation by doing: Social interaction in everyday activities among persons with schizophrenia. *Scandinavian Journal of Occupational Therapy, 15*, 162–172.