

Flourishing in the face of mental illness: A heuristic examination of the contribution of  
leisure to creating a meaningful life

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I dedicate this work to my co-researchers for having the courage to tell their stories and, to the millions of people who experience mental illness each year. May you always know you're not alone in this journey, and may you someday experience a world in which there is no stigma against mental health...

And, to my beloved Abby, you have been my loyal partner over the past 10 years. You have saved me from suicide, you have loved me on the darkest days and you have inspired me to get well, stay well and someday become the person you already believe am. Thank you for sharing this life with me. There will never be a love more pure or powerful than that of a well-loved dog...

**Abstract**

The purpose of this research was to examine the ways in which individuals with mental illness create a life of purpose, satisfaction and meaning. The data supported the identification of four common themes: (1) the power of leisure in activation, (2) the power of leisure in resiliency, (3) the power of leisure in identity and (4) the power of leisure in reducing struggle. Through an exploration of the experience of having a mental illness, this project supports that leisure provides therapeutic benefits that transcend through negative life events. In addition, this project highlights the individual nature of recovery as a process of self-discovery. Through the creation of a visual model, this project provides a benchmark for how a small group of individuals have experienced living well with mental illness. As such, this work brings new thought to the growing body of mental health and leisure studies literature.

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Graduate students learn from those who guide them, from the examples set for them and the challenges that they manage to overcome. They say if you haven't cried by the end of your second month as a master's student, you're doing something wrong. What they forgot to tell me is that at some point it's a good idea to stop! Ironically, this project is rooted in the study of abnormal psychology, so there's something comforting about being a student who, at times, needed a little extra care. As a student in the Department of Recreation and Leisure studies, I have had the honour of learning from a committee of dedicated faculty members who have made the unique challenges of being a mature student somewhat easier to face.

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## **Chapter 1 - Introduction**

In Canada, mental illness is the second leading cause of human disability and premature death (Dewa, Chau, & Dermer, 2010). According to Health Canada (2002), one in five Canadians will experience a mental illness in their lifetime, and the remaining four will have a friend, family member or colleague who will. Understanding mental illness and, more importantly, how people live well with mental illness, is an important and pressing concern for individuals, organizations, and governments. Of the mental health population in Canada, individuals with schizophrenia represent one percent of the population, individuals with major depression represent eight percent and individuals with anxiety disorders represent an additional twelve percent. In addition, Canadians who are of low socioeconomic status are three to four times more likely to report fair to poor mental health than those of high socioeconomic status (Centre for Addictions and Mental Health, 2009). However, according to Statistics Canada (2002), only one-third of individuals in need of mental health support services will actually receive them. The Government of Canada (2006) reported mental health to be a leading cause of disability in the country, accounting for thirty percent of disability claims and seventy percent of total costs (Centre for Addictions and Mental Health, 2009).

Leisure is a domain of life that is likely to be perceived as relatively free from external pressures, that is likely to generate positive emotion, and that can help people identify personal strengths, interests, and talents (Carruthers & Hood, 2007; Kleiber, 1999). Leisure, well used, has the potential to contribute significantly to the creation of meaningful social networks, community connections and a sense of enjoyment in life (Carruthers & Hood, 2007). Yet, the benefits of leisure are based on the assumption that

participants have the biological, psychological, social and environmental resources to engage in leisure that is personally meaningful and supportive of their well-being. This research is based on the primary assumption that participants have the biological, psychological, social and environmental resources to engage in leisure that is personally meaningful and supportive of their well-being. More simply stated, this project assumes that leisure is both possible and desired by the participants.

The role of leisure in the lives of individuals with mental illness who are socially connected, satisfied with their lives and demonstrating success in educational/vocational pursuits has not been examined and this gap in the literature frames this exploratory, heuristic study. The primary assumption of this project envelopes three additional conventions with regards to leisure. The first is that individuals derive pleasure and gratification from their leisure and ascribe meaning to such experiences. The second, leisure is not entertainment but rather purposeful engagement in free time activities with the intent of a preferred experience. And lastly, leisure provides an opportunity for transcending negative life events and provides context for freedom of self-expression and self-directed development (Kleiber, 1999).

Heuristic methodology is a form of phenomenology and is designed to determine the lived experiences of participants. Within this framework the participants are recognized as co-researchers with voices to be heard. This phenomenological approach is particularly useful for research on sensitive topics as it empowers the strengths and experiences of the participants and allows them to articulate their own perspectives on their lives (Moustakas, 1990). In addition, heuristics arise from a personal interest in a

particular area of inquiry. Moustakas suggests that heuristic inquiry begins with a question that the researcher seeks to answer.

The question is one that has been a personal challenge and puzzlement in the search to understand one's self and the world in which one lives. The heuristic process is autobiographic, yet with virtually every question that matters personally there is also a social – and perhaps universal – significance (p. 2).

My own experiences with mental health and my subsequent journey of creating a life of meaning provide a context for this study, as my own story became part of the data. In addition, my experience made the choice of heuristic methodology an appropriate one and will be further outlined in chapter 3.

The purpose of this research was to examine the ways in which individuals with mental illness create a life of purpose, satisfaction and meaning. This project sought to explore the problem of mental illness as it pertains to an individual's sustainability, to critically examine the potential role of leisure in recovery and to explore how individuals who identify their lives as meaningful despite their mental illness conceptualize and incorporate free time engagements (leisure) into their lives as a means of creating meaning. Through an exploration of current literature, I have highlighted the connection between leisure and the supportive role it could play in facilitating individuals with mental illness living well, while acknowledging the potential assumptions made by professionals within the mental health setting. Through the implementation of a heuristic methodology this research narrated the concepts of leisure as it pertained to the establishment of personal meaning within the lives of the participants. Finally, this research worked to contradict the assumption that leisure is psychologically unimportant and to highlight the contribution it makes to the establishment and maintenance of one's well-being (Kleiber, 1999).

This project incorporated the concepts of the Leisure and Well-being Model (LWM) of Therapeutic Recreation (Hood & Carruthers, 2007) as a framework for the exploration of the role of leisure as it pertained to the establishment of personal meaning within the lives of individuals with mental illness. This model is grounded in the literature arising from positive psychology including savouring, mindfulness, authenticity, resiliency and coping; and although these concepts were not the primary focus of my work, Hood and Carruthers' (2007) and Carruthers and Hood's (2007) examination of well-being was central to the conceptualization of this project. The LWM identifies the key components of well-being as positive experience and emotion in daily life, and the use and development of personal strengths and capacities. Hood and Carruthers (2007) further articulate that leisure is central to increasing positive emotion and supporting the development of strengths. Further discussion of this work is woven throughout the subsequent chapters, as this conceptual framework was foundational to the study.

A focus on positive emotion and strengths is supported by the work of Davidson, Shahar, Lawless, Sells, and Tondora (2006), who proposed that positive life experiences promote resilience and adaptation and through play and pleasure individuals with mental illness build up their restorative power, self-efficacy and social agency which contribute directly to an overall sense of well-being. Carruthers and Hood (2007) agree with the link between positive emotion and strengths, suggesting that "the development of resources and capacities related to the experience of positive emotion is an equally valued focus for Therapeutic Recreation service" (p. 284). Carruthers and Hood also suggested that leisure is a means through which clients can experience positive emotions that are central to

one's well-being. Carruthers and Hood also outline literature linking positive emotion to increased levels of physical, emotional and social health. As a result of these benefits, it is obvious that positive emotion offers outcomes including but not limited to one's achievement of well-being.

Shahar and Davidson (2003) examined the role of positive life events in the recovery process from severe mental illness. Within this work it was identified that individuals who report a higher number of positive life events also report higher levels of self-esteem, sense of self and overall quality of life. As a result, I suggest positive life events produce protective effects on individuals and assist them in dealing with the daily challenges associated with mental illness. Additional evidence to support this notion is presented within the Fredrickson's (1998, 2001) broaden-and-build theory, as well as Ryff and Singer's (2003) work on resilience.

Davidson, Haglund, Stayner, Rakfeldt, Chinman and Kraemer Tebes (2001) examined the impact of leisure engagements on individuals with mental illness and found that ongoing purposive activity in daily living provides participants with a sense of normality within a life that is otherwise dominated by treatment appointments. In addition to respite, this research identified that leisure engagements provide individuals with mental illness the opportunities for connectedness, increased sense of hope and savouring. When reflecting upon this work, Davidson et al. (2006) wrote "This sense that life has something more to offer than just disease, disability and despair appears central to people's ability to remain hopeful in the face of persistent dysfunction and disappointment and to become committed to making things better" (p. 156).

In the subsequent chapters I outlined the literature and methodological processes that supported my exploration of leisure as it pertains to living well with mental illness. It was through this study that I hoped to understand the thoughts, perceptions and experiences of individuals living well with mental illness in an attempt to demonstrate the value of leisure in recovery. By exploring how participants described the experience of mental illness and its impact on daily living and leisure, as well as the strategies employed by individuals to support living well, this research sought to answer the primary research question *how do individuals live well with mental illness?*

## **Chapter 2 – Literature Review**

### **The Problem of Mental Illness**

#### **Characterizing Mental Illness**

Mental illness is frequently associated with disruption in one's quality of life. Although the DSM IV provides psychiatric guidelines of symptoms associated with specific illnesses, for the purpose of this project, mental illness (unspecified) can be understood as abnormal psychiatric pathology that manifests symptoms which may include: auditory hallucinations, delusions, thought disorder, chronic sadness, mania, thoughts of harming self or others, and emotion dysregulation. As a result, many individuals with mental illness experience inertia; anhedonia; isolation/exclusion; apathy; lack of energy; low levels of motivation; and general dysfunction in daily living. Mental illness can affect one's thinking, mood or behavior and can be associated with impairment of functioning, however, it is important to note that individual symptoms will vary (American Psychiatric Association, 2000; Centre for Mental Health and Addictions, 2009; Davidson, 2003).

In Canada, at both the provincial and federal level, mental illness is often discussed in terms of financial expenditure and allocation of resources within budgets. However, it is my intention to illustrate the consequence of mental illness as it extends beyond the health care system and transcends throughout all aspects of one's life, creating challenges that may include underemployment, low social economic status, increased isolation, increased boredom and self medication (Drake, Bond, Thornicroft, Knapp, & Goldman, 2012; Government of Canada, 2006; Health Canada, 2002). As such, these issues outline the primary concerns that could be experienced by individuals with mental illness.

**Stigma**

Goffman (1963) suggested stigma to be the process by which the reactions of others spoils one's sense of normal identity. Social stigma is a broader issue that is represented by the disapproval of a person or group of people based on the assumption that certain characteristics distinguish them from other members of a society. Current existing literature suggests the stigmatization of mental illness that has proven to be widely endorsed by the general public is a significant problem that greatly impacts treatment and recovery opportunities. Corrigan and Watson (2002) identified three general themes that described public stigmatized attitudes: fear and exclusion; authoritarianism; and benevolence. Fear and exclusion encompasses a belief that individuals with mental illness are dangerous and should be removed from communities in order to keep people safe. Authoritarianism involves the adopted belief that individuals with mental illness lack the capacity to live an autonomous life and as a result require decisions to be made for them. And lastly, benevolence is the belief that individuals with mental illness are childlike and need to be cared for. As a result of the transcending mental health stigma from society to the individual, the accessibility and efficacy of treatment for individuals with mental illness becomes increasingly challenged.

Self-stigma is associated with one's internal process, and has a negative association with self-esteem, and impedes on social opportunities. Self-stigma is a product of the adoption of social beliefs or views by the individual that perpetuates negative self talk and may result in feelings of shame, hopelessness, fear, or anxiety and can result in moral disengagement from self and society. However, qualitative studies have identified that self-stigma is mediated by more than just the public. Individuals with mental illness have

identified stigma experiences within families and spiritual communities such as churches, with co-workers and even mental health caregivers, such as nurses, doctors and support staff. As a result, self-stigma has the potential to prevent participation in treatment programs, allowing much of the population to live with undiagnosed, untreated mental illness for prolonged periods of time.

Leisure provides an opportunity for transcending negative life events and provides context for freedom of self-expression and self-directed development (Kleiber, 1999). As such, leisure, well used, could provide an outlet of self-acceptance for individuals with mental illness that could work combatively towards recovery and living well despite the stigmatization that exists within society. In addition, leisure may also provide an opportunity for social connections, further supporting the acquisition of happiness and resilience in daily living. A focus on positive emotion and strengths is supported by the work of Davidson et al. (2006), who proposed that positive life experiences promote resilience and adaptation and through play and pleasure individuals with mental illness build up their restorative power, self-efficacy and social agency which contribute directly to an overall sense of well-being. Consistent with Carruthers and Hood (2007; 2013), it is obvious that positive emotion offers outcomes including but not limited to one's achievement of well-being.

### **Employment**

The mental health-underemployment paradigm is a product of the social stigma that exists around mental illness. Though the disclosure of one's mental health may increase the opportunity for supportive employment, it could synonymously limit the potential success of one's career, regardless of evidenced productivity (Tal, Moran,

Rooth & Bendick, 2009). Stable and supportive employment could be a social solution for the current mental illness epidemic worldwide (Drake et al., 2012). Employment creates an opportunity for individuals to experience higher levels of financial and emotional sustainability. Through a reduction in isolation and boredom, a supportive work environment can provide an appropriate space for individuals to foster a sense of autonomy and self-worth. As such, this may reduce instances of self-medicating behaviours, meanwhile alleviating the financial burden of government-based support funding.

Individuals who are unemployed or underemployed are more likely to have adverse mental and physical health consequences and are more likely to engage in damaging behaviours such as unhealthy eating, smoking and substance abuse as a means of coping with lower levels of life satisfaction (Rosenthal, Carroll-Scott, Earnshaw, Santilli, & Ickovics, 2012). In addition, underemployment affects the health and well-being of individuals by increasing the instances of chronic disease, lowering one's positive self-concept and impacting abilities and motivation required to engage in leisure and physical activity (Friedland & Price, 2003).

Current literature suggests a dichotomy exists between inadequate and adequate employment that mediates mental health. As such, individuals experience an increase of depressive symptoms when experiencing inadequate employment. Interestingly, there is additional literature to support that marital status buffers the depressive effects of changes in employment status thus supporting one's need for positive social connectedness. Within the same literature, the economy is identified as a precursor to one's well-being, in that productivity and commercialism provides employment power, which in turn

supports one's need for meaningful work (Dooley 2003; Dooley, Prause, & Ham-Rowbottom, 2000).

Dooley (2003) suggests that volunteer based positions do not yield the same benefits as do paid positions, which may support the economy as a catalyst to individual sustainability. However, Hood and Carruthers (2007) would disagree, suggesting that leisure, rather than paid employment, is central to increasing positive emotion and to supporting the development of strengths. Hood and Carruthers (2007) present the concept of virtuous leisure and suggest it is based on the "notion of building a life around one's strengths and using them to contribute to the world" (p.316). As a result, it is obvious to me that within the context of virtuous leisure, it is reasonable to suggest that leisure is not synonymously altruistic but rather a bi-directional relationship between participant and agency that is mutually beneficial. In fact, virtuous leisure is engagement in the service of something larger than oneself. Arguably, the benefits described by Hood and Carruthers (2007) could be applicable to engaging in meaningful experiences that would support one's social, emotional and financial sustainability. As a result, the subjective experience of the participant may be the determining factor between underemployment and virtuous leisure. And furthermore, virtuous work for individuals with mental illness becomes important in that it provides an opportunity for personal contribution to self, family and society, meanwhile fostering a sense of autonomy, yielding employable skills and providing structure within one's life.

### **Socio-Economic Status**

Literature supports low socioeconomic status as a cause and consequence of mental illness.

“Mental disorders perpetuate the cycle of poverty by interfering with the individual’s capacity to function in either paid or non-income roles, leading to decreased social, as well as economic, productivity” (Jenkins, Baingana, Ahmad, McDaid, & Atun, 2011, p.88). Jenkins et al. (2011), describe individuals with mental illness to be the “poorest of the poor” (p. 88), suggesting that poor mental health in childhood or adolescence is likely to sentence a person to a lifetime of impoverishment. In addition, there is evidence to support the likelihood that children of parents with mental health disorders will experience an adverse impact on their educational outcomes (Jenkins et al., 2011). Aneshensel and Sucoff (1996) agree, “mental health disorders in adolescence are pervasive, often carry into adulthood and appear to be inversely associated with social status” (p. 293). Furthermore, it is suggested that mental health is both a precursor for and a product of socioeconomic status and a significant relationship between the structure of residential neighbourhoods and mental health exists (Aneshensel & Sucoff, 1996).

As outlined within the literature there is clear bi-directional relationship that exists between mental health and socioeconomic status that is potentially cyclical and multi-generational. As such, socioeconomic status has a significant impact on recovery and one’s ability to live well with mental illness. Wadsworth and Achenbach (2005) identified socioeconomic status as a primary factor affecting accessibility to support services. Individuals with lower financial means are likely to have lower levels of education and skills, making them less desirable candidates for well-paid employment. As a result, there is an obligation to work longer hours as a means of compensating for lower wages. Long hours impacts the amount of time remaining for self-care, meaningful relationships and leisure, all of which have been identified as factors contributing to

recovery. In short, the multidimensional impact of a lower socioeconomic status results in decreased access to services and oppression of an individual's right to leisure (Davidson, 2011; Hood & Carruthers, 2007; Kleiber, 1999).

Leisure is the only context within which an individual has the freedom to choose activities that are personally significant and help them to ascribe meaning to their lives. However, in order for leisure to enhance one's well being and to recover from mental illness, leisure choices and practices must be physically, socially, cognitively or emotionally engaging (Hood & Carruthers, 2007). Although leisure is a domain of life that supports the enhancement of well-being, it is also a space of privilege through which individuals exert their power and wealth through consumer capitalist behaviours (Roberts, 1999; Veblen, 1967). As such, many leisure opportunities become constrained by disposable income and are therefore exclusionary of the lower class. As a result, not only does this pose issues of accessibility and affordability but also the risk of further perpetuation of self-stigma and exclusion. It is within this context that this research emphasizes the significant impact that low socioeconomic status could have on recovery and living well, and furthermore, emphasizes the need for accessible support services that facilitate recovery and promote the attainment of higher socioeconomic positioning.

### **Isolation/Exclusion**

Exclusion for individuals with mental illness is prevalent across five primary domains: consumption, production, social interaction, political engagement, and service exclusion (Boardman, 2011). Within this context the term exclusion refers to an individual's lack of participation in fundamental activities that make up the society in which his or she lives. Although exclusion is a subjective experience based on the

individual, there is ample literature that supports exclusion and/or isolation are primary concerns experienced by individuals with mental illness (Boardman, 2011; Mostafanejad, 2006; Sommer & Hall, 1958). Accordingly, isolation and exclusion are the bi-products of public stereotype or counterhegemonic behaviour. When individuals are perceived as outliers from the general population there is greater risk of exclusion. However, there are additional variables that drive exclusion such as poverty, lack of social capital and stigma. Additional factors such as age, gender, ethnicity, education, underemployment, family adversity, and criminal activity further immerse individuals with mental illness into cycles of isolation and exclusion from social support networks, thereby lessening their opportunity for recovery (Boardman, 2011; Davidson, 2003; Mostafanejad, 2006; Sommer & Hall, 1958).

Davidson (2011) examined the journey to recovery within the mental health setting and sought to identify the role that love (relationships) plays in this process. Within this work he suggested self-love and the love of others are integral to the recovery process. As individuals face the reality of a mental health diagnosis they often lose sight of their sense of self, and therefore self-love. Within this context, an individual who is unable or unwilling to love him or herself will continue to struggle in maintaining reciprocal relationships with others. In fact, Davidson suggests that love offers spirit-nourishing properties that enhance therapeutic relationships. Hood and Carruthers (2007) and Kleiber (1999) agree and support the notion that social resources, through leisure, are inaugural in the establishment of well-being and therefore must be developed throughout the recovery process for individuals with mental illness.

The Leisure and Well-being Model of Therapeutic Recreation (Hood & Carruthers, 2007) could be a framework that exemplifies the significance of leisure as it pertains to recovery from mental illness. This model identifies the key components of well-being as positive experience and emotion in daily life, and the use and development of personal strengths and capacities, suggesting that leisure is central to increasing positive emotion and supporting the development of strengths (Hood & Carruthers, 2007). Interestingly, leisure has also been acknowledged as a space within which individuals have the opportunity to establish personal connections with others that facilitate the establishment of personal support networks (Hood & Carruthers, 2013; Kleiber, 1999). As such, leisure may be a potential solution to the reduction of isolation and exclusion for individuals with mental illness. However, one must first develop the capacity to engage in positive leisure before it can provide benefit (Hood & Carruthers, 2007).

### **Boredom**

“Boredom remains a poorly understood phenomenon despite its evident association with dysfunctional behaviour and mental health problems” (Martin, Sadlo, & Stew, 2006, p.193). Within this context, boredom is an emotional state, in which individuals experience a lack of external stimulation and engagement with the world around them; it is often associated with anhedonia and/or inertia and has explicit links to anxiety and depression (Csikszentmihalyi, 1990; Csikszentmihalyi & Csikszentmihalyi, 2006; Newell, Harries & Ayers, 2011). Boredom is a predominant issue in the mental health population and has the potential to undermine treatment and recovery as it often leads to self-destructive behaviours that provide immediate relief from the negative emotions and

dissatisfaction associated with the experience (Davidson, 2003; Hood & Carruthers, 2013; Newell et al., 2011; Shahar & Davidson, 2009).

Literature suggests there is a bi-directional relationship that exists between boredom and both physical and mental illness (Binnema, 2004; Bracke, Bruynooghe & Verhaeghe, 2006; Davidson, 2003; Martin et al., 2006; Newell et al., 2011). Within this context, boredom is often experienced as a product of personal limitation, isolation/exclusion and/or lack of social capital. As such, boredom not only enhances the potential for one's perceived lack of purpose, but also provides an opportunity for individuals with mental illness to persevere over the negative symptoms associated with mental illness such as auditory hallucinations, delusions, thought disorder, chronic sadness, mania, thoughts of harming self or others, and emotion dysregulation (Binnema, 2004; Bracke et al., 2006; Davidson, 2003; Martin et al., 2006; Newell et al., 2011). Furthermore, a causal relationship between mental health and physical health has been identified and supports that boredom affects an individual's ability for self-activation and therefore has a negative impact on health (Richman, Kubzansky, Maselko, Ackerson, & Bauer, 2009).

Leisure, well used, has the potential to contribute significantly to the creation of meaningful social networks, community connections and a sense of enjoyment in life (Carruthers & Hood, 2007). Purposeful engagement in leisure activities that provide individuals with a balance between challenge and skills and therefore are optimally engaging could provide an opportunity to reduce boredom and increase levels of life satisfaction and well-being for individuals with mental illness.

**Self-Medication**

The mental health-substance abuse paradigm is a predominant issue highlighted within current literature (Breckenridge, Salter, & Shaw, 2012; Dembo et al., 2012; Winstanley, Steinwachs, Stitzer, & Fishman, 2012; Witkiewitz & Estrada, 2011; Zimmermann, Lubman, & Cox, 2012). Presently, one in ten Canadians fifteen years of age and older report symptoms consistent with alcohol and/or drug dependency and it is estimated that approximately twenty percent of people with a mental disorder have a co-occurring substance use problem (Rush et al., 2008; Statistics Canada, 2003). The prevalence of concurrent substance abuse within the mental health population illustrates a significant barrier to recovery from mental illness. Not only will individuals need to overcome their maladaptive coping strategies but there are also issues of physical and psychological dependence that will need to be addressed. As previously highlighted, living with a mental illness presents individuals with significant life challenges that are rarely experienced in other facets of life.

Davidson (2003; 2011) examines how individuals live outside of mental illness. Within his work he suggests learning to cope with the negative symptoms such as isolation/exclusion; apathy; lack of energy; low levels of motivation; boredom; and general dysfunction in daily living can often become more challenging than positive symptoms such as auditory hallucinations, delusions, thought disorder, chronic sadness, mania, thoughts of harming self or others, and emotion dysregulation that can often be effectively managed with medication. Here in lies the opportunity for substance use and abuse that often provides immediate escape from the present, but may result in long term negative effects (Davidson et al., 2001).

In the initial stages of recovery, leisure could be a technique of distraction that provides an opportunity for the individual to escape from the incongruency of trying to accept the identity of being an individual with a mental illness. When engaged in optimal leisure experiences individuals are less likely to think about the negative experiences associated with their symptoms. As such, leisure could provide a space of respite from a life that is otherwise consumed by medical appointments that emphasize one's deficits (Kleiber, 1999). Over time, through leisure, one could begin to form new meaning and regain a sense of purpose outside of their mental illness. Hood and Carruthers (2007) suggest that a sense of meaning facilitates the management of emotional distress and assists in the development of a revised narrative that incorporates values aspects of the past self with a realistic assessment of the post-diagnosed self.

Being diagnosed and learning to live with a mental illness may provide a significant disruption in one's current narrative. However, through positive leisure pursuits and the provision of experiences that result in an increase in positive emotion and the acknowledgment of personal strengths and capacities, an individual could uncover an opportunity to build a new identity that may include a mental illness but is not defined by it. More simply stated, leisure well-used, can facilitate the narration of one's next-best life (C. Hood, personal communication, March 25, 2013).

### **Treatment Approaches for Mental Illness**

#### **Medical Model**

Mental health treatment facilities inclusive of inpatient and outpatient services primarily adhere to the medical model that is defined as the following:

A traditional approach to the diagnosis and treatment of illness as practiced by physicians in the Western world since the time of Koch and Pasteur. The physician

focuses on the defect, or dysfunction, within the patient, using a problem-solving approach. The medical history, physical examination, and diagnostic tests provide the basis for the identification and treatment of a specific illness. The medical model is thus focused on the physical and biologic aspects of specific diseases and conditions. Nursing differs from the medical model in that the patient is perceived primarily as a social person relating to the environment; nursing care is formulated on the basis of a nursing assessment that assumes multiple causes for the problems experienced by the patient (Anderson, Keith, Novak, & Elliot, 2002, p.1067).

The World Health Organization Quality of Life Group (1998) criticize the use of the medical model in current health practices, suggesting that quality of life is based on six domains: physical, psychological, level of independence, social relationships, environment, and spirituality/religion/personal beliefs. As such, they propose that wellness should be a measure of one's physical, psychological and social health. Brightbill (1960) agrees, suggesting, "man is a whole being and not just a batch of chemicals" (p.11). The discrepancy between the medical model and the world health organization model of health provides a foundation for the problematic approaches to the treatment of mental illness.

Although the initial purpose of medicine was to prevent or delay death, in more recent years there is a significant shift in ideal from death-prevention to quality of life. It is within this paradigm shift that mental illness needs to be recognized by medical professions as more than a biological factor. The preceding pages have outlined the psycho/emotional and social issues experienced by individuals with mental illness and the potential role these issues play in the destruction of a life well lived. Yet, the medical model remains the most widely used conceptualization of health in western medicine (Larson, 1999). As result of this prominent tension, perhaps the field of psychiatry is in dire need of a paradigm shift.

A strengths based approach to therapy as endorsed by Carruthers and Hood (2007)

and Hood and Carruthers (2007) is rooted in positive psychology and builds on the preexisting strengths of an individual rather than highlighting personal vulnerabilities. Through this process we are able to remind individuals that they have the potential to benefit both themselves and their community. However, within the same task it is also important for individuals to consciously acknowledge their limitations as a means of measuring personal growth and achievements and approach their recovery with realistic expectations (Shatte, Seligman, Gillham, & Reivich, 2005).

Leisure, well used, could be a facet of life within which individuals are best supported in the engagement of a lifestyle that is socially, emotionally and physically healthy and inclusive of community-based networks. As such, therapeutic recreation may be an essential service in recovery-oriented practice that supports the examination and conceptualization of one's next-best life and the development of one's capacity to engage in a life that is rich with purpose and meaning (C. Hood, personal communication, February 18, 2013). It is within this context this research positions the medical as a barrier in recovery from mental illness, as it focuses solely on the cure of biological dysfunction and therefore is counter therapeutic to recovery from mental illness.

## **Recovery**

Recovery from mental illness involves a reduction in clinical symptoms, neutralization of internal conflicts and resolution of disruptive external tensions (Davidson & Roe, 2007). Accordingly, there are five domains that influence an individuals' potential for recovery: personal psyche, vocation/education, family, social and recreation (Greenblatt, 1957). Although there are both clinical and social issues associated with mental illness, as previously illustrated by the bi-directional relationship

that facilitates negative symptoms (inertia, anhedonia; isolation/exclusion; apathy; lack of energy; low levels of motivation; and general dysfunction in daily living) recovery involves a dynamic systematic process that must first address the biological, and then the psychological and lastly the social processes of living (Anthony, 1993; Calabrese & Corrigan, 2005; Davidson & Roe, 2007; Greenblatt, 1957; Jacobson & Greenly, 2001).

The first step to recovery is often initiated by pharmacological intervention in an effort to reduce the clinical symptoms associated with the illness. Once clinical symptoms are managed, the second step to recovery involves the establishment of internal conditions that will support the individuals' external sustainability. These conditions are inclusive of an individuals' sense of identity, hope, healing, empowerment, and connection. Lastly, once an individual has attained the necessary internal conditions, the final stage involves community reintegration and the establishment of external networks that support the individuals' strengths and capacities, as well as interests and allow them to resume a meaningful narrative. As such, recovery oriented practice involves clinical care, peer and family support, power and control, community involvement and access to community resources (Jacobson & Greenly, 2001).

Leisure provides a setting within which an individual has the freedom to choose activities that are personally significant and help them to ascribe meaning to their lives. However, in order for leisure to enhance one's well being, leisure choices and practices must be physically, socially, cognitively or emotionally engaging (Carruthers & Hood, 2007; Hood & Carruthers, 2007; 2013). Within the context of well being, Hood and Carruthers (2007; 2013) identify literature to support leisure as an effective coping mechanism for stress, a source of positive emotion, supportive development for personal

strengths and capacities, and an opportunity to develop friendships and social connections.

Iwasaki, Coyle, and Shank (2010) examined the potential contribution meaningful leisure experiences have in active living, recovery, health and quality of life for individuals with mental illness. Within this work, they identify that leisure pursuits can create a sense of normalcy, an opportunity to cope and heal, a sense of identity as well as the opportunity for positive emotions and social connectedness. Frank and Davidson (2012) examined the self-esteem based experiences of individuals diagnosed with psychosis as a means of understanding how individuals with mental illness experience self-esteem. Interestingly, within this work they were able to conclude individuals with mental illness maintain a high sense of self by pursuing social and interpersonal activities that enhanced their efforts to maintain a positive body image. As a result, this lends support to the benefits of physical activity in the achievement of well being. And through maintained self-care activities, individuals with mental illness have the opportunity to enhance their sense of self. Lastly, Gruber, Culver, Johnson, Nam, Keller and Ketter (2009) examined the impact of positive emotions on individuals with bipolar disorder, highlighting the importance of positive emotion as a means of reducing one's functional impairments and morbidity associated with the disease.

Caldwell (2005) examined why leisure is therapeutic. She too identified leisure as a buffer to the impact of negative life events and a context for prevention, coping and transcendence, further suggesting that mental health can be influenced positively by the therapeutic benefits of leisure. Fullagar (2008) examined leisure as a counter-depressant aid in assisting women in their recovery from depression. Within this work Fullagar

(2008) identified leisure as an opportunity for identity transformation, personal expression and creativity as well as a modality for increased self-care, concluding that leisure can facilitate recovery in ways that biomedical treatments cannot.

Vitterso (2011) describes the effects of leisure on well being outlining that even the earliest of studies on leisure and well being identified a positive influence on personal affect. However, within this work, Vitterso (2011) emphasizes that literature is yet to identify causation between leisure and well being and that leisure activities and well being may not be dichotomous. In fact, the potential exists that leisure activities themselves do not increase positive emotions or well being, but rather positive emotion is a product of the personal meaning derived by the individual. Vitterso (2011) concludes by reiterating that literature does exist to support that leisure activities are an important factor in quality of life, and that positive emotions are *usually* increased during well-chosen leisure activities. As a result, Vitterso (2011) suggests that “given the right context and motivational states, leisure may offer opportunities for both recovery and positive change” (p. 303).

In a recent report to the Ontario Minister of Health and Long-Term Care there was an identified approach to wellness that included “doing things that build confidence, building and maintaining healthy relationships with family, friends, neighbours and co-workers, developing healthy recreational habits and volunteering” (p.18). Interestingly, each of these concepts are supported by Carruthers and Hood (2007) and Hood and Carruthers (2007) as a means of promoting the attainment of well being. Therefore, a positive leisure lifestyle may be an essential element to individuals living well and staying well despite the presence of chronic mental illness.

### **Positive Emotion and Experiences in Everyday Life**

This project is aligned with a leisure-based philosophy that has contributed to the primary researcher's well-being. Through daily purposeful engagement in meaningful activities she has been able to experience higher levels of optimism, positive emotion and personal resilience. As a result, it is proposed that ongoing engagement in leisure experiences is an essential aspect of well-being. Hood and Carruthers (2007) agree, that leisure is the means through which clients are provided with opportunities to experience positive emotions that are central to the treatment process.

However, within the framework of the leisure and well-being model, it is noted that one's experience of positive emotion can vary in both quality and quantity, as well, it can be experienced as past, present or future events (Carruthers & Hood, 2007; Hood & Carruthers; 2007). As a result, this research has adopted the definition of positive emotion as stated by Carruthers and Hood (2007) "the combination of positively valenced physiological and/or psychological experiences (positive affect) coupled with some type of positive evaluative appraisal of the experience" (p. 284).

Multidisciplinary research supports the notion that positive emotion is connected to increased levels of physical, emotional and social health. Richman et al. (2009) examined the causal relationship between mental health and physical health, identifying a direct relationship between positive emotion and physical health. Gruber et al. (2009) examined the impact of positive emotions on individuals with bipolar disorder, highlighting the importance of positive emotion as a means of reducing one's functional impairments and morbidity associated with the disease. Lastly, Carruthers and Hood (2007) examine the relationship between leisure and well being, suggesting that through

leisure individuals can increase their capacities to engage in meaningful social relationships. As a result of these benefits, it is obvious that positive emotion offers outcomes including but not limited to one's achievement of well being.

Ryff and Singer (2003) discuss the notion of flourishing and "positive human functioning" (p.15) which occurs through the development of personal resilience as a protective barrier against the natural adversity life brings. Within this context, the pinnacle of the human experience must include negative and traumatic events as a means of providing opportunity for personal growth and achievement. Accordingly, there are three protective factors that contribute to individual resilience- personality, family and community. Interestingly, research suggests individuals with resilient personalities are "relatively free from psychopathology" (Ryff & Singer, p. 18). As a result, it is appropriate to suggest that individual's living well with mental illness must be developing resilience through family and/or community supports.

### **Resiliency**

Fredrickson (1998, 2001) presents the *broaden and build theory* as the foundation for creating resilience. Within this theory, she proposes that through the ongoing daily experience of positive emotion, individuals build up a protective barrier against adverse life events. And furthermore, through these momentary experiences of positive emotion, individuals are able to expand the possible thoughts and actions that come into their minds. In fact, within this context, Fredrickson notes that the retained benefits from positive emotions throughout a given day are not expunged by simultaneous negative events.

As previously stated, Shahar and Davidson (2003) examined the role of positive life events in the recovery process from severe mental illness. Within this work it was identified that individuals who report a higher number of positive life events also report higher levels of self-esteem, sense of self and overall quality of life. As a result, Davidson et al. (2006) suggest positive life events produce protective effects on individuals and assist them in dealing with the daily challenges associated with mental illness.

However, Fitzpatrick and Stalikas (2008) discuss broaden and build theory and relate it to the process of change, yet criticize that positive emotions are not a solution for all client problems. Within this research Fitzpatrick and Stalikas suggest the broadening aspect of Fredrickson's (1998, 2001) theory holds more value than the build and it is through one's awareness of their positive emotion that therapeutic change begins; unconscious coping strategies emerge, and in the case of individuals with mental illness, one's potential to flourish grows.

Wu, Wu, Liao, Chang, and I-Chen (2009) examined coping strategies of individuals hospitalized with psychiatric disabilities. In their research they suggested that individuals within the hospital setting experience greater challenges than those within the community. Along with illness-related symptoms, challenges for this population were "separation from family and/or friends, loss of key roles, diminished self-image and self-esteem, loss of autonomy, weakened support networks, unpredictable futures, and increased anxiety and resentment" (p.24). Within this context, perhaps it is appropriate to question the strategies individuals utilize in order to cope with the adversity associated with hospitalization and furthermore the impact this has on their future resilience. And furthermore, it may be necessary to examine the negative experiences associated with this

treatment process in order to understand how individuals are able to live well with mental illness.

Iwasaki and colleagues (2010) examined meaningful leisure as a means of promoting “personal identity and spirituality, positive emotions, harmony and social connections, effective coping and healing functions, human development, and physical and mental health” (p.492). Within their framework they discovered that meaningful leisure could present a negative or positive impact on individuals with mental illness. This notion is based on the aspect of harmful leisure pursuits that includes but is not limited to substance abuse. Iwasaki et al. suggest if individuals with mental illness engage in meaningful deviant leisure pursuits there would be a negative impact on recovery. However, if individuals engage in meaningful positive leisure pursuits, their engagement is suggested to have a positive impact on their recovery through increased physical and mental health and the potential reduction in risk of future episodes.

Iwasaki et al. (2010) suggest that in order for leisure pursuits to be meaningful they must be culturally sensitive, and therefore unique to the individual. Hood and Carruthers (2007) support this notion in their emphasis on person-activity-fit, suggesting that authentic leisure activities are a reflection of the essential aspects of one’s self. Selections for authentic leisure pursuits must therefore be based on one’s self-awareness. As a result, an integral part to the facilitation of authentic leisure is the provision of opportunity to explore one’s own interests and capacities as a means of self-discovery.

### **Flow**

Nakamura and Csikszentmihalyi (2003) discuss the theory Csikszentmihalyi (1990) originally termed *flow*. Within his theory, Csikszentmihalyi proposes that flow is

the subjective involvement of the full experience during which individuals who experience this state become completely absorbed in the activity and lose conscious awareness of the world around them. Nakamura and Csikszentmihalyi summarize flow to include:

“Intense and focused concentration on the here-and-now; loss of self-consciousness as action and awareness merge; a sense that one will be able to handle the situation because one knows how to respond to whatever will happen next; a sense that time has passed more quickly or slowly than normal and an experience of the activity as rewarding in and of itself, regardless of the outcome” (p.89).

Flow may be particularly important for individuals with mental illness in that it could provide a unique escape from chronic symptoms and highlight an individual’s strengths and capacities allowing them to develop a heightened sense of competence that exists beyond the limitations of the challenges associated with daily living.

In the context of flow, the Leisure and Well Being model (Hood & Carruthers, 2007) implements leisure gratifications (experiences that are optimally challenging and engaging) as a component of enhancing leisure. Within this concept, they suggest that gratifications are linked to the development of resources and well being. Through further review of positive psychology research, Hood and Carruthers (2007) detail positive outcomes from leisure gratification engagements to include increased participant interest, motivation, feelings of competence, and self-realization. As a result, through the exploration of leisure activities that present individuals with an opportunity for leisure gratifications, there is prospect for personal growth through the development of self-awareness and an increased sense of meaning.

Nakamura and Csikszentmihalyi (2003) also wrote about the construction of meaning through a concept referred to as “vital engagement” (p.83) and suggest that

people are able to ascribe meaning to their lives by becoming deeply involved in activities that promote a balance between challenge and skill. Accordingly, a key element to the vital engagement process is the attention one gives to the experience. However, within this work, Nakamura and Csikszentmihalyi emphasize that vital engagement is distinguished from similar theories, such as flow, in that it involves attention to the experience.

Participants engaged in mindful leisure pursuits demonstrate a non-judgmental yet conscious awareness of the unfolding experiences and are disengaged from any concerns about daily life. Mindful leisure interventions mandate a focus on the development of one's ability to be fully present in the experience, setting aside any distractions (Hood & Carruthers, 2007). Furthermore, in their evaluation of previous literature, Hood and Carruthers (2007) also identify evidence of increased autonomy, competence, relatedness, as well as physical health benefits: all of which have been identified as challenges within the mental health population. As a result, it is difficult to ignore the potential significance of meaningful leisure experiences, as mindful leisure pursuits evidently become an excellent resource in the combat of challenges associated with mental illness.

Teasdale, Williams, Soulsby, Seagal, Ridgeway, and Lau (2000) examined mindfulness-based cognitive therapy (MBCT) as a means of reducing the recurrence of major depression. Within their literature review Teasdale et. al. suggest cognitive behavioral therapy (CBT) reduces risk of recurrence through the acquisition of skills and changes in thinking. As a result of these findings, MBCT was a proposed method for use in group settings, applying the founding principles of CBT without the emphasis on changing thoughts. "The focus of MBCT is to teach individuals to become more aware of

thoughts and feelings and to relate to them in a wider, decentered perspective” (p.616).

The research determined MBCT reduced the rate of recurrence by approximately half, and was most effective for individuals who had experienced three or more previous episodes of major depression.

Savouring leisure is the opportunity for participants to make connection with the positive aspects of an experience. Accordingly, savouring leisure provides individuals with an opportunity for increased positive emotion that in turn supports heightened levels of happiness. Hood and Carruthers (2007) suggest research has found the effects of positive emotion to include:

“More positive self-evaluation, higher self-efficacy, greater expectations for success, increased sociability, greater satisfaction with social relationships, greater interest in leisure activities, greater ability to resolve conflict, increased likelihood of pro-social behavior, improved immune function, improved creativity and problem solving, improved performance on complex cognitive tasks and others” (p.311).

Bryant and Veroff (2007) agree, suggesting savouring is one’s ability to monitor their positive affect, thus, the more aware an individual the greater the impact on one’s overall happiness. Though there is little research on the benefits of savouring within the mental health population, the notion of skill development is very much supported by the literature examining the effects of positive emotion on individuals with mental illness. In addition, the link between savouring leisure and positive emotion provided by Hood and Carruthers (2007) lends additional support as to the value of acquired savouring techniques for individuals with mental illness.

Based on the evidence supporting the benefits of vital engagement, mindfulness and savouring, it is appropriate to question whether the implementation of such techniques would be an acquired skill that was purposefully taught to and is now

practiced by individuals living well with mental illness.

As previously identified, the primary researcher aligns herself with the philosophy that ongoing engagement in leisure experiences is an essential aspect of well-being and furthermore is the primary means through which she has been able to live well with depression. Through the establishment of a lifestyle rich in leisure pursuits and positive emotion, individuals with mental illness provide themselves with the opportunity to elevate their level of resilience. However, resilience does not simply involve one's ability to overcome difficult events, but rather emphasizes sustained competence under stress (Rutter, 1990; Werner, 1995).

This section identified a series of concepts that contribute to the establishment and maintenance of well being. However, the attainment of well being involves more than the enhancement of the leisure experience. The following section will emphasize psychological resources and provide a brief overview of the cognitive, social, physical and environmental resources that allow individuals to embrace life fully and increase personal resilience (protection) in the face of daily living and adversity.

### **Development of Personal Strengths and Capacities**

#### **Psychological Resources**

Psychological resources are the internal abilities that serve as capital and enable an individual to cope with adversity more effectively (Hood & Carruthers, 2007). As an individual with depression, the primary researcher identified a series of psychological resources that increased her potential to live well including: emotional regulation, self-acceptance, autonomy, competence, optimism and sense of meaning. Gamble and Garling (2012) examined the relationship between life satisfaction, happiness and current mood.

Within this study they conclude that happiness is related to life satisfaction but mediated by current mood. As a result, in order for individuals to experience a sense of happiness they must experience an elevation in current mood. It is through this concept that leisure has the potential to increase life satisfaction through this proposed happiness-current mood paradigm.

One's capacity for happiness, ability to regulate emotion, self-awareness, self-determination, competence, optimism and sense of meaning are all identified as common resources that influence well being (Hood & Carruthers, 2007). Although research has identified that one's capacity for happiness has a degree of genetic dependency, Lyubomirsky (2007) proposes forty percent of one's happiness to be dependent on intentional activity based engagements. As an individual learns to create opportunities for and acknowledge multiple pleasant events on a daily basis, their capacity for happiness will increase. In addition, savouring experiences and the active engagement in meaningful activities will also increase one's potential for happiness. Although one's genetic set point for happiness may ultimately remain low, through the implementation of happiness-based strategies, it is unrealistic to suggest an individual to be powerless against their genetic predisposition.

For the primary researcher, emotional regulation remains the most challenging resource to maintain. Emotional regulation is the effort to moderate positive and negative emotional responses and expression. Through the process of regulation an individual needs to learn to recognize internal states, label them, assess the context and decide the appropriate social behaviour within this context. However, without the development of this capacity, one's ability to engage with others and participate in social engagements

with family or friends becomes implicitly challenged (Fresco, Mennin, Heimberg and Ritter, 2013; Mennin, 2004). Although friends and family may be accepting of one's labile interactions, there may be inevitable social restrictions for individuals who are unable to interact with others in a socially appropriate manner. In fact, Hood and Carruthers (2007) outline a body of literature that directly relates emotional expression and regulation to leisure. However, within this outline, there is literature to suggest that leisure can be an outlet through which individuals gain the ability to emotionally regulate themselves, if engaged in activities that are meaningful and provide the potential for gratifications and/or result in an increase in positive emotion.

Interestingly, Thompson (2011) suggests that emotion is the interaction between neurobiological and behavioural systems, as a result, in order for emotional responses to change an appeal to only one of these systems would be inadequate. Based on this notion, perhaps it is appropriate to suggest that when dealing with mental illness it is necessary to treat both the biological and the psychological components. As a result, a question to consider would be whether or not the benefits of leisure are able to augment the appropriate endocrinatic chemical response to treat the biological side of mental illness or rather is leisure a means through which we can only augment the psychological aspects?

Knowledge of self that includes self-awareness, acceptance, and congruence are essential elements to the development of resources. This involves personal acknowledgement of strengths as well as limitations. Without such knowledge individuals will remain challenged in their ability to engage in authentic leisure, develop goals that reflect personal meaning, or improve on elements of personal limitation (Hood & Carruthers, 2007). Within the development of self awareness, acceptance and

congruence an individual must be conscious of their personal attributes and capacities, accept their strengths and limitations and be able to express this identity in a variety of contexts including personal, vocational and leisure based pursuits (Kleiber, 1999).

Shatte and colleagues (2005) discuss a strengths based approach to therapy suggesting that positive psychology builds on the preexisting strengths of an individual as opposed to highlighting personal vulnerabilities. Through this process we are able to remind people they have the potential to benefit both themselves and their community. However, within the same task it is also important for individuals to consciously acknowledge their limitations as a means of measuring personal growth and achievements and approach their recovery with realistic expectations.

Autonomy is a concept that involves one's perception of control that they maintain over the choices made in a given situation. Within the context of mental health, autonomy can be enhanced by one's ability to participate in the goal-making process and modify such goals as required in an effort to make them achievable. Ryan and Deci (2000, 2001) identify both autonomy and competence as essential human needs through which behaviour is motivated. In the context of mental health, if an individual is unable to identify with a personal sense of autonomy and competence, they are less likely to engage in positive behaviour that will assist them in living well. As previously mentioned, Davidson et al. (2006), proposed that positive life experiences promote resilience and adaptation and through play and pleasure individuals with mental illness build up their restorative power, self-efficacy and social agency that contribute directly to an overall sense of well-being. As a result, for the primary researcher, leisure became an outlet through which she was able to maintain a sense of control and increase her sense of

competence. By discovering activities that were personally meaningful and optimal in challenge and skill she was able to embrace the sense of identity gained from such engagements.

In the beginning, leisure was often a technique of distraction that allowed the primary researcher to escape from the incongruence felt when trying to accept the stigmatized identity of being an individual with a mental illness. When engaged, she was no longer focused on the chronic sadness associated with depression, thinking about suicide, or worried about the future. However, through such engagements she unexpectedly gained a new sense of meaning. Over time, through leisure, her life began to form new meaning and through which she formed a sense of purpose. Accordingly, Hood and Carruthers (2007) suggest that a sense of meaning facilitates the management of emotional distress. In addition, a personal sense of meaning assists in the development of a revised narrative that incorporates valued aspects of the past self with a realistic assessment of the post-diagnosed self. In the case of the primary researcher, although thoughts of suicide would still enter her mind when upset or feeling down, life had gained meaning and she was able to enter into a self-dialogue that inevitably rationalized against ending her own life.

### **Cognitive Resources**

Cognitive resources involve one's ability to learn and process information and engage optimally with one's environment. Cognitive resources include one's ability to attend, concentration, memory, ability to follow directions and problem solve and even goal setting (Hood & Carruthers, 2007). Within the context of mental health, an individual's cognitive ability may become compromised by their illness. The DSM-IV

identifies both concentration and memory as evaluative factors when diagnosing mental illness. According to the Centre for Mental Health and Addictions (2009) mental illness can affect one's thinking, mood or behavior and can be associated with impairment of functioning, however, individual symptoms can vary. Hood and Carruthers (2007) propose leisure to enhance cognitive resources within individuals and suggest a reciprocal relationship between such resources and leisure in that as cognitive resources are increased, so too will the leisure experience.

### **Social Resources**

Social resources are capacities related to the development of interpersonal connections, they include communication skills, interpersonal skills, reciprocal relationship skills and social confidence. Though leisure presents the opportunity to support the development of social skills and relationships, within the same context, there could be participatory limitations to leisure based on the current status of one's social behaviours (Hood & Carruthers, 2007). Within this context, perhaps in order to develop social resources an individual must have an established psychological resource foundation as a means of coping with the adversity associated with social interactions with others.

Davidson (2011) examines the journey to recovery within the mental health setting and seeks to identify the role that love (relationships) plays in this process. Within this work he suggests self-love and the love of others are integral to the recovery process. As individuals face the reality of a mental health diagnosis they often lose sight of their sense of self, and therefore self-love. Within this context, an individual who is unable or unwilling to love themselves will continue to struggle in maintaining reciprocal

relationships with others. In fact, Davidson (2011) suggests that love offers spirit-nourishing properties that enhance therapeutic relationships. Kleiber (1999) agrees with Davidson (2011) as well as Hood and Carruthers (2007) and supports the notion that social resources (through leisure) are an inaugural process in the establishment of well-being and therefore must be developed throughout the recovery process for individuals with mental illness.

### **Physical Resources**

Physical resources are the basic physical capacities that support ongoing involvement in activities of daily living and allow for independence, this includes physical health, mobility, fitness (endurance, strength, flexibility) and energy. Hood and Carruthers (2007) outline literature that links physical resources directly with psychological well being through mood enhancement. Interestingly, recreation based physical activities provide the optimal setting for the development of physical resources. Though initially such pursuits may not be leisure-based, as one's physical abilities increase they may find themselves interested and engaged in leisure based physical activity.

### **Environmental Resources**

Environmental resources are the capacities that support the negotiations of constraints to community involvement inclusive of the resources outside of the person such as social class, education, community involvement, and social support. Environmental resource capacity is inclusive of social connectedness and social networks, community engagement and leisure resources and opportunities each of which enhance the opportunity for personal meaning, the development of resources and

increased well being (Hood & Carruthers, 2007). Environmental resources are particularly important for individuals with mental illness in that the creation of social networks that provide opportunities to disclose and/or discuss the impact of one's illness in a safe space could create a sense of normalcy around such experiences and in turn buffer the negative impact of stigma on daily living.

### **Potential Role of Leisure and Therapeutic Recreation in Recovery**

As a recreation therapist the primary researcher acknowledges her propensity to assume leisure is good. She agrees with Hood and Carruthers (2007; 2013) that leisure has the potential to cultivate pleasure, autonomy, social connections, hope and a sense of identity and thus could support individuals with mental illness in their second and third stages of recovery. However, as Griffin (2005) reminds us, recreation therapists often assume that by facilitating leisure opportunities within therapy we are simply providing clients with the potential to develop leisure skills that will carry over into independent positive functioning. And it is within this framework that we, as leisure professionals, assume our work is true because we are often successful (Henderson, 2011).

The primary researcher problematizes leisure as it pertains to treatment, suggesting that if we assume the perspective that leisure is always good we are just as narrow minded as those who employ the medical model. To suggest that leisure is universally good, denies the intimacy of the experience as multifaceted, individualistic and unique. It is through leisure that many individuals employ negative coping strategies and thus leisure could manifest opportunities to relive or persevere over negative life events (Griffin, 2005). As such, this final section will critically explore the concept of leisure as it pertains to the attainment of well being and work to contradict the

assumption that leisure is psychologically unimportant and highlight the contribution it makes to the establishment and maintenance of one's well-being (Kleiber, 1999).

Leisure is an evolving concept that encompasses the experiences that occur in our discretionary time and provides us with freedom from work (Brightbill, 1960; Kleiber, 1999; Parker, 1983). Leisure delivers choice, supports development, empowers us and enables a sense of control, it is through leisure that we permit ourselves to give up the necessity of being occupied and explore our most authentic self (DeGrazia, 1962; Kleiber, 1999). However, there are two sides: true leisure and forced leisure (Brightbill, 1960). It is within this concept that this research presents the negative side to leisure as it pertains to therapeutic recreation. According to Brightbill (1960), true leisure is the engagement in experiences that are not imposed on the individual but rather freely chosen and therefore provide the greatest potential for recovery from the stress of daily living. However, within an institutional setting, recreation therapists program leisure opportunities for clients in an effort to support their recovery. As such, therapeutic recreation service cannot facilitate truly authentic opportunities in that the interventions align themselves closely with the concept of forced leisure. In fact, Brightbill (1960) suggests that forced leisure primarily happens as a result of illness and therefore forced leisure involves opportunities that are not self-initiated. As a result, although therapy may focus on client aspirations, support positive emotion, generate hope for the future, encourage self-acceptance, facilitate choice, mobilize strengths and promote activation and engagement in life, therapeutic recreation is simply an artery through which individuals can begin to gain insight into their interests and develop the necessary skills to support themselves within community living.

Leisure is an umbrella term that refers to freely chosen non-work engagements, including play. Play is the component of leisure that activates the expressive behaviours that cultivate the social proficiencies necessary to function in society (Kleiber, 1999). This notion is strongly supported by the therapeutic recreation profession, and play is utilized as a modality to assist clients to resolving the tension that result from underdeveloped skills.

Hood and Carruthers (2011) discuss the underrepresented relationship between leisure and well being. They propose leisure to be the only context within which an individual has the freedom to choose activities that are personally significant and help them to ascribe meaning to their lives. However, in order for leisure to enhance one's well being, they suggest that leisure choices and practices must be physically, socially, cognitively or emotionally engaging. However, within this work there is an acknowledged lack of research involving leisure and well being and it is within this gap that this project has been inspired.

Though indeed there may not be adequate literature that identifies causation between leisure and well being, the personal experiences of the primary researcher support the ascription to such beliefs. This study intended to explore the experiences of other individuals who are living well with mental illness, as a means of answering the question: *what role does leisure play in the lives of individuals living well with mental illness?* Following the collection and evaluation of the data the primary researcher applied the lens of the Leisure and Well-Being Model as a foundation for broader themes that may have resulted from the narratives. In doing so, the primary researcher hoped to uncover themes she had not yet considered to further support the phenomenon of people

living well with mental illness. Moustakas (1990) discusses the notion of tacit knowing, suggesting that we know more than we can tell. It is with this concept in mind, that the primary researcher embarked on a journey of self-exploration in hopes that her intuition would become more than just her own lived experience.

This chapter outlined a current body of literature to explain the problem of mental illness. Stigma, unemployment/underemployment, socioeconomic status, isolation/exclusion, boredom and self-medication are presented as central issues that challenge recovery and perpetuate the negative symptoms associated with mental illness. Within the context of this project, the primary researcher felt it was important to briefly outline such challenges, given that nearly twenty percent of all Canadians will experience a mental illness in their lifetime (Health Canada, 2002) but only one-third of individuals in need of support will actually receive it (Statistics Canada, 2002).

Recovery from mental illness involves a reduction in clinical symptoms that facilitates the opportunity to increase daily functioning (Davidson & Roe, 2007). As previously discussed, recovery is a process that begins with the treatment of biological indicators, followed by an augmentation of emotional and social supports. More simply stated, recovery involves a connection to the biological, psychological and social self. This chapter has highlighted the impact of positive emotion on resiliency and outlined literature that supports leisure as a central component to pleasurable experiences. In addition, it has outlined literature that supports leisure as a space for individuals to explore and express their strengths and capacities in a way that embeds a sense of freedom and control over their life. Leisure was also suggested to provide the opportunity for individuals with mental illness to develop a sense of competency and to assist them in

envisioning a life beyond the challenges associated with daily living. The purpose of this research was to explore the role of leisure in the lives of individuals who live well with mental illness and to gain further insight into how such individuals conceptualize and incorporate free time engagements into their lives and create meaning through such experiences. The next chapter will outline the methodological process employed by this research.

### **Chapter 3 – Research Methods**

As previously outlined, the purpose of this study was to examine the role of leisure as it pertains to the establishment of personal meaning in the lives of individuals within the Niagara community who self-identify their lives as meaningful despite their mental illness. The intent of this study was to focus on the intersection of leisure in the lives of individuals who are living well with mental illness. This study sought to understand the personal meanings ascribed by the participants that are associated with engagements that take place during their discretionary time. By interviewing individuals who have experienced this phenomenon, this research sought to elicit the nuances associated with leisure as a contributor to mental health and well being. Within this study I gathered narratives of leisure-based experiences and how such events have embodied a sense of purpose or meaning within the lives of the participants as a means of unpacking this lived dynamic. Simply stated, this research was about the lived experiences of individuals who live well with mental illness and the role of leisure in recovery, quality of life and well being. The following discussion will further outline the methodological details of this study.

#### **Research Questions**

Central research question:

How do people live well with mental illness?

Sub-Questions:

1. How do people describe the experience of having a mental illness?
2. What is the impact of having a mental illness on daily living?

3. What is the role of leisure in the lives of individuals who live well with mental illness?
4. What strategies are employed to support living well with mental illness?

### **Epistemology**

This project examines how the co-researchers construct and make meanings of their own realities as means of filling a gap in current literature. Within this context, I sought to understand how individuals view their experiences of mental illness and subsequently build a meaningful life outside of this identity and learn to live well. As such, this project incorporates an interpretivist approach to research. This research is supported by the notion that reality is a self-constructed product of one's social interactions and the meanings one ascribe to it from his/her own interpretation. Truth is not absolute, but rather a product of human judgment (Angen, 2000; Black, 2006; Cresswell, 2007; Ferguson, 1993).

The interpretivist paradigm is encompassed within the post-positivist movement and was developed in response to the emphasis on positivism in the social sciences (Pickard, 2007). Interpretivist work is rooted in two main assumptions. First, that reality is constructed within the individual and meanings are developed socially. Second, interpretivism highlights that people cannot separate themselves from what they know and there is a reciprocal relationship between the self and the world we live in. In other words, how we understand the world is central to how we understand ourselves and vice versa (Angen, 2000; Black, 2006; Cresswell, 2007).

As such, the assumption of the interpretivist approach embodies my own values as inherent and valuable in all phases of the heuristic process. Truthfulness will be

established through the dialogue of this work as knowledge continues to develop throughout the investigation. Furthermore, as new findings emerge, they are continuously negotiated between the co-researchers, as this project is not utilizing a singular case study approach but rather seeks to find commonalities between the lived experiences of individuals within a small sample (Angen, 2000; Black, 2006; Cresswell, 2007; Ferguson, 1993).

Interpretivist approaches rely heavily on naturalistic methods (interviewing, observation and analysis of texts). As such, this project utilizes multiple interviews to emphasize the value of the participants' lived experiences and triangulate the data to ensure validity and truthfulness. The interpretivist paradigm supports the heuristic methodology well in the project, in that both mandate that meanings are emergent as a result of the process and support the nature of reality to be a collaborative construction between the self and others (Angen, 2000; Black, 2006; Cresswell, 2007; Ferguson, 1993).

The interpretivist paradigm supports the belief that although reality is a product of social construction, it is a fluid process that is constantly evolving. As our environment changes, so too does our reality but understanding is simply the product of interpretation. Furthermore, this perspective mandates that objectivity is incongruent with truth, because truth is a product of the interaction of self and others within a lived experience. However, truth is temporal, situated and fluid (Angen, 2000). A person's reality is therefore negotiated through the meanings they derive from experiences. As such, there is a multi-directional relationship between reality, truth, and the meanings people ascribe to their lives (Black, 2006; Cresswell, 2007; Ferguson, 1993).

Interpretivist research must exercise careful consideration and articulation of the research question, as the question is central to the project's purpose and heavily influences the data. Angen (2000) supports Moustakas' (1990) notion of validity by suggesting that within interpretivist research, validity is embedded in the moral responsibility of the primary researcher and their willingness to seek alternative explanation if the results differ from their personal construct. In addition, self-reflection is an integral part of the interpretivist paradigm and reflexivity must be evident throughout the process (Angen, 2000).

The adoption of an interpretivist approach to this research was the first step in moving towards heuristic inquiry. However, this project is heavily influenced by the privileged background of the primary researcher and, as a result, may require further consideration as to the criteria for participants. Within the context of the interpretivism, culture plays a primary role in the construction of reality (Angen, 2000; Black, 2006; Cresswell, 2007; Ferguson, 1993). Perhaps if the lived experiences of the participants, including the primary researcher, are significantly divided by socioeconomic status, education and life stage it will be difficult to assess commonalities between the co-researchers. Yet, a divide between participants may prove to illustrate the significant diversity that exists within the mental health population, further emphasizing mental illness as a relevant and pressing concern within Canadian culture.

### **Methodological Framework**

Phenomenology is an umbrella approach to the study of the meanings that people attach to experiences, within which the researcher seeks to identify the essence of human experiences. This study sought to identify how individuals live well with mental illness,

and to determine the role of leisure within this phenomenon. The primary purpose ascribed by phenomenology is the illumination of a particular phenomenon through inductive qualitative methods with an emphasis on how interpretations and meanings have been placed on the experiences of the participants (Bourgeault, Dingwell & De Vries, 2010; Cresswell, 2003; 2007; Denzin & Lincoln, 2011; Guthrie, 2011; Moustakas, 1990; Pickard, 2007; Willis, 2007).

Phenomenological research is particularly useful when examining unique issues and challenging normative assumptions. As a result, it was a beneficial approach for this study in that this project was fueled by an effort to reject the deficits-based medical model more commonly employed by mental health service providers. Phenomenological research is not concerned with generalizability, but rather seeks to understand outlying social issues through the use of interviews, conversations, participant observations, action research, focus meetings and the analysis of personal text. Within the framework of all phenomenological research, rapport and empathy are critical to the process and allow the researcher to obtain data that expands the depth and breath of what might already be known about the phenomenon.

Heuristic methodology is a form of phenomenology and is designed to determine the lived experiences of participants. As such, phenomenology formed the theoretical framework of this study. Within this framework the participants were recognized as co-researchers with voices to be heard. This phenomenological approach is particularly useful for research on sensitive topics as it empowers the strengths and experiences of the participants and allows them to articulate their own perspectives on their lives (Moustakas, 1990). In addition, heuristics arise from a personal interest in a particular

area of inquiry. Moustakas (1990) suggests that heuristic inquiry begins with a question that the researcher seeks to answer.

The question is one that has been a personal challenge and puzzlement in the search to understand one's self and the world in which one lives. The heuristic process is autobiographic, yet with virtually every question that matters personally there is also a social – and perhaps universal – significance (p. 2).

My own experiences with mental health and my subsequent journey of creating a life of meaning provided the context for this study and my own story became part of the data.

This research assumes a qualitative heuristic approach to inquiry because I, the primary co-researcher have personal experience with the phenomenon of living outside of mental illness through an ongoing leisure based lifestyle. In addition, as a recreation therapist I have spent much of my career as an allied health professional in an acute mental health setting. Thus, I have a unique interest in talking with others about this phenomenon in order to illuminate the essence of the experience of living with a mental illness and the subsequent journey towards living well.

“The focus in a heuristic study is a quest for the recreation of the lived experience” (Moustakas, 1990; p.39). Heuristic research is a form of phenomenology that is useful when dealing with sensitive topics. Within this methodology participants are referred to as co-researchers and are encouraged to participate throughout the entire research process. Heuristics has been regarded as a form of research that empowers marginalized populations, which makes it particularly useful when examining individuals with mental illness (Cresswell, 2007; Moustakas, 1990). As such, heuristics was an appropriate methodology for this study because it valued tacit knowledge and intuition – placing

myself within the study – and allowed the co-researchers to extend their knowledge and enhanced meanings in an effort to better understand the phenomenon of living well with mental illness (Moustakas, 1990).

As an individual living well with mental illness, my story was the catalyst for this project. Reflexivity is central to the heuristic process and provides significant influence on the trustworthiness and authenticity of the study. Within the framework of heuristic research my own story became part of the data. As such, I needed to be conscious of my own thoughts and feelings making them equal to that of my participants. In an effort to tease out my own experiences, I was the first participant in the study to answer the questions in the interview guide. And, during the interview process I was open to sharing my own experiences without leading or front-loading my co-researchers. Following each interaction I unpacked my own perspectives and experiences as similar or different from the co-researchers in a reflective journal as a means of ensuring an accurate account of my own reality as it is shaped by the engagement in this work. Within the reflective journal I recorded the thoughts and emotions of this process as I experienced them, as well as the coping strategies I employed in order to maintain an optimistic mindset as I continue to live outside of my own mental illness (Cresswell, 2007; Denzin, 2011; Moustakas, 1990).

## **Method**

The methods utilized within heuristic research are open-ended. As such, there is no standard list of methods for this research but rather heuristics is a process that unfolds upon itself (Cresswell, 2007; Moustakas, 1990). Heuristic methods are envisioned by the primary co-researcher and constructed as merely a guide to the project. They are designed

to encourage flow within the investigation, but remain flexible enough to yield rich, accurate and complete depictions of the phenomenon. In essence, the goal of heuristic methods is to facilitate the phenomenon in revealing itself completely and uncovering as many meanings as possible. However, regardless of the method being utilized, the purpose must always relate back to the question and facilitate data that will disclose the nature, meaning and essence of the phenomenon (Cresswell, 2007; Denzin & Lincoln, 2011; Moustakas, 1990).

“The methods and procedures within heuristic research must yield accurate and vivid dimensions of the experience” (Moustakas, 1990, p. 44). Within the framework of heuristic research, the primary co-researcher must construct methods that will elicit meanings and patterns of experience that are relevant to the question and will encourage open expression and dialogue with the co-researchers. In fact, within heuristic research, the methods often begin with immersion in the topic or question and the primary co-researcher being open to discover personal meanings through daily observations and conversations, as well as published works (Cresswell, 2007; Moustakas, 1990). As a result, the study of mental illness has become the center of my world. My attention began to focus on my own experience of being diagnosed with, recovering from and maintaining a life outside of mental illness. Through journaling I have embraced a new realm of self-exploration and reflexivity that has allowed me to become connected to my own experiences with mental health issues.

### **Participant Selection/Recruitment**

This project sought to examine how individuals live well with mental illness; as a result, the specificities of diagnosis were not deemed integral components of this project

and therefore were not direct questions in the interview guides. However, each of the co-researchers did disclose their diagnosis at some point in their two interviews, and introduction to the participants is provided in chapter 4. The following is an overview of the participant recruitment process that was utilized in this project.

Based on the sensitivity of this phenomenon there are very few known participants to recruit as co-researchers for this project. The executive director of a local mental health organization was the gatekeeper for this project. Following the receipt of the ethics clearance certificate from Brock University, the project supervisor and primary researcher attended a joint meeting with the executive director and volunteer coordinator of the organization. The purpose of the meeting was to solidify a partnership with the organization, clarify the purpose of the project, number of participants sought, and the criteria for participant inclusion. Following this meeting, the volunteer coordinator distributed copies of my letter of invitation to volunteers of the organization that were known to meet to outlined criteria.

Non-probability chain sampling was the anticipated technique for this project. However, based on the support from the local mental health organization, convenience sampling was employed for this project. This project was not intended to conclude generalizability from this sample, but rather to simply gain insight into the lives of people who live well with mental illness (Cresswell, 2003; 2007; Denzin & Lincoln, 2011; Guthrie, 2011; Moustakas, 1990). This inquiry was not reliant on predetermined number of participants given that heuristic methods can include 1 to 15 co-researchers. However, as a result of the partnership established with the local mental health organization, this

project met the targeted goal of 6 participants, including myself. No other recruitment strategies were utilized.

Inclusion guidelines were proposed to the volunteer coordinator of the local mental health organization, as a means of assisting her in identifying potential candidates, based on her predetermined knowledge of each individual. Participants of this research were evaluated initially by the volunteer coordinator based on the following criteria; (1) must have received a formal diagnoses of mental illness from a physician/psychiatrist. This stipulation is based on the experience of the primary researcher, and was validated by a number of the co-researchers. Many individuals with mental illness received a diagnosis from a family physician, rather than a psychiatrist. As a result, stipulating one over the other would have narrowed the criteria and further limited the small population of whom this project was trying to access. (2) Must self-identify as an individual who lives well with mental illness (the notion of living well will be described as some combination of full engagement in daily life activities, ongoing experiences of positive emotion, hopefulness and a future orientation, social connectedness, and a self-story that includes mental illness but is not defined by it). This criterion is based on the notion that living well is subjective to the individual; however, there is an element of external judgment associated with the prescreening process of having gatekeepers. (3) Must be comfortable engaging in open dialogue about their experiences with mental illness, treatment and recovery. Individuals who self-identified as meeting the above criteria were contacted by the Volunteer Coordinator with a letter of invitation. The letter of invitation outlined the purpose of the research and benefits of participation, including the receipt of a \$10 Tim Horton's gift card (see appendix A).

Upon receipt of invitation, three of the co-researchers contacted the primary researcher, via email, and two via telephone. Following the initial contact, an email containing the informed consent and interview guides was sent to the potential co-researcher for review. Upon agreement to participate, participants were educated in person, regarding the purpose of this research project and informed consent was collected (Appendix B). Confidentiality was assured verbally and in writing, however due to the nature of the heuristic process, anonymity could not be granted. Participants were informed of their right to withdraw from the study at anytime. Decorative Brock University folders were purchased at the Brock Bookstore and used to create an intake package for each co-researcher. Each package included a hard copy of the signed informed consent and the guides for interview one and two (appendix C & D). The \$10 Tim Horton's gift card honorarium and a copy of the primary researcher's business card were stapled to the inside right pocket of the folder. Each co-researcher was given their intake folder prior to the start of the first interview.

Participants were encouraged to review the interview guide prior the initial meeting, and first informal interview to further reduce any anxiety. The interviews were conducted in a semi-structured format, audiotaped, and guided by the primary and sub-research questions. To enhance the comfort of the co-researchers, the interviews primarily took place in the office space provided by the local mental health organization, however, three of the ten interviews were conducted in the part-time instructors office in the Department of Recreation and Leisure Studies at Brock University. Records of the interviews are currently being stored in a secure location and will be destroyed upon expiry of ethics clearance. The interviews were considered complete once the participants

had reached a natural break or ending to their story as it pertains to the primary research question, however, in each case the entire interview guide was utilized. Once each interview was completed the co-researchers were asked if they had any concerns about the interview dialogue or the research process. There were no questions or concerns expressed by any of the co-researchers, however, this was done in an effort to ensure the co-researcher's sense of safety within the project had not been compromised (Cresswell, 2003; 2007; Denzin & Lincoln, 2011; Guthrie, 2011; Moustakas, 1990).

There were no prevalent risks associated with participating in this study. However, the research ethics board granted clearance on the premise that the informed consent highlights the inclusion of possible psychological risks. As such, the informed consent explained potential risks and benefits. In addition, contact information for external support was listed in bold and the below the signatures section of the informed consent, in case any of the co-researchers required it. The informed consent also encouraged participants to notify Brock University research ethics board of any adverse events. Research records have been maintained with strict confidentiality and stored in a locked file. Only the principle investigator (primary co-researcher) and faculty supervisor have access to these records, which will also be destroyed following the expiration of ethics clearance.

### **Data Collection**

Informal conversational interview methods permit the use of pre-formulated interview guides. However the genuine dialogue embodied within heuristic research cannot be deliberate. Rather, it is a product of the co-operative sharing and a willingness to freely express what one thinks and feels as it relates to the research question(s). As a

result, this project utilized two semi-structured personal interviews as the primary method of data collection.

Moustakas (1990) emphasizes the use of personal artifacts such as poems, pictures or inanimate objects that are connected to the lived experience. These artifacts assisted the primary researcher in understanding the essence of the phenomena through vivid, accurate and comprehensive portrayals described by each co-researcher. In addition, artifacts demonstrate tangibility to the experience and assist in generating deeper conversation. This project integrated the use of a personal artifact selected individually by each participant as an item that holds particular meaning to his or her recovery. Upon conclusion of the first interview each co-researcher was asked to bring an item symbolic of their recovery to the next interview. This artifact became part of the discussion in the second interview. There was twofold purpose for this additional form of data collection. First, it was intended to provide the co-researchers alternative forms of expression while encouraging personal reflexivity. Second, it assisted with rigour and provided opportunity for triangulation (Cresswell, 2007; Denzin & Lincoln, 2011; Guthrie, 2010; Moustakas, 1990). The details of the artifacts are further outlined in chapter 4.

Although heuristic methods are flexible, they must still remain congruent with the ethical responsibility of the primary co-researcher. This study obtained ethical clearance from the university before participants were approached. As a result, the step of locating and acquiring participants, did not take place until a clearance notification had been received. Following the literature review and the establishment of a research question, an

interview guide (Appendix C) was created for participants and included in the submission for ethics clearance.

Interviews were conducted in a face-to-face setting using an audio recording device. There were separate interview guides for each interview and each interview lasted 30 to 60 minutes in duration. As a participant in this study, I provided written replies to each of the interview questions prior to the conduction of my first co-researcher interview. Once my answers were complete, I then recited the responses into audio files in an effort to include my own experience as equally weighted data. Consistent with the rest of the interviews, the files of my responses were added to the project files, coded and linked to themes in atlas.ti.7.

The first interview focused on the establishment of trust between myself and the co-researcher and understanding the nuances of their vocational life, family, social relationships and health. However, it should be noted that neither interview guide focused on the use of medications or requested specific diagnosis. This information was not deemed pertinent to the project, and could have resulted in co-researchers feeling over exposed or judged. It was anticipated that if a co-researcher felt medication was integral to their ability to live well, they would disclose that information without being asked directly. The questions within interview guide #1 were intended to focus on how the individual conceptualizes the experience of having a mental illness. Although it was initially anticipated that the interview guides might require changes following the review of the first few interviews, upon assessment no amendments were required.

The second interview was designed to identify the role of leisure in living well with mental illness. As such, this interview focused on how individuals conceptualize free

time engagements and the meaning derived from such experiences. In addition, this interview included the use of a personal artifact that the co-researcher identified as symbolic of their turning point in recovery. Congruent with the first interview guide, following the employment of the second interview guide, the data was reviewed and the need for changes was assessed, however no amendments were made to the guide. In both interviews, the inquiries were considered complete when the individual's story reaches a point of natural closing. As such, the length of each interaction was determined by the participant's willingness to express meanings and share experiences, as they pertain to the research question (Cresswell, 2003; 2007; Denzin & Lincoln, 2011; Guthrie, 2011; Moustakas, 1990).

Table 1 – Questions asked in interview 1

Questions	Prompts
1. Tell me a bit about yourself:	<ul style="list-style-type: none"> <li>• What is your educational and/or vocational background?</li> <li>• Tell me about your family and your social connections (friendships)</li> <li>• What is your current relationship status?</li> <li>• How would you describe your health?</li> <li>• What do you do for enjoyment?</li> </ul>
2. How would you describe who you are as a person?	
3. What was it like to be diagnosed with a mental illness?	
4. What has it been like to live with a mental illness? Are there certain aspects that stand out to you? What is the impact of having a mental illness on daily living?	
5. What has changed in your life since being diagnosed with a mental illness?	<ul style="list-style-type: none"> <li>• Are there any changes in your vocational life?</li> <li>• Are there any changes in your relationships with family/friends/significant other?</li> <li>• Has your health changed?</li> <li>• Has your mental illness impacted what you do in your free time? Or how much free time you have?</li> </ul>
6. How the experience of living with a mental illness changed you? Or has it?	
7. When you think of living well with mental illness, what comes to mind?	

Table 2 – Questions asked in interview 2

Questions	Prompts
1. How do <u>you</u> live well with mental illness?	
2. Thinking about your own experience with mental illness, what was a turning point for you?	<ul style="list-style-type: none"> <li>• What was life like before?</li> <li>• What is life like after?</li> <li>• What changed?</li> <li>• You brought in a [artifact] today, tell me about it. Why did you choose this item, what does it represent for you?</li> </ul>
3. How have you coped with relapse as part of your recovery?	
4. Are there any aspects of your life that are particularly important to your experience of living well?	
5. What strategies do you use to support yourself living well?	
6. Thinking about the things you do for enjoyment in your free time, how do these experiences affect the way you live with mental illness?	
7. What kinds of things do you do in your free time?	<ul style="list-style-type: none"> <li>• What is important to you about [activity/experience]?</li> <li>• How does [activity/experience] impact your sense of self?</li> <li>• How does [activity/experience] affect coping?</li> <li>• How does [activity/experience] affect living well?</li> <li>• Was this an engagement that you did prior to diagnosis or that you have added since?</li> </ul> <p><i>[IF NEW ACTIVITY]</i></p> <ul style="list-style-type: none"> <li>• How did you come to add it?</li> </ul> <p><i>[IF PREVIOUS ACTIVITY]</i></p> <ul style="list-style-type: none"> <li>• How did you maintain participation (continuity) from diagnosis to recovery? How has the meaning or experience changed for you, or has it?</li> </ul>

## **Data Analysis**

### **Immersion**

Data analysis began with the immersion phase, during which I reviewed the data to become intensely familiar with it, but in accordance to Moustakas' (1990) guidelines, did not begin to take additional notes or interpret any of the findings. Notes from each interview and personal documents were gathered together and organized into a sequence that tells the story of each co-researcher (Cresswell, 2007; Moustakas, 1990). Once the data had been used to develop a representation of each co-researcher, the data was then checked with each member for affirmation of accuracy to ensure the sample expresses a thorough depiction of each member's experiences. Each member was contacted via email and asked to review the data, confirmation of receipt was received from each of the 5 co-researchers and no concerns were expressed with regards to the findings. Following the member checking process, I began a reflexive self-dialogue and self-searching in an effort to unpack any intuitive clues that have been a product of the tacit dimension of the study. As previously mentioned, I utilized personal journaling strategies throughout the data collection phase. Within my journals I exposed my own personal beliefs and preconceived notions about living well. This process allowed me to keep my own experiences valid, but separate from the co-researchers. The data from my journals and notes I made through the data collection process were reviewed, prior to the initial data analysis.

**Audio Coding.** This project employed the use of Atlas.ti.7 and utilized the audio-coding feature for analysis- an unanticipated process during the proposal of this project. This software allows the researcher to make internal notes on the audio files directly,

connect portions of the files to the codes created in the project and link codes to central themes, the process still involves the use of verbatim transcription, the process permits the researcher to code only the data they intend to use as direct quotes. Following their completion, the first two interviews were transcribed verbatim, however, following a discussion with a colleague the use of audio-coding was introduced. A brief literature review was conducted to familiarize myself with the nuances of this process. However, there is currently a limited body of research surrounding the use of this method as it is a new feature that only recently came available to atlas.ti.7 users. Upon completion of the interviews, it became clear to me that I have a strong auditory learning style, as I was able to accurately recite large portions of data by memory after only having heard it once. As I compared the experiences I had with audio-coding versus transcribing, I noted a personal loss of participant voices when reading the transcripts. As such, the use of atlas.ti.7 became central to my process of analysis.

Within the analysis I used the five research questions as my primary thematic codes. I listened to each of the interviews focusing on one question at a time, creating colour-coded notes on the audio files in the appropriate sections of the interviews. Once I had teased out all possible links to my primary codes individually, I then reviewed the differences between the responses and clustered them into the sub themes represented by the visual diagram. In total, each of the interviews was reviewed seven times prior to entering the incubation phase.

I experienced pros and cons to this method. There was a learning curve with the software that was initially time consuming. There is still transcription involved, and the interviews are reviewed in real-time. However, the use of audio-coding permits that the

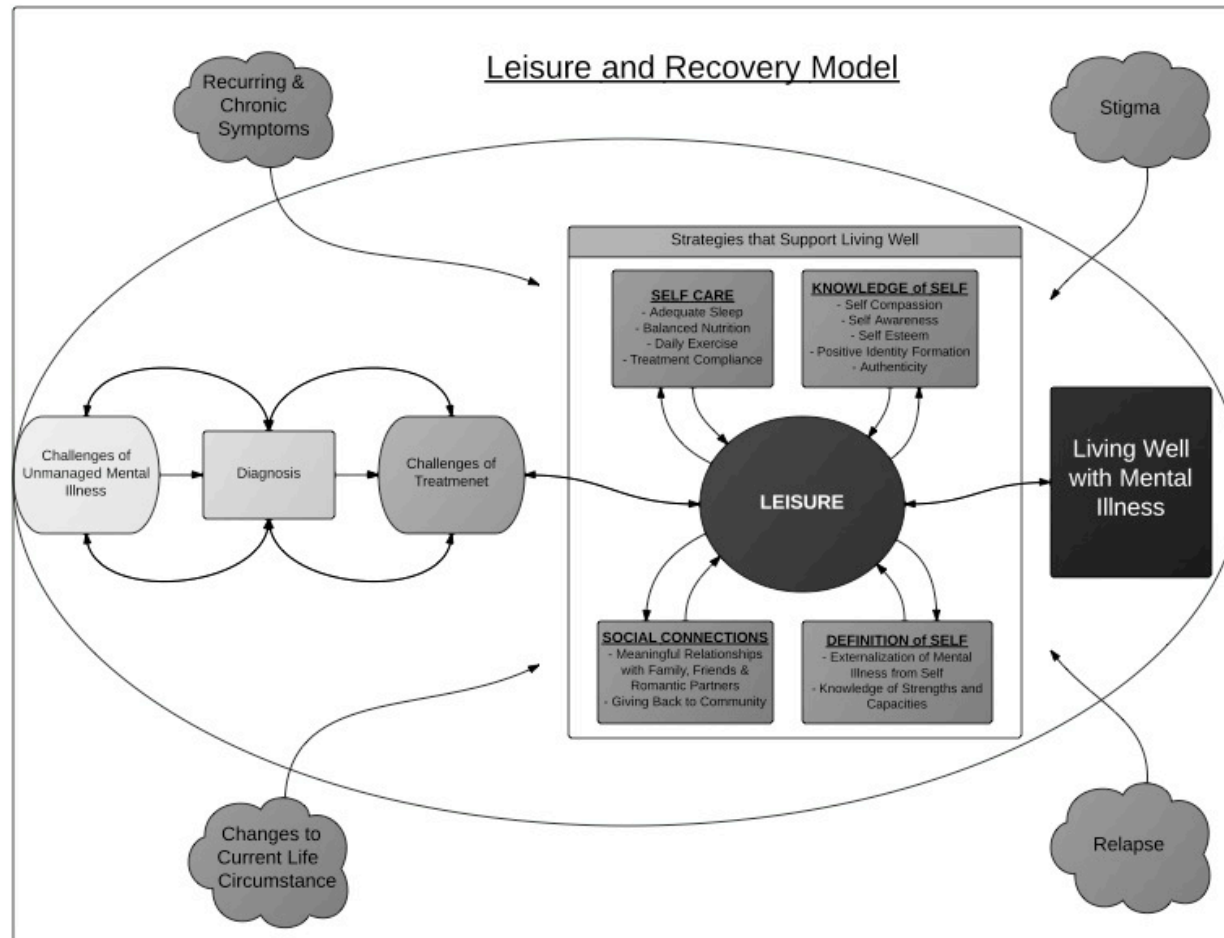
researcher only transcribes the exact data they plan to use. The process of analysis is similar to that of verbatim transcripts, however it involves listening to the audio files many times over. For me, this was an ideal choice, as I found myself connecting to the words and intonations in the co-researcher's voices, a process that is often lost when using verbatim transcripts. The purpose of heuristic research is to give voice to marginalized people; by utilizing a method of data analysis that allowed the co-researcher's voice to stay alive, I believe this research found new meaning in Moustakas' (1990) process. Once my analysis reached a point of reflexive saturation and all additional connections with the research question had been teased out, I then transitioned into the second phase of data analysis – incubation (Moustakas, 1990).

### **Incubation**

The incubation process involves the purposeful retreat from the intense focus on the primary research question. This phase yields the opportunity for respite and recovery, and allows for the rumination and expansion of knowledge. The incubation process is said to “enable the inner tacit dimension to reach its full possibilities” (Moustakas, 1990, p. 28). This phase occurred concurrently with a series of professional conferences at which I presented my preliminary findings. This opportunity invited a dialogue with others about the work I was doing and provided new perspectives, inspiring deeper thoughts about how I conceptualized my data and the implications of this conception. The incubation process included the development of a visual model informed by the data. Throughout the incubation phase I continued to write reflexive journal entries, as needed, in an effort to retain appropriate thoughts. This process was intended to provide an understanding of the question on a level that is outside of the immediate awareness and

prepares the researcher for the next phase of data analysis – illumination (Moustakas, 1990). However, as this phase progressed and I continued to present my preliminary findings and engage in conversations with others I found myself questioning the layout of the model that subsequently led to changes during the illumination phase.

### Original Conceptual Model of Living Well with Mental Illness

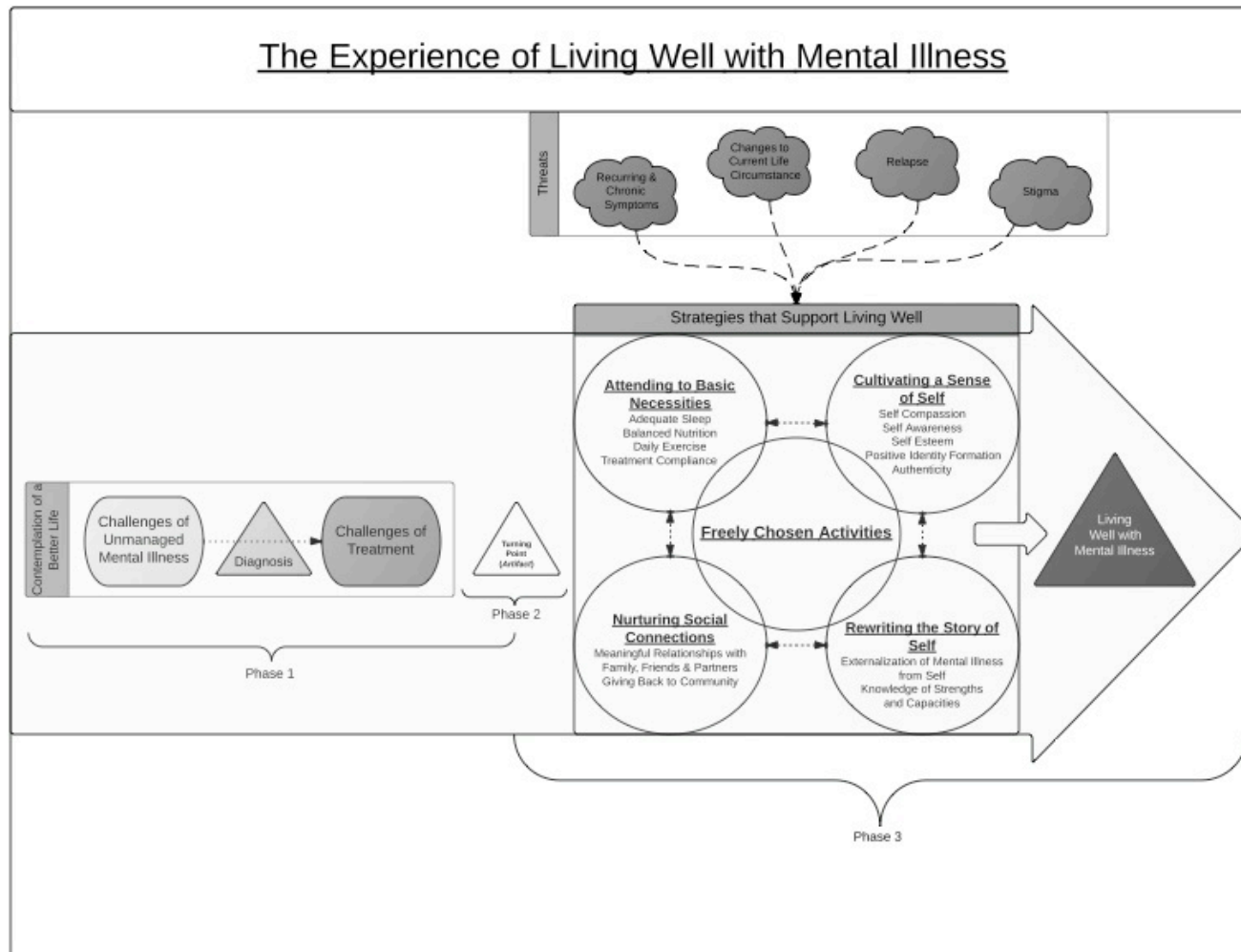


**Illumination**

“The process of illumination is one that occurs naturally when the researcher is open and receptive to tacit knowledge and intuition” (Moustakas, 1990, p. 29). This phase is regarded as the turning point of the project and is intended to add new dimensions of knowledge. The illumination phase intentionally follows the reflexive phase of incubation as a means of providing an opportunity to yield additional truthfulness within the project. This phase began with changes to my original model created during the incubation phase. Although the model was indeed a reflection of the data, it was not a clear representation of the progressive process of recovery. As such, I revised the appearance of the model to be encapsulated by an arrow, which to me, better illustrated the process described by the co-researchers.

The changes to the visual model were made in an effort to better highlight relevant themes, qualities and components of mental health as it pertains to living well. Within this phase I wrote the first draft of my findings in an effort to fully describe the meanings illustrated by the visual model. Once this was accomplished the transition to the fourth data analysis stage, explication, was possible (Moustakas, 1990).

### Revised Conceptual Model of Living Well with Mental Illness



**Explication**

“The purpose of the explication stage is to fully examine what has awakened in the consciousness, in order to understand its various layers of meaning” (Moustakas, 1999, p. 31). Within this phase the researcher capitalized on a series of heuristic processes including focusing, indwelling, self-searching and self-disclosure. This phase emphasized the uniqueness of the experience and relied heavily on the researcher’s internal frame of reference. As such, this analysis was recorded through written documentation (Moustakas, 1990). During this phase, I applied the lens of the leisure and well being model to guide an analysis of broader themes represented by the data. Within this process I identified four additional themes that were supported by the narratives of the co-researchers; activation, resiliency, authenticity, reducing struggle. These themes will be discussed in chapter 5.

**Creative Synthesis**

The final phase of heuristic data analysis is the process of creative synthesis. According to Moustakas (1990) “[this] can only be achieved through tacit and intuitive powers. Once the researcher has mastered knowledge of the material that illuminates and explicates the question, the researcher is challenged to put the components and core themes into a creative synthesis” (p.32). For the purposes of this project, the creative synthesis takes the form of a narrative depiction that integrates verbatim material and examples throughout. Once the final narration was complete, it was sent out to be member-checked. As the primary co-researcher I sought honest feedback from the co-researchers and made adjustments to the narrative as required to ensure it was an accurate depiction that encapsulated the essence of the experience. The co-researchers have not

yet provided any feedback (Cresswell, 2003; 2007; Denzin & Lincoln, 2011; Guthrie, 2011; Moustakas, 1990).

### **Triangulation**

The three points of triangulation were represented by the overlapping questions of the two interview guides and the application of personal artifacts. The co-researchers each provided an artifact that was personally significant in their recovery and provided a subsequent narrative surrounding it. During the analysis phase, the discussion of each artifact was coded on the audio track and linked back to the findings from each of the research questions. In addition, there was overlap between the two interview guides, and notes were made on the audio files as the co-researchers iterated comparisons between previous answers. Although the artifacts supported an in-depth discussion, the narratives were not all directly related to a turning point, as requested by the primary researcher. As a result, the strength of the triangulation in this project may have lacked a degree of strength. More details surrounding the strengths and limitations of the artifacts is further discussed in chapter 4.

### **Trustworthiness**

The validity of heuristic research is heavily reliant on the truthfulness of the primary co-researcher. Within the framework of heuristic research Moustakas (1990) suggests:

“the question of validity is of meaning: Does the ultimate depiction of the experience derived from one’s own rigorous, exhaustive self-searching and from the explications of others present comprehensively, vividly and accurately the meanings and essences of the experience? This is a judgment that can only be made

by the primary researcher, who is the only person in the investigation who has undergone the heuristic inquiry from the beginning of formulation of the question through phases of incubation, illumination, explication and creative synthesis not only with himself or herself, but with each and every co-researcher” (p. 32).

As a result, I will engage in a continuous cycle of appraising the significance of my findings, checking and judging my own interpretation to facilitate a valid depiction of the experience of living well with mental illness. Member checking also contributes to the validity of the project, although it should be noted that limited dialogue from the co-researchers has been reciprocated. However, since this project is not intended to yield generalizability, reliability within the study remains an irrelevant discussion (Cresswell, 2003; 2007; Denzin & Lincoln, 2011; Guthrie, 2011; Moustakas, 1990).

This chapter outlined the methodological process of this research. Through the adoption of a heuristic methodology; this project utilized a qualitative approach to inquiry in an effort to understand the lived experiences of the co-researchers. The following chapter will provide a brief introduction to each of the co-researchers and outline the findings of this work. This Master’s thesis project was not intended to provide generalizability across a large population. However, the lived experiences of the co-researchers supported the creation of a visual model that denotes three phases and encapsulates their experience of living well with mental illness. The findings and implications of this study, as outlined and discussed in the final two chapters, will underpin my program of research at the doctoral level.

## **Chapter 4 – Results**

### **The Co-Researchers**

The heuristic method emphasizes the individual co-researcher's voices throughout much of the data analysis and presentation of findings (Moustakas, 1990). The following is a brief personal introduction to each of the co-researchers in an effort to highlight the personal attributes each brought to this project.

#### **Lauren**

I am a 31-year-old female with dark features that contrast with my fair skin. I have an average build that is reflective of my underemployed athletic ability. As a child I was most frequently described as having big brown eyes and long dark eyelashes, a trait that has stuck with me into adulthood. I have a vibrant, likeable personality, am kind-hearted, loving and other-oriented. I am a passionate person that tends to bring her whole-self to every situation, but am quiet and introverted when given the opportunity. I share my home with six dogs and two cats and, for the most part, I tend to like them more than people.

I am a family oriented person, and share a close connection with my parents and sister. I am fortunate enough to be an aunt of two tiny men, who are recent additions to our family but most definitely the center of our world. I have recently separated from my husband of 5 years and am still adjusting to the start of this new chapter, but am optimistic about the future that lies ahead of me. Of course, as the primary researcher in this project, part of who I am is also defined by my life as a student. I would describe myself as an ordinary student with extraordinary drive. I am hard working and dedicated but continue to challenge myself to find balance between academia and the real world.

This chapter marks one of the final months I will spend as a master's student as I prepare to transition into my role as a full time Ph.D. student at Brock University. I was diagnosed by my family physician with major depressive disorder at 21 years of age.

### **Doug**

Doug is a 50-year-old male, clean cut with glasses. He has medium build, with kind eyes and a deep mumbling voice. Doug has a relatively flat affect when you first meet him, but livens up as he becomes more comfortable. Doug is a well-educated man with a diverse background. He began his career as a public high school teacher where he spent 20 years dedicated to his students both in and out of the classroom. When Doug speaks of his experience as a teacher, much of what he shares is centered on the extra curricular activities he supervised, in particular his robotics club. After spending many years battling substance abuse and mental illness, Doug requested an early retirement package from his teaching career. A few years later, Doug returned to school where he completed a Master's degree in Counseling and Psychotherapy. Following that he and his partner moved to the Niagara community.

Doug is an active member of the community; he is self-employed, a weekly volunteer at a local mental health organization and an active member and sponsor for a local addictions support group. Doug maintains a busy but balanced lifestyle, always leaving time in the evenings for his partner. Doug is an avid reader and painter but requires prompting to talk about them. Much of his identity is rooted in his sobriety which he says requires a daily commitment.

Doug has lost both of his parents over the past decade, but speaks of them fondly and expresses gratitude for their love and support, in particular throughout the years when

he was unwell. Doug is one of three brothers, but was forced to sever connections with one of his brothers after a toxic relationship developed between them as a result of his appointment as the executor of his parent's estate. Doug received a dual diagnosis from his psychiatrist of bi-polar affective disorder- type 2 and alcoholism at 35 years of age; he has been sober for 13 years.

**Mark**

Mark is a young man approaching his mid-20's, with dark features that compliment his smooth dark skin. He has a slim athletic build, is easy to talk to, and is very well-spoken. He has a slight Indian accent and comes from a tight knit Indian family. He has two siblings, a brother and a sister, both of whom are nearly a decade older. He describes his family as traditional and somewhat disconnected from the Canadian culture that he ascribes belonging to. As the youngest of the children, he describes his family as protective but supportive of him, which has presented elements of challenge as he developed through older adolescence into adulthood. Mark is the only child left in his family home, his sister is currently living in Europe and his brother in the USA.

Mark is well educated for his age; he has a degree in Psychology, and recently returned to school to complete a second degree through distance education. Mark is a huge sports addict and he lights up when given a chance to talk about NCAA basketball, the Toronto Raptors or the Toronto Blue Jays. Mark also enjoys playing sports, going to the gym and long distance running. He has an active lifestyle that includes a balanced diet and regular exercise.

Mark is an avid reader and has particular interests in studying the philosophy of living a good life. He devotes time out of every day to journal and works hard to create space for his illness without being consumed by it. Mark is a volunteer and part-time employee of a local mental health organization. He is also a member of a local group of individuals who volunteer their time to speak in the community about their own experiences with mental illness. Mark is an advocate for individuals living well with mental illness and his own experiences have inspired his desire to pursue his second degree. Mark was diagnosed by his psychiatrist with obsessive-compulsive disorder at 11 years of age.

**Donald**

Donald is a 23-year-old male; he is tall and thin, with fair skin and a soft voice. He presents as shy and uncomfortable when you first meet him, but warms up with time. His quiet, shy demeanor made the interview process challenging, but he was kind, funny and a pleasure to spend time with.

Donald comes from a blended family; together his parents have seven children. Donald currently resides in a student home with his parents only a few blocks away. Currently in his family he has two biological siblings and two adopted siblings. His parents have fostered children for Family and Children's Services Niagara for the past 10 years, and recently adopted two of the children that came into their home as infants. Donald describes his family relationships as close, but busy. He says his parents have played a supportive role in his recovery, but as an older brother he has felt the need to protect his younger siblings from the knowledge of his experiences with mental illness.

Donald has just completed his degree and is attending college in September to complete a post-graduate certificate. He has been in a relationship since his first year of university and met his girlfriend living in residence at university. He describes his relationship as healthy and supportive. Donald also speaks highly of his core group of friends, noting that they are supportive of his experience with mental illness and have helped him feel comfortable telling his story to others. Donald was diagnosed by his family physician with social anxiety and major depressive disorder at 19 years of age, during his first semester at university.

**Wanda**

Wanda is a full figured, middle-aged women. She has short hair and glasses, is well groomed and always has a coffee in hand. Wanda has a vibrant personality with a loud voice and infectious laugh. Wanda carries herself with confidence and is well spoken, but is very guarded about the details of her personal life. She is has a son, a husband and a dog. She describes her relationship with her family as supportive and trustworthy, with her husband being her best friend.

Wanda has a close relationship with her parents and sisters and describes having a large network of acquaintances, but her sisters are her closest friends. Wanda has a college education and is a successful entrepreneur in the Niagara community. She is also a volunteer for a local mental health association and is a member of a local group of individuals who volunteer their time to speak in the community about their own experiences with mental illness. In addition to her volunteer work, Wanda enjoys reading and watching TV, spending time with her family. She describes herself as an excellent cook and loves finding time to take long baths. Wanda was diagnosed by a former

psychiatrist with bi-polar affective disorder type 2 at 25 years of age but received a subsequent diagnosis from her current psychiatrist of bi-polar schizoaffective disorder at 30 years of age.

### **Sally**

Sally is a middle-aged woman, with medium length light brown hair, glasses and a petite structure. Sally is well groomed with a modern yet sophisticated style. Sally has a caring, fun-loving personality, with a loud but heart-felt laugh. She presents as a naturally happy person who is optimistic and confident in whom she is.

Sally is the single mother to two boys who are the center of her world. She describes her relationship with her sons as satisfying, often expressing how much she enjoys their company as adults. She has been divorced twice, but has managed to maintain a healthy connection with both of her former husbands. Sally did not speak of any family outside of her husbands and boys, but spoke highly of the large network of friends she has in her life. Outside of her generous volunteer roles, Sally is an avid reader and writer and she enjoys finding creative ways to express this passion.

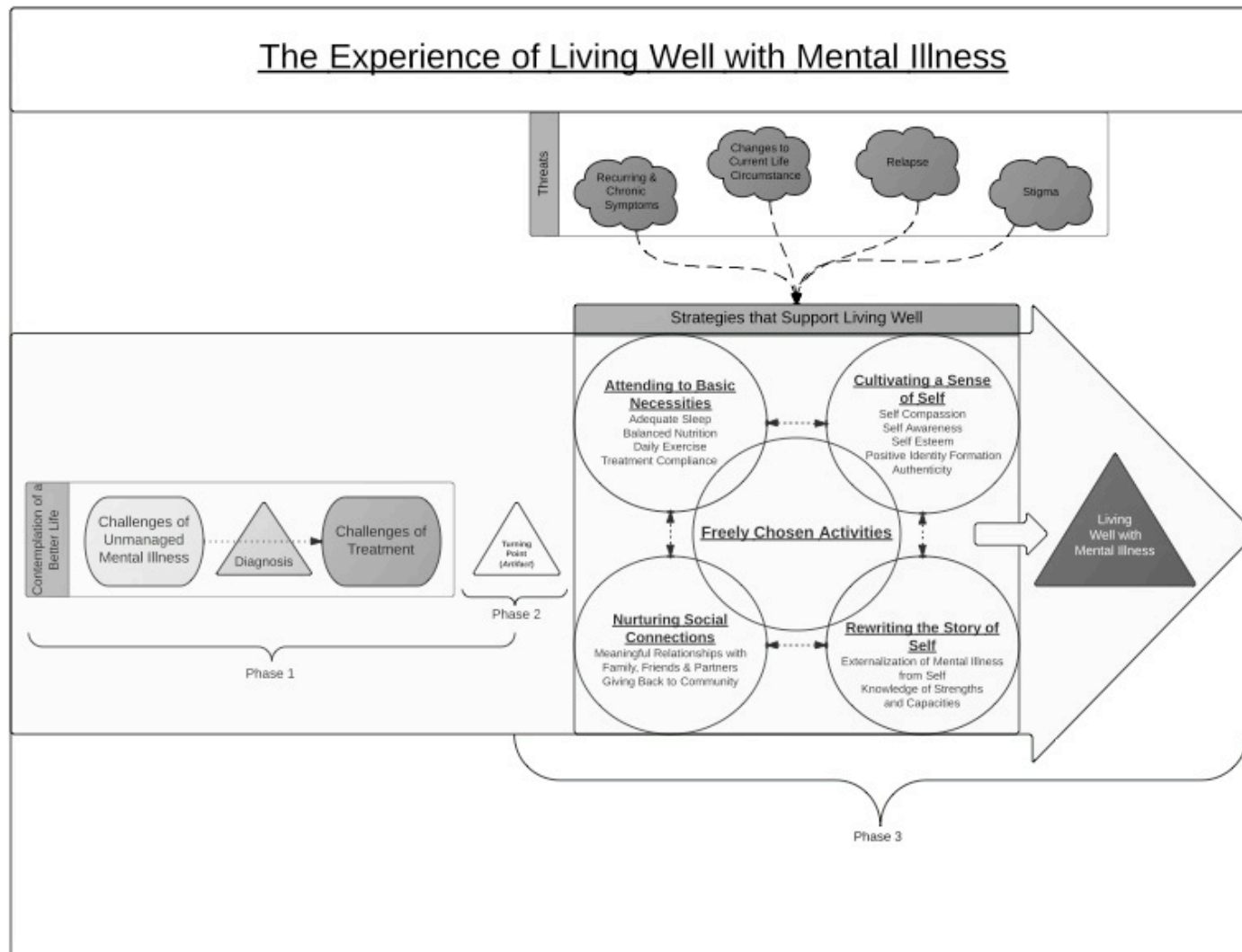
Sally is a university graduate, where she studied English. Sally was an employee of a medium sized university for 22 years, and recently lost her job during cutbacks. She is an active volunteer in the community and devotes significant time to the board of directors for a local mental health organization. Sally is also member of a local group of individuals who speak in the community about their own experiences with mental illness and a board member for a local mental health youth organization. Sally was also recently hired as a blogger for an online mental health website. Sally was diagnosed by her family

physician with major depressive disorder at 23 years of age and alcoholism at 43 years of age; she has been sober for two years.

### **Findings**

This study sought to understand how individuals live well with mental illness. Six co-researchers constructed the findings of this project. A total of twelve interviews were completed, yielding approximately ten hours of useable data. Free-time engagements appear to be central to the life well lived for the co-researchers in this study. For the co-researchers, free-time engagements provide a reciprocal context through which they can employ supportive strategies that facilitate the attainment and maintenance of a life that includes mental illness, but is not defined by it. The following model is a representation of the research findings, which will be further discussed in this chapter. This model has been reviewed and accepted by the co-researchers as representative of their experiences of living well with mental illness.

### Conceptual Model of Living Well with Mental Illness



### **Contemplation of a Better Life**

Within this framework of this project, the narratives of the co-researchers led me to conceptualize life prior to recovery as the phase in which individuals contemplate change, but are challenged by familiarity. As represented in my diagram, there are three parts to this phase, the challenges of unmanaged mental illness, diagnosis, and challenges of treatment. Interestingly, there was much similarity between each of the co-researchers descriptions of this first phase in their journey to recovery.

### **Challenges of Unmanaged Mental Illness**

Consistent with many of the themes depicting the challenges of mental illness presented within my literature review, the co-researchers spoke of their unmanaged symptoms negatively influencing life events including unemployment, substance abuse, divorce from romantic relationships, severed friendships, suicide attempts and hospitalization. As Wanda explained *“I had 9 suicide attempts, my first one at 13 years of age, but now I can joke and say when I was very ill I couldn't even do suicide right!”* (Interview 1).

In spite of the negative impact of symptoms, many participants spoke of the familiarity and comfort associated with being ill. Wanda said it best as she reminded me of the sense of security associated with unmanaged symptoms that makes it difficult to envision change.

*“You have to remember, when you're very ill, even though it's a bad-bad place to be, it's what you know and it's what's familiar. And I did, I stayed there for a long time because it was comfortable, it wasn't great, but it was comfortable and it was what I knew and so when I had to step outside of myself and make changes, um, well, that is when you start growing and that's when you start becoming who you are and not your illness any longer”* (Interview 2).

As many of the co-researchers echoed, the effects of the symptoms became part of the life that one is accustomed to living. The co-researchers described the challenges they experienced in their lives before recovery; isolation, thoughts of harming self or others, hallucinations, psychosis, racing thoughts, lack of ability to focus, lack of ability to perform activities of daily living, insomnia, anhedonia, inertia and physical pain, yet they unanimously articulated a sense of safety in the life they had come to know.

The co-researchers also expressed similar experiences surrounding their diagnosis and challenges of treatment. They reported moderate to high level of dysfunction and lack of connection to the world around them prior to seeking medical support. However, I was the only co-researcher who discussed the catalyst that sprung me from dysfunction in daily living to treatment. For me it was a hard response to write, perhaps for others, it was simply too personal to share.

*“I had my plan, I woke up in the morning knowing what I had to do. I had reached the end of my story and was finally ready to say goodbye. I put on a pink robe that my sister had given me as a gift a few years earlier and was heading for the stairs leading down from my attic bedroom, just as I reached for the banister I felt a pair of eyes connect to my soul. My dog Abby was lying on the end of my bed, just 6 months old and she looked at me in a way that told me I was more than the bad decision I was about to make. After I was gone, I wasn't sure anyone would step up and love her as much as I did. What would happen to Abby if I wasn't there? I went over to the bed and sat with her, I wasn't entirely sure how I was going to share this one with my parents, but I did. I called my mom and she very quickly became my person. I'm not actually sure who saved me from myself, my dog, or my mother, maybe it was actually me! But when I think about it now, I realize I actually just wasn't ready to leave...At my worst it was as if I had no purpose in the world at all, my life had become consumed by sadness and despair and at my worst I couldn't envision a future beyond my current state. I always had a quiet voice that reminded me, life as it was – was not worth living, and over time that voice became dangerously loud. But now, I appreciate that I had to find rock bottom; I had to create that plan of when and how I would end my life. More than a decade later, I realize, the day that was supposed to be my last was actually the day my real-life began. Abby and I still share life together, though she is now a senior. I love all of my dogs, but Abby is my soul mate. By giving her my heart, she gave me back the world, literally. I fear the indescribable loss I will*

*feel when I have to let her go, but I know this journey couldn't possibly be for nothing. This story is part of who I am now and always the hardest part to share, but I choose to do so because I can, I'm here, and I live really well!"* (Lauren, Interview 1).

Sally echoed similar a theme, life at her worst was not completely hopeless, but rather, associated with a tacit-knowledge that despite the discomfort of change there might be more to life than the depression she was currently living. As Sally remarked,

*"I joke with people and tell them how my oldest son was 5 years old before he realized that other moms didn't play with their children by lying on the living room floor...if I could have found someone that was competent to raise my boys to be good people, I would have checked out a long time ago. I realize now how irrational that is, but at the time it kept me going."* (Interview 1).

## **Diagnosis**

Within my own responses, I wrote that living with mental illness has been a blessing that formed me into the self-committed person I am today and has given me a sense of purpose that is rooted in a greater good. However, when I responded to my experience of being diagnosed, there is a clear reverberation that continues to challenge me in daily living:

*"Receiving the diagnosis of a mental illness was the hardest part of my journey thus far. My diagnosis has given me permission to self-stigmatize and negative self-talk has over-shadowed many aspects of my life, in particular my successes. How could I possibly forge a life for myself that was wasn't solely defined by this obvious shortcoming? How could I possibly be deserving of the accolades and opportunities that my academic life is lending? My diagnosis has left me with a sense of inadequacy that to this day is an ongoing battle. Although I can rationalize my illness as a product of insufficient neurochemical production that should make it equitable to a metabolic disease such as diabetes, stigma keeps me from feeling less than vulnerable. For me the label of a formal diagnosis has left me to live with a quiet fear of being judged as less deserving than others because of the previous life I have lived"* (Lauren, Interview 1).

Interestingly, the other five co-researchers recognized diagnosis as a positive step that gave them a sense of relief, that validated their experiences of daily challenges and

allowed them to access services that would subsequently inspire them to build a life with greater meaning. *“I would have to say, what was it like to be diagnosed? It was a relief actually. It was how I began to get help”* (Doug, Interview 1).

*“Going to see the psychiatrist, it was definitely relieving, to actually get some answers, to know that what I was experiencing was legit. And to begin getting help so I could have a better life”* (Mark, Interview 1).

*“I always knew I was different, but after I was diagnosed I was prescribed medication and that helped a lot. I discontinued myself off of them, for sexual dysfunction reasons mostly...but the medication gave me the confidence I needed to begin living again”* (Donald, Interview 1).

*“I always say the diagnosis are just words because really you’re just living your life. There is no change from before to after. The only thing is, now the medical system knows who you are and that you have something and you can be treated appropriately; medications are more narrowed down. But your life doesn’t change because you have a diagnosis, it’s just words”* (Wanda, Interview 1).

*“It [mental illness] has made me dig into who I am and what’s important to me, I know that, I know who I am now. Um, it has made me really put the important things in my life into priority and I think I’ve made a difference for other people too. So being out there, talking about my experience, has helped other people...It’s a gift of resilience and it’s a gift of really living well, I figured that out!”* (Sally, Interview 1).

### **Challenges of Treatment**

Following diagnosis, all of the co-researchers accepted pharmacological support in the initial stages of their treatment. However, Mark and I have not remained on medication long-term. In both cases, it was the adverse side effects of various medications that precluded our treatment compliance. The co-researchers that remain compliant with pharmacological interventions each expressed how their medications have required ongoing adjustments since diagnosis, which, according to them, is a reality for most psychiatric medications.

Wanda and Doug were hospitalized as a result of their illness and both described voluntary admissions to the hospital as a much-needed place of respite from the dysfunction that was further exacerbated by home-based living. Specific treatment interventions following diagnosis were not a focus for this project and therefore were not discussed in detail during the interviews. However, a notable finding with regards to initial treatments is the expressed challenges associated with the initial stages of treatments and the limitations that are placed on individuals seeking such treatment, which may further perpetuate the dysfunction in daily living beyond the initial diagnosis.

*“When I was told my diagnosis, I was told I was never going to work again because I had been sick for so long. And so that was, you know, accepting that, which I did momentarily and then I kind of got mad and I thought NO! I can’t, this isn’t forever....Just because I can smile and laugh now, doesn’t mean I wasn’t the person that wasn’t shuffling down the hallway in the hospital with so many drugs in her system that there was no smile, there was no nothing. And so, ya, for a while I looked like a mental patient, ya, I acted like a mental patient. But what I want people to know is that your life can change a lot, it doesn’t always have to be that way” (Wanda, Interview 2).*

The co-researchers also suggested that the contemplation of a better life phase is integral to living well with mental illness. Within this context, individuals must live a life of dysfunction in order to envision a life outside of it. As Wanda joked in her second interview *“You’ve had your mental illness for a while obviously, because you don’t get diagnosed at the beginning of it!”* Though the initial stages of unmanaged symptoms, diagnosis and treatment present as challenging experiences for the co-researchers, it was through this experience of challenge that resiliency was inspired.

### **Turning Point (Artifact)**

As discussed in chapter 3, Moustakas (1990) emphasizes the use of personal artifacts such as poems, pictures or inanimate objects that are connected to the lived

experience. The purpose of such artifacts in this project was to demonstrate tangibility to the co-researchers experience of recovery and their journey of living well. Upon completion of the first interview, each co-researcher was assigned the task of bringing an artifact to their second interview, which for them was symbolic of a turning point in their recovery. Even though the co-researchers were asked to bring an item that represents a turning point, many of the participants did not discuss their artifact in that way. Perhaps the phrase of turning point was not relevant to them, but rather they took it as an opportunity to share something of personal significance to them that is personally symbolic of how they live well.



As the primary researcher, this project was inspired by my own experience with mental illness. Consistent with the experiences of the co-researchers, my early 20's were the most challenging. After living with a mask on for many years, I finally sought help. Supported by my family and doctor, I began on a path to recovery. I have spent the past 10 years living well and determined to forge a life that isn't defined by an illness that makes activation and engagement in life challenging. After completing my written responses to the first interview guide, I decided a photo of Abby would best represent the turning point in my recovery. As I completed my written responses to the second interview guide, it became even more obvious to me how much all of my dogs have augmented my ability to live well physically, emotionally and spiritually.

*"I live well by creating space for challenge and allowing others to help. Living with depression isn't something I would wish on someone else. It is challenging at best, but I accept the challenge and appreciate the gifts that come along with it. People with depression often wake up feeling naturally low and for me, this low*

*used to distract me from the day I had ahead. But my depression has allowed me to know myself, love myself and learn to care for myself. My depression has made me more dedicated and resilient than most, exceptionally kind hearted, empathic towards others, and appreciative of the world around me. I am fortunate to have a loving, supportive family and grateful to have an education. But most of all, I feel privileged to share my life with dogs. They get me moving in the morning, which is the only time of day I consistently need support. By the time we return from our walk the endorphins have taken over and I have reconnected with the best version of myself. I realize dogs wouldn't be the best fit for everyone, but for me they are the key that unlocks the door to a life that is so much more than an illness. I may have a disability, but thanks to the life I have learned to live I choose not to be disabled. I live each day with gratitude for the life my dogs have helped me to discover, but they too are only one piece. I will remain forever grateful for the life they remind me to live, for the love that they give and person they help me to be. My dogs have been central to my recovery and inspire me everyday to become the person they already think I am” (Lauren, Interview 2).*



Doug frequently spoke of painting as an engagement that has allowed him the opportunity to reconnect with himself and express current emotions as they arise. Interestingly, when asked to provide an artifact that symbolized a turning point in

his recovery, he arrived to the second interview with a framed painting from his dining room. When asked why he chose this particular item, Doug explained how he created it from an image he saw online, at a time when he was struggling with the loss of his father. Throughout the interview, it became evident that Doug felt a great sense of accomplishment seeing his work hang in his home. He explained *“I often find myself looking at it [the painting] and thinking I can’t believe I did that”* (Interview 2). As he went on to describe how he created the painting there was a narrative surrounding his family and how painting allowed him feel connected to his deceased mother. A narrative did not accompany this artifact that supporting Doug’s turning point, but it certainly provides evidence into the power of leisure in living well.

*"I didn't paint this in a day, it took me hours, there are many layers. I'm not good at landscapes and still-lives, but abstracts I can do...Painting has been, I think, an important part of my recovery. It's a way for me to express some of my emotions in something that is concrete. Some are very colourful and some are really dark and sad. Each painting represents a different state of mind. Painting is a voice. When I am struggling or when I have free time- I paint, it just helps" (Doug, Interview 2).*



Mark identified studying the philosophy of

living a good life as a key motivator in his recovery. Within this context he identified

Brian Johnson's website as the artifact that symbolized a turning point in his recovery.

*"[Brian Johnson] reads all these philosophy books and he takes away the big points from them and he creates a cheat sheet of the important points they talk about and creates a video as well on the important points explored in the book. When I discovered this I just started watching these videos, and the videos gave me a snap shot of what some of these books were about and what some of these great philosophers and psychologists were saying and it was just broken down into big ideas that at the time I could understand...as I watched the videos I started to apply the strategies from these books to my life, like mind-mapping and gratitude journaling and certain visualization exercises. Sometimes picking up those big thick books when you're in a state of anxiety or depression is so tough to get through, so, having these videos there where he's offering a Coles notes on them was something I could use every day and apply some of the big ideas to my life. Even today, I try and watch a couple of these videos per week just to kind of keep up with it. It's been something I go back to regularly and was definitely a big part of my turnaround" (Mark, Interview 2).*



Donald identified music as his artifact. Although he did not

articulate a clear turning point, he explained how music gave

him a voice to express emotions he could not otherwise

express. In addition, for Donald, music was an escape from the

negative emotions associated with depression and anxiety but

also a companion that kept him from feeling completely alone. As an individual living

with social anxiety, Donald spoke often of his challenges relating to others and his lack of

personal identity as a teen. But he also explained how music buffered his ability to be in

crowds, *“People with social anxiety don't like big groups, I avoid those types of situations. I don't know if you know what a mosh pit is, but that is one of the few places that I feel safe”* (Interview 2). Interestingly, he attributes music as the primary way through which he was able to befriend himself and, in turn, begin to foster the confidence and motivation to develop relationships with others.

*“I brought an album, there's nothing in particular about this album, just music in general, that was a major factor that aided me in getting over the issues. Whenever I was feeling down and depressed music was always kinda there to be the comforting shoulder I needed I suppose...it's the energy behind music that does it...it expressed the things I felt but was too anxious or too depressed to express myself so I was able to let it all out through music. It is always something to turn to, it makes me feel comfortable, I enjoy it, it is just something stable I guess. It wasn't going to change, I knew the bands I liked and was always finding new bands I liked...I don't play any musical instruments myself...my girlfriend says I can't keep a beat, so in that sense I'm not musical, but I do love music... Music is kind of a comfort, something to express myself and something to conform an identity to, that was a major issue for me, especially in high school, I never really had much of an identity and that was kind of brought on by the depression and the anxiety, it didn't let me form much of an identity for myself but through music I kinda was able to, um, it's my safe haven I suppose”* (Donald, Interview 2).



Wanda identified a stuffed bear, wearing a “happy being me” bamboo t-shirt as the artifact that symbolized a turning point in her recovery. She explained how the bear represented the acceptance and commitment she could finally make to her illness and her readiness to create a life beyond disability and despair. The bear resides on her desk by her computer as a reminder of her ability to live well with mental illness.

*“My little bear always sits on my desk and it just reminds me of the moment that I could finally be who I was and I didn't have to hide all the pieces and I didn't have to put on this face so nobody knew who the real me was. I could speak about my illness and go inspire other people and I could talk to other people who also have a mental illness who are struggling along just as I once did. So that to me symbolizes my turning point and being able to live with who I am”* (Wanda, Interview 2).



Sally identified a personal tattoo as her artifact symbolic of a turning point in her recovery. She explained the tattoo was part of her commitment to herself in living well and staying well after cycling between well and unwell for many years.

Sally's narrative does not articulate a particular turning point, but it does speak to her level of resiliency and to me, Sally's frog is a daily reminder of the person she has become!

*"I was looking up the frogs and meaning online and the frog, in addition to other meanings, it was about transformation. So it was like, WOW, that's very connected for me...so it's about who I am now, that I wasn't before. And I chose my frog as my artifact because it is something that I did that people who perhaps do not know me well, would not think it was part of who I am. And it is a very freeing kind of thing for me, it is a statement about me, and that I am comfortable being whoever I am going to be and this was a piece that I wanted to do. I don't just wear cardigans, I swear like a sailor and now I have a tattoo...I always had the responsible safe route that I took in life and this is kind of my way, my statement of authentic ownership of myself...It means transformation of the person that I used to be, to the person that I am today, and it's a happy tree frog!" (Sally, Interview 2).*

The artifacts in this project represent the second phase in my visual representation of living well with mental illness. Through the co-researchers narratives, it has become evident to me that leisure plays a central role in the attainment of a life that supports individuals living well with mental illness. In particular, for the co-researchers, leisure engagements were influential factors in recovery and became part of their journey in living well. The co-researchers often spoke of the value of leisure as a space in which they have been able to explore and develop the capacity to begin and maintain a life that was not solely defined by their illness. As the primary researcher, I approached this project with a curiosity to discover whether others would narrate similar experiences in

leisure and living well. The subsequent pages of this chapter will outline the strategies employed by the co-researchers and their intersection with freely chosen activities.

### **Strategies that Support Living Well**

In chapter 2, I highlighted a discrepancy between the medical model and the six domains that encompass quality of life. Specifically, I problematized the use of the medical model in supporting individuals living well. Moreover, I remind the reader that because quality of life is supported by physical, psychological, social, environmental and spiritual health it is possible that leisure could be central to recovery from mental illness. In proposing this study I suggested leisure could be a facet of life within which individuals are best supported in the engagement of a lifestyle that is socially, emotionally and physically healthy and inclusive of community-based networks. As a result, the second interview guide focused heavily on the strategies individuals have employed in their recovery, which they believe support their experience of living well. The third phase of my visual model represents the strategies employed by the co-researchers. Within this phase, it is important to note that there is an ongoing reciprocal relationship between each of the categories in that they support the attainment of one-another, but also foster independent equity. The following sections will outline the four categories and sub-categories supported by the data in this project.

### **Attending to Basic Necessities**

This theme focuses primarily on strategies related to the biological maintenance of one's self. There are four core strategies that one must attend to on a daily basis in order to fulfill the biological requirements of physical health. The co-researchers suggested that the care of the physical self is an important first step in recovery and a

component that often requires the highest amount of ongoing attention. (1) Adequate sleep, (2) Balanced nutrition, (3) Daily exercise and (4) Treatment compliance were the four core strategies identified by the co-researchers as foundational to the support of one's physical health.

*"I try to get enough sleep but not too much, I eat really healthy and go to the gym 2-3 times per week, because I know that keeps my mental health intact" (Mark, Interview 1).*

*"I take my medication everyday and I try to get lots of sleep, which I do. I go to bed very early and I like to get up very early in the morning. I like to keep myself occupied. I like to um, schedule things during the day. Whether it's work, or something like this, a volunteer thing...exercise is important, I know I need to do that, even if it's just getting out of the house and going for a walk...it gives me so much more energy and a clear mind to go onto the next thing I have to do. Those are some of the ways I live well with mental illness" (Doug, Interview 2).*

*"I'm better now than I've ever been in terms of my mental health and that in part is due to, ya know, taking care of my physical health. Eating well, going to the gym, staying active, getting enough sleep that kind of thing. My mental health is something I have to work on regularly" (Mark, Interview 1).*

In addition, some of the co-researchers alluded to the purposeful engagement they have to exercise each day. In my opinion, there is effort required to eat well, exercise and get enough sleep. As I wrote in my interview 2 response:

*"Despite having a mental illness, I live a very normal life. However, I do believe the purposefulness I bring to everyday living makes me unique. I don't believe most people have to create space in their life to care for themselves the way individuals with mental illness do"*

The co-researchers spoke of being conscious of how they spend their energy, likely as a result of the calculated efforts they have to make in order to maintain the physical foundation required for living well. As Sally said, *"I only have so much energy and I have to really think about where I spend it and so I make conscious decisions about where I spend it and with whom I spend it"* (Interview 1). Wanda echoed a similar theme:

*“I have learned I don’t have to explain to people when I can’t do social things. Quite honestly, it’s none of their freakin’ business. I don’t do a lot in the evenings, I’m exhausted by then. Especially during the week, I watch TV or play on the computer. I go to bed early...everything I do takes longer so I have to allow time for that. People with mental illness have to try harder and we need energy to do that.” (Wanda, Interview 1).*

### **Cultivating a Sense of Self**

This theme focuses on strategies used in caring for the psychological self, in particular identity. The co-researchers emphasized a valued necessity for the development of the following skills: (1) self-compassion, (2) self-awareness, (3) self-esteem, (4) positive identity formation and (5) authenticity. In my experience, there is an element of counter-reliance between each of the sub-categories. For me, self-compassion helped increase my ability to be self-aware. In turn, my self-awareness helped me to form a positive identity, feel good about myself and translate that knowledge in a way that felt authentic. I have been fortunate enough to forge a life for myself that supports my core beliefs and values, but I developed this knowledge by exploring who I was, what I like and what I’m good at; an exploration that for me, happened through leisure.

Self-compassion involves the extension of kindness towards oneself in situations of perceived inadequacy or weakness. According Sally and Wanda, one’s ability to extend kindness and understanding to themselves is central to the creation of a life that includes but is not defined by mental illness.

*“When things do happen and I am debilitated I give myself the opportunity to just step back, so now I can say, no- you know that I can’t do that right now. No, I’m not able to do that right now. I just need a little bit of time. Stepping back and doing my own thing and I don’t feel that somehow it’s a reflection on me and my strength. It’s just part of who I am and what I need to do to stay well...What I found in the past little while is that, when I have a relapse I am much less focused on what went on in the past and more about okay, what do I need to do to make sure that, well what can I learn from this in the first instance, and how do I*

*incorporate that to make sure that down the road this doesn't necessarily happen again in that way” (Sally, Interview 2).*

*“Don't set your expectations so high that you fail all the time...I do have limitations and there are things I have to take into consideration that maybe other people don't, but I also know now that I don't have to explain everything away...change what you have to change, change what you want to change, but remember it's okay to take care of you” (Wanda, Interview 2).*

Self-awareness is one's ability to connect to personal needs and advocate for themselves in benefit of those needs (Miller & Rollnick, 2013). Sally suggested that self-awareness is representative of the ability to acknowledge when symptoms associated with one's illness have changed, and knowing the necessary steps to take in order to overcome such challenges.

*“The other piece is just being a little more cognizant of the signs and symptoms, I know when I have been doing too much, I have to step back and I don't beat myself up for that anymore, I just do it, and recognize that it just is what it is and I am going to carry on from there. Um, I think being open about having mental illness and addiction is a piece that makes me honest with myself because I am honest with other people. And so when I do have a relapse I am also very open about it, so I ask for help. Oh my god! I HATE asking for help, I hate it, hate it, hate it. But I do it now, because I need to and that's been a good piece for me to learn. And as I say, resilience, recognizing that it's a point in time not a forever thing, even if it feels like a forever thing, I know it is time limited because I have the experience that tells me it doesn't last forever” (Sally, Interview 2).*

Doug echoed a similar experience:

*“Life is a lot better because I know I have a mental illness and I know what my diagnosis is and I know what kinds of things I have to look out for if I think my mental health is declining or deteriorating in any way” (Doug, Interview 2).*

It has been my experience that self-awareness is also reliant on my ability to be self-compassionate and accepting of setbacks as a means of moving forward.

Self-esteem involves a positive evaluation of one's worth and is often cultivated through positive self-talk (Miller & Rollnick, 2013). I believe there is a positive

relationship between the development of self-esteem as a result of particular levels of self-compassion and self-awareness. Donald suggested:

*“Be confident, as hard as it might be, um, understand you have your own personal needs and you have to focus on yourself sometimes and that’s okay. Depression makes you feel like you are worthless at points and you don’t really think you deserve to be treating yourself well...treat others well, depression affects other people too, the way you act rubs off on other people, so treating other people well affects you more positively”* (Donald, Interview 2).

Perhaps, in fact, self-esteem is central to recovery and living well, in that it creates the foundation for one to explore new experiences and relationships that further support a well-lived life. As Donald went on to explain:

*“I guess I just do what I need to do at the time, um, sometimes I do push through it [anxiety] kinda push myself into situations where I feel uncomfortable but that kinda helps me. Like social situations that I know I’m especially nervous to get into that week or whatever the issue might be, but I just push myself into that and kind of not let it control me I suppose. Um, I don’t know, having an overall confidence level that is strong enough to kinda get through that”* (Interview 2).

Positive identity formation, involves a sense of connection to core values and beliefs and the recognition of oneself as a separate entity to anyone else (Miller & Rollnick, 2013). In my opinion, identity formation is heavily connected self-esteem and authenticity but supported by self-awareness and self-compassion. As Sally alludes below, individuals with mental illness often struggle with identity formation. However, once the struggle is resolved there is a positive relief associated with knowing yourself, which provides the space required to determine one’s life purpose.

*“I think that I am who I was supposed to be. I am a much more authentic person, having gone through what I have. Having had to really dig down and figure out what’s my purpose, what’s important to me, what are my priorities. Um, it really means that I have a pretty solid understanding of who I am as a person and I’m much less inclined to try to be what other people think, or what I think other people think I should be. And I’m also a whole lot less judgmental than I think I*

*otherwise might have been. I've learned a tremendous amount of humility in the course of going through some of the things I have"* (Sally, Interview 2).

Authenticity is the behavioural component of positive identity formation. Though it is dependent on an established connection to one's identity, authenticity involves the manifestation of the true self in every day living and a willingness to be vulnerable as a result of bringing your whole self into every situation. In the context of this project authenticity involves the incorporation of truthfulness about one's whole self, sincerity towards self and others, and devotion to living well. Sally and Wanda explained:

*"If you're not prepared to be vulnerable, if you're not prepared to be out there with who you are, then you don't get the good or the bad. You can't numb the negative experiences and the things you're scared of without numbing all of the joy and the goodness as well...so it's like, whatever it is today- bring it on, I'm ready, bring it on!"* (Sally, Interview 2).

*"Actually what I wanted was a normal life, then I figured out that nobody has a normal life so figuring that out is a big one [for living well] ...realizing that there are different people in this world and not everybody has to be the same, in fact, how boring would the world be if we were?"... "I get to talk about my mental illness because I don't have to hide it any longer. That is probably a huge thing. I think also, just acceptance makes it easier to live with your mental illness"* (Wanda, Interview 2).

*"As much as it feels like it's never going to end, it does and it will. And you can live well with a mental illness, I know tons of people who are living proof of that and I am living proof too. And I actually think that there is a gift that comes with it because you get to look inside yourself, of necessity, and you become more of your authentic self than you ever would be if you weren't in a position where you had to slow down and figure that out"* (Sally, Interview 2).

### **Rewriting the Story of Self**

This theme focuses on strategies related to caring for the whole self. Within this theme there is a demand for one to narrate a life that incorporates the experiences associated with having a mental illness, but is defined beyond these experiences. The co-researchers narrated the two sub-strategies as the externalization of one's mental illness

from self and the acknowledgement of one's personal strengths and capacities. The co-researchers narrated identities that were defined beyond the limitations of their illness and suggested that realizing "*you are so much more than just your illness*" (Wanda, Interview 1) is an integral part of living well. According to the co-researchers, a positive self-narration must also incorporate the discovery and acceptance of one's strengths and capacities as a means of supporting life choices and engagements that support positive experiences and provide opportunities to further explore one's best-self.

Externalization of mental illness from self involves a self-narrative that depersonalizes mental illness and places one's diagnosis of it outside of the self. This strategy is frequently supported through professionally guided therapy, but may also be self-taught and is often employed as a coping strategy to aid in the acceptance of illness or disability. Regardless of the origin, this sub-strategy results in language that names one's mental illness as a separate entity from oneself. As I listened to the interviews over and over, it struck me how consistently Donald employed this sub-strategy:

*"A major thing is distracting yourself from the illness and not letting it be at the top of everything, it doesn't have to be all you are, let it simmer out without consuming you"* (Donald, Interview 2).

Acknowledgement of strengths and capacities involves the exploration of abilities in combination with the recognition of limitations. This sub-strategy involves accountability and is heavily reliant on honesty with oneself and others. The acknowledgement of strengths and capacities provides the opportunity for the individual to foster a sense of self-efficacy and recognize areas in one's life in need of improvement.

As I wrote in interview 1:

*"I very much believe my experience over the past 10 years has been a gift. I have learned to find time for and recognize the things in my life I am good at; I create*

*opportunities to experience positive emotion in everyday living by being mindful of the things around me; and I remember to find pause for myself so I don't become consumed by the stresses associated with daily living. Most of all, my illness has forced me to dig deep, know my values and live life with integrity. Thanks to the depression, I know who I am, I know where I've been and I know where I will never return" (Lauren).*

It has been my experience that through this process, individuals become further connected with their own reflexivity and able to foster a stronger sense of self-awareness that is further supported by their previously developed ability to practice self-compassion.

Donald would agree,

*"I've always had difficulty connecting with people, more recently it has definitely gotten better, just with family, friends and what not. I think that's a major aspect of living well for me, I suppose" (Donald, Interview 2).*

### **Nurturing Social Connections**

This theme focuses on strategies related to caring for the social self. The co-researchers emphasized that reciprocal relationships with others assist in the development of a meaningful life. In addition, the co-researchers consistently expressed value in the volunteer-based positions they held within the community through which they are able to support others in their journey of recovery from mental illness. As a result, this strategy is supported by two sub-categories; meaningful relationships with family, friends and partners and giving back to the community.

Meaningful relationships with family, friends and partners involve the establishment and maintenance of connections that are supportive of one's biological, psychological and emotional health. Within the context of this research, this process was supported by the individual's ability to be self-aware of the impact negative relationships were having on their ability to stay well. As Doug exemplified earlier in the chapter when he disclosed the impact of the negative relationship he shared with his brother, one must

be willing to sever unsupportive relationships or establish boundaries within such relationships as a means of maintaining their safety and mental health. In contrast, Donald spoke of how relationships that are supportive of one's emotional health provide the opportunity for individuals to increase levels of self-compassion, self-awareness and self-esteem.

*"I think just taking time for myself, it's hard to do with my schedule. But just doing things that are relaxing and not so anxiety provoking. Um, relaxing in general, talking to friends about things that are going on in life or things that I need to talk about, it helps"* (Donald, Interview 2).

Giving back to the community involves a sense of agency towards helping others live well with mental illness. In particular, this sub-category was rooted in the advocacy for mental health, in an effort to combat stigma and restore the exaggerated images perpetuated by popular culture. Each of the co-researchers, including myself, took pride in the work they do in the field of mental health. In my case, it is research and advocacy, for the other co-researchers it is volunteerism and public speaking. According to the co-researchers, giving back to one's community provides therapeutic opportunities for individuals to relay their experiences and inspire hope in others.

*"[As a volunteer at a local mental health organization], I advise journal, journal, journal, journal and journal some more, because it's amazing sometimes I would write things down and go WOW I didn't know I felt that way, until it came out of my brain and onto the page"* (Sally, Interview 2).

*"When I finished my degree and moved home from Montreal, I contacted [local mental health organization] and became a volunteer with the speakers bureau. I wanted to give back to my community, and help others understand they can create lives that aren't defined by mental illness, it only has to be one part of who they are, now I am also employed by them, I'm good at my job, but it takes me longer to get everything done, so I stay late a lot. I know the work I do matters and that feels good"* (Mark, Interview 1).

### Free Time Engagements

Free time engagements are the activities that individuals participate in on a voluntary basis, that are likely to generate positive emotion and often encourage self-discovery and foster the development of strengths and capacities central to living well.

When I proposed this project, the notion of leisure supporting living well for individuals with mental illness was based on my own experience of creating a meaningful life. What I did not anticipate was how heavily my co-researchers would emphasize the value of leisure in their lives. The co-researchers expressed leisure as a central component to living well, but also as the principle factor that incited their development and maintenance of the strategies previously discussed. As a result, within my conceptual diagram, free time engagements are placed in the center of the strategies capsule, overlapping with each of the four core strategies.

For me, leisure acts as an effective coping mechanism for stress, a source of positive emotion, supports the development my personal strengths and capacities, and provides the opportunity to develop friendships and social connections. Leisure has supported the development and maintenance of my physical, psychological, emotional and social self, and helped me integrate all the positive aspects of my life into my whole self, but also helps me to escape from the pressure associated with being a graduate student.

*“My free time keeps me well, and I am fortunate enough to have a professional life that is rich in purpose and meaning, but a huge part of who is am and how well I live is thanks to my dogs. The time I have with my dogs gives me a chance to recharge my batteries and allows me to escape from the everyday stresses of life. They get me moving in the morning and keep me moving at night. And more importantly they remind me to live in the moment, be mindful and savour. To be honest my dogs inspire me to be the best version of me; the kind of person that they already think I am” (Lauren, Interview 2).*

Leisure delivers choice, empowers and enables a sense of control. For Doug, leisure was connected to his need to feel engaged in daily living. Over time, he has learned that for him, idle time creates space for negative emotions that have an adverse effect on his mental health. As previously discussed, volunteering is central to his self-concept, but through leisure, he has also been able to further develop his sense of self, attend to daily necessities, and nurture social connections.

*“Have something to get up for, somewhere to go, somewhere I have to be at a certain time. It’s the days that I get up in the morning and look at my calendar and there is nothing and it’s like okay, great, what the fuck am I going to do today? So I know something now that I didn’t know before and that is that self-care is very, very important! My volunteer work at [the local mental health organization] is very important to me, it gets me out and seeing people, I know lots of people there and I do it weekly. But mindfulness meditation or going to a yoga class or going for a massage, things like that I wouldn’t have done before and it has changed me” (Doug, Interview 1).*

Leisure can provide context for self-expression and self-directed development. According to the co-researchers, the connection to positive experiences in their free time supported the development of their identity. Donald spoke earlier of the way in which leisure support him in cultivating his sense of self and supported the social relationships that he suggests are central to living well. Donald was able to find companionship through music, he spoke of a sense of belonging associated with being a fan, and the community that is created with others who share similar interests. Below he reminds us of the impact music and relationships have on living well.

*“Having a thing to kinda turn to when I’m down, music and friends are the things I enjoy doing, having to live without those things would kind of not work, I suppose. These little things kept me sane in a sense, I probably couldn’t live without them really. Or at least not well” (Donald, Interview 2).*

Leisure can also be ritualistic in nature and a central support in daily living. Sally starts each day expressing her gratitude for life through her love for words. When she spoke of her passion for writing, she expressed how the time she spends writing is part of a daily routine for which she must allot time. She described how writing helped her stay connected with herself and was a guaranteed way to bring positivity into her day.

*“I have my rituals that I do, which is really grounding for me. So every morning, I have my gratitude journal; my sons, my health and sobriety, love and connections with others are three that are there everyday and then the rest, usually four or five others, are just what’s good today...I focus on the positive gratitude side of things, too. Having that on the page just makes a difference for me; change your thoughts, change your world”* (Sally, Interview 2).

In addition, leisure also provided the context for Sally to become more conscious in the world, and experience new pleasure in every day life.

*“Being conscious is a double-edged sword. It allows us to plan for the future, and remember the past. But often we are so busy worrying about what might happen, or stressing about what already has, that we forget the miracle of today. Add to this a mental illness where anxiety is a daily struggle and the unfortunate result is often the perfect storm that over the years has robbed me of my happiness through disease and dis-ease. I practice using all of my senses. It can be as simple as listening to the lyrics of a song, pausing to feel the sunshine on my face, really tasting the sweetness of my favourite red cherry ice cream, or inhaling the heavy scent of the lily of the valley in bloom. When I am successful, my anxiety is contained and I am able to be with the people I love without having my attention hijacked out of that moment by my own thoughts of the past and future.”* (Sally, Interview 2).

Leisure provides the context for self-acceptance and the opportunity for self-compassion. For Wanda, leisure creates space for self-inspired exploration and she does this through books, volunteering, and sharing her story with others, all things she couldn’t do before her recovery.

*“Give the gift of forgiveness and start with yourself, I thought my illness was a character flaw, but it is only one piece of me...Do something new, as often as you can, embrace your free time and say yes! And remember what Thomas Edison said “I have not failed, I’ve just found 10,000 ways that won’t work”. I hope to*

*inspire anyone living with or loving someone who has a mental illness, my message is simple: accept help, forgive and believe that recovery is possible, but most importantly, I want people to finally be able to say I am happy being me!”* (Wanda, Interview 2).

### **Threats**

There is no cure for mental illness and therefore, living well cannot be defined as a life devoid of challenge. The co-researchers suggested that living well is experiencing a life that is rich with positive emotion and supportive of resiliency. A life that includes the presence of a mental illness, but is not defined by it; within this context it is the purposeful employment of the previously discussed strategies that work to buffer the negative effects of mental illness that can impact living well. My visual model suggests (1) recurring and chronic symptoms; (2) changes to current life circumstance; (3) relapse and (4) stigma as “threats” to living well with mental illness.

Recurring and chronic symptoms may include: auditory hallucinations, delusions, thought disorder, chronic sadness, mania, thoughts of harming self or others, and emotion dysregulation. The co-researchers did make reference to recurring and chronic symptoms they experience. As a result, it is important to acknowledge that living well with mental illness must include the ability to cope with symptoms as they increase in prevalence. However, according to the co-researchers, by living well, individuals foster a sense of mastery over their symptoms, accepting their company without being consumed by it.

*“Music, doing things I like to do. It’s about not letting the depression rule my life, um it’s kinda tough battling it sometimes but as it comes on and off, knowing that I’ve gotten over it before is a good indicator that I can get through it again. From my experience living with it I just know, this too shall pass.”* (Donald, Interview 2).

Changes in current life circumstance are the unplanned or unwanted changes in one’s life that most often result in a significant disruption of the individual’s current

narrative. Status changes with regards to employment, relationships, parenthood, housing, finances and physical health all have the potential to impact how individuals live well with mental illness. However, the co-researcher suggest the establishment of a daily routine that incorporates strategies for living well is likely to generate daily experiences of positive emotion contributing to a resilient barrier that protects individuals from the negative impact associated with unwanted changes in their lives. As previously discussed, Sally is very purposeful in her daily morning rituals, and when describing recent adversity, she said:

*“I lost my job recently and there was a modeling piece to it. I had to show my kids that no, we didn't plan this, although in hindsight I probably should have. It is a hard situation, but when you’ve lived in very dark places, this just doesn't seem quite so bad”* (Sally, Interview 1).

Relapse by definition is the recurrence of a past medical condition, however, in the context of mental illness such a definition implies the potential for remission or cure. As stated many times throughout this thesis, there is no cure for mental illness. For the purpose of this study, relapse is recognized as a setback in one’s recovery during which time the individual disconnects from daily living. During relapse one is likely to narrate the experience of being unwell, and may require hospitalization. Based on this notion, there is an obvious connection to relapse as a threat to one’s experience of living well.

*“I think just the whole understanding that I’ve been dealing with it for a long enough time that I’ve gotten over it and I know I’ll get over it again has helped the relapse shorten itself because I know what I can do, what works and what doesn't work.”* (Donald, Interview 2).

Stigma is the disgrace associated with the status of having a mental illness (Corrigan & Watson, 2002). As discussed in my literature review, stigma is a social process that is further perpetuated by the manifestation of societal reactions that spoil

one's sense of normal identity. According the co-researchers, self-stigma is menacing in their construction of a positive sense of self. The manifestation of stigma was not a direct focus of this study. Multiple co-researchers identified self-stigma as an obstacle they had to overcome as part of the process of recovery. As a result, the notion of stigma as a threat was supported by the data in enough detail to attribute it as a threat to living well.

*“It’s not hopeless, it’s very much a gift, and it’s not a weakness. It’s just something you have. If you were diabetic and you had to take insulin, you wouldn’t feel bad about that. But you would do things to mitigate the damage that it does to your health. So you’d eat what you were supposed to, you’d monitor your sugar, you’d do all of those thing, um, in addition to the medication and depression is no different than that!”* (Wanda, Interview 2).

The data from this project supports that living well cannot simply be defined as a life devoid of challenge, but rather the experience of a life that incorporates one's mental illness in a way that is supportive of an ongoing commitment to the care of his or her self. For the co-researchers, living well was a progressive effort that began as a linear process and led to a relational set of strategies that assisted in buffering the external threats associated with mental illness. As such, I suggest, living well is a process of self-development that is highly individualized and requires the opportunity to foster a sense of hope for a life that is defined beyond the limitations of a particular set of symptoms. As stated in chapter 1, there is no cure for mental illness, but recovery is possible. This research supports that there is no formula for living well with mental illness but there are strategies that have been central to the recovery of the six co-researchers. The following chapter will further explore the implications of these findings and how they might guide future research.

### **Chapter 5 – Discussion**

The purpose of this research was to examine the ways in which individuals with mental illness create a life of purpose, satisfaction and meaning. This project sought to explore the problem of mental illness as it pertains to an individual's sustainability, to critically examine the role of leisure in recovery and to explore how the co-researchers conceptualize and incorporate free time engagements (leisure) into their lives as a means of creating meaning. The literature review highlighted the connection between leisure and the supportive role it could play in facilitating individuals with mental illness living well. Through the implementation of a heuristic methodology this research has given a voice to six individuals who live well with mental illness, which led to the creation of a conceptual model that visually depicts the lived experience of the co-researchers. This research highlights the contribution leisure makes to the establishment and maintenance of living well with mental illness.

Through an exploration of the experience of having a mental illness, this project supports that leisure provides therapeutic benefits that transcend through negative life events. The findings supported the identification of four larger themes that represent leisure as a mechanism of living well. Once I had digested the initial analysis and written up my fourth chapter, I revisited the visual model and raw data with a broader leisure lens supported by my leisure studies background and the framework of the leisure and well being model (Carruthers & Hood, 2007; Hood & Carruthers, 2007). By applying this broader leisure lens it became evident that, for the co-researchers, leisure supported the following four functions: (1) the power of leisure in activation, (2) the power of leisure in resiliency, (3) the power of leisure in authenticity, (4) the power of leisure in reducing

struggle. The implications of these themes will be further discussed in this chapter.

### **The power of leisure in activation**

Leisure provided the opportunity for the co-researchers to engage in an active lifestyle that supported the regulation of physical and emotional health and assisted in the reduction of sedentary behaviours. In addition, the co-researchers spoke of the value of regular physical activity in supporting the maintenance of mental health, insisting that exercise is central to caring for the physical self that in turn provides opportunities for development and care of the psychological, emotional and social self.

As outlined in chapter 2, leisure provides a setting within which an individual has the freedom to choose activities that are personally significant and help them to ascribe meaning to their lives. However, in order for leisure to enhance one's well being, leisure choices and practices must be physically, socially, cognitively or emotionally engaging (Carruthers & Hood 2007; Hood & Carruthers, 2007; 2013). Within the context of well being, Hood and Carruthers (2007; 2013) suggest that leisure is an effective coping mechanism for stress, a source of positive emotion, supportive of the development of personal strengths and capacities, and provides a context in which to develop friendships and social connections. And through their narratives co-researchers have provided examples of this process.

Donald spoke of the contributions of music in his recovery, suggesting that it facilitated the internal connection he found with himself, as well as an external connection he has developed with others. For Donald, music has become a mechanism through which he is able cope with challenges and facilitates a constant level of engagement in life. Not only does music provide physical activation in daily living, it

describes it as buffering the sometimes-debilitating symptoms of anxiety, which for him, represents an important reason to maintain activation.

Donald described being challenged by large crowds and avoiding them as much as possible. Yet, in contrast, he also described mosh pits at music concerts as a space in which he feels safe enough to be himself and release his emotions. So the draw of music activates him to overcome some of the limitations associated with his illness. In chapter 4, Donald described music as one of the few things he could not live well without, he spoke of how it provides him with comfort and has become his “thing” to turn to when he isn’t as well as he could be. Donald also spoke of how music reminds him of the capacity he has previously demonstrated to overcome episodes of anxiety and depression – also a means through which to maintain some level of activation in the work needed to recover and live well. For Donald, music acts as a positive pursuit when he is well, and a reminder of his strength when he is not. In addition, music has also created a sense of social belonging and identity that Donald described as not previously experiencing in his life. Donald found a sense of belonging through music, which to me, has also served to activate him. He has now discovered the value of sharing his life with others. I couldn’t agree more with his suggestion *“We are social beings, we’re meant to love [and be loved]. That was a big part missing in my life I guess, I have had my girlfriend since first-year and she gets me, it helps me want to stay well”* (Interview 2).

The results of this study provide a framework for how the co-researchers understand their experience for living well and could act as a guide for the skills necessary for individuals to begin on a path to recovery from mental illness. However, through this research, I have come to recognize that recovery is highly individualistic and

therefore afforded by those who are willing to engage in a process of self-discovery. As a result, I find myself questioning whether recovery is possible for everyone? Nearly two years ago I embarked on the challenging journey of a graduate degree, and since then have learned how hard change actually is. For me, change is about being vulnerable enough to discover things about yourself and others that you don't particularly like, and then having the courage to tell the truth about that. Within this context, I believe the following questions should be considered in future research:

- 1.) Are there particular characteristics necessary for change?
- 2.) Are there particular personality traits that best support recovery from mental illness?
- 3.) Is it possible that individuals who are courageous enough to embrace change, are the same individuals who could support living well with a mental illness?

For the co-researchers, leisure gave purpose to daily living and through this they established a commitment to themselves and others that helped them find reason to stay well. As Wanda described:

*"I just try to do things that I enjoy. Just having things to do, like going for a walk with the dog or my husband or, you know, out for breakfast. Anything I can do that is an enjoyment for myself. When you're really ill you don't do anything you enjoy because it consumes you, so that being said, you find the things that bring you happiness and just focus on those things and try to build them into everyday"* (Interview 2).

Activation in daily living is a key component that supports individuals in taking responsibility for their own health. In my own experience, activation has been central to achieving and maintaining good mental health. By committing myself to activities, I have created accountability in my life that for me, suggest purpose outside of my own existence. In the case of my dogs, having to care for them creates a sense of responsibility

in my life that is altruistic; they depend on me and therefore I am needed. However, what I have come realize is that I too depend on them. They get me moving in the morning, keep me physically active, and distract me from life when it's particularly challenging. As a result, it is obvious to me that there is very much a reciprocal relationship between activation and leisure. Leisure gets people activated, but in participating in activities that are personally gratifying we are able to ascribe meaning to our lives. Sharing my life with my dogs is no longer about their dependence; it's about appreciation for the world around me, the acceptance of my own care and commitment and the inspiration to be the best version of me.

The results of this study provide insight into the ways in which well-used leisure can motivate individuals to stay well, and support them in discovering their own strengths and capacities. For individuals with mental illness, having the opportunity to make choices about their free time supports a sense of control and competence in a life that can often be dominated by treatment appointments. If individuals are able to connect with leisure engagements that are personally satisfying and increase levels of positive emotion, it is likely they will experience higher levels of motivation, treatment compliance and willingness to change previously established patterns of behaviour. It is through such engagements that individuals gain insight into the power of leisure in activation, although it may not have been a conscious process that was harnessed by the term activation. The co-researchers were able to express the value of enjoyment in their free time activities and how it impacted their desires to stay well – this for me is central to activation. As a result of this research, there may be relevance in exploring *how individuals come to*

*understand leisure as a conduit of hope* and perhaps this question should be adopted into my program of research at the doctoral level.

### **The power of leisure in resiliency**

The results of this study also suggest that leisure provides meaningful experiences that support increased levels of positive emotion and build up a restorative power that assists in buffering the negative symptoms associated with chronic mental illness. This finding is particularly relevant in that it provides further context, and practical application for the theories surrounding resiliency previously outlined in chapter 2.

Fredrickson's (1998, 2001) broaden-and-build theory suggests that through the ongoing daily experience of positive emotion, individuals build up a protective barrier against adverse life events. And it is through these momentary experiences of positive emotion that individuals are able to expand the possible thoughts and actions that come into their minds. Within this context Fredrickson notes that the retained benefits from positive emotions throughout a given day are not expunged by simultaneous negative events.

The co-researchers would agree, when choices were made to support experiences that are rich in positive emotion, not only did the experience provide a buffering effect against the negative experiences associated with the challenges of treatment, but also assisted them in envisioning a life of living well.

Mark spoke of his need to control the negative thoughts about himself that he experiences as a result of his obsessive-compulsive disorder. However, he also spoke of how physical and intellectual engagement each day enhanced his ability to be compassionate towards himself, accept the thoughts as they come, and dismiss them with

much more ease than he had previously experienced. For Mark, volunteering, playing basketball, working out, watching sports and reading about the philosophy of the good life were all activities that impacted his sense of self, and supported an increased sense of positive emotion. As a full time university student, Mark had limited free time outside of school and work, however when asked how he lived well, he described the experiences that took place in his free time as being central to his recovery and well-lived life.

Ryff and Singer's (2003) work builds on the experience of resilience suggesting positive functioning occurs through the development of personal resilience as a protective barrier against the natural adversity life brings. However, they suggest the pinnacle of the human experience must include negative and traumatic events as a means of providing opportunity for personal growth and achievement. The results from this study strengthen this notion, as the co-researchers exemplify the opportunity for, and achievement of personal growth that is often provided through the acquisition of disability or illness.

Sally described living a life of wellness and then illness, a cycle that took her many years to recognize. Sally's unmanaged depression negatively affected her relationships with two spouses, her ability to parent, and eventually led to self-medication that resulted in an impaired driving arrest in 2007. As Sally shared her story, it became evident to me that she was no stranger to challenge; yet she narrates gratitude for these experiences that she refers to as her "*divine kick to the head*" (Interview 2). According to Sally, "*It's a gift, you don't realize it at first, it takes time, but thanks to my depression, I know who I am now, and I quite like her*" (Sally, Interview 1).

Wanda also described a life riddled with challenge as a result of her bipolar schizoaffective disorder, including 9 suicide attempts between 12 and 35 years of age. As

discussed in chapter 4, upon diagnosis, her psychiatrist told Wanda that she would likely never work again. Nearly 15 years later, she has completed a college education and is a successful entrepreneur. *“I went from being totally disabled; not being able to work, or really care for my family, to going back to school. I went on to college, I went on to working full time and then I went onto self-employment”* (Interview 2). Inspired by her journey of learning to live well, Wanda is now an entrepreneur of a successful company that promotes personal expression – the authentic self. For me, Wanda’s vocational success further demonstrates the notion of personal growth, in the face of an illness that according to medical professionals, should have kept her unwell for the many years ahead.

The power of leisure in resilience is also consistent with the work of Davidson et al. (2006) and Shahr and Davidson (2003) who found, that positive life experiences promote resilience and adaptation and through play and pleasure individuals with mental illness build up their restorative power, self-efficacy and social agency which contribute directly to an overall sense of well-being. The co-researchers also advocated that positive life events produced protective effects on in their lives and assisted them in dealing with the daily challenges associated with mental illness.

The co-researchers in this project were active volunteers at a local mental health organization, as such, there was a consistent theme of social agency narrated by them. According to Sally, becoming an active member of the organization is an essential role in living well. Advocating, for Sally, was about modeling a life of possibilities that people who are unwell often struggle to envision. *“I give back because I can and I think that has*

*been an important piece for me. I want to inspire others to know they are so much more than a mental illness” (Sally, Interview 2).*

For me, leisure has promoted resiliency by allowing the opportunity to harness space within which I can express my emotions, seek respite and gain back the sense of competence I am often challenged to feel in other aspects of my life. For example, attending hot yoga is something I do nearly every day, and has become part of my practice of self-care. Initially, I began attending yoga in an effort to rehabilitate a back injury. I quickly discovered that it was an activity that not only helped improve my back pain, but also forced me to slow down and connect to my body and mind in a new way. More recently, hot yoga has become the activity that helps me let go of daily stresses and creates the space I need to be selfish enough to put myself first. With the heat wrapped tightly around my body, it is no longer possible for me to feel anxious or afraid of my unknown future. For that hour, the studio becomes a security blanket that reminds me of my strengths and abilities. Although it sometimes feels like too much effort to go, I always leave with a smile on my face; feeling reconnected to a more grounded version of myself. In fact, I have never left studio feeling worse than I did when I arrived. For that reason, it has become an invaluable asset in my ability cope with the recent challenges I face as I uncouple from my marriage and grieve the loss of the sense of belonging I once felt.

### **The power of leisure in authenticity**

Leisure provided safe opportunities for the co-researchers to explore, express, establish and maintain a multifaceted identity that was connected to their best-self and created space for the self-acceptance, care and compassion that were identified as central

to living well. The co-researchers expressed the value of cultivating one's sense of self, suggesting that the ability to employ strategies that support the psychological self is an integral component to recovery. However, I must admit, the notion of authenticity through the cultivation of self, was an unanticipated finding in this project.

Kleiber (1999) emphasized leisure as an important factor in identity development. Within this context, he suggests that not only is leisure the space in which people can explore various versions of themselves, but also that people attach themselves to leisure identities that create a sense of belonging within a particular community and allow individuals to feel socially connected. For the co-researchers, much of their free time was rooted in volunteering with a local mental health organization and sharing their stories of recovery. Perhaps these experiences facilitated a sense of a belonging in a community where having a mental illness felt safe. By telling their stories, they found opportunities to connect to their whole self, and in having their experiences validated it is possible that the co-researchers grew more confident in the experience of feeling vulnerable and being authentic. In contrast, I also find myself wondering if perhaps being of service has somehow shaped a new identity for the co-researchers, an identity that I would describe as being very much defined by their mental illness. This notion is likely true for Wanda, who described mental health to be a quite encompassing part of her personal and professional identities.

*"I am so wrapped up in mental illness that it has become part of everything I do, but in a good way. I live it, I talk about it, I write about it, now I have a business about it. But I tell people I'm in the business of happiness, just because you work with mental health doesn't mean it can't be happy"* (Interview 2).

Both scenarios validate the need for individuals to experience a sense of safety in their environment in order to facilitate the development of positive self-regard that can

help individuals begin to connect with their whole self. In addition, through the establishment and maintenance of positive environment, individuals can begin to identify personal aspirations, set related goals and learn to mobilize strengths towards the attainment of such goals; an approach to mental health that remains vastly under-recognized for its value in public settings (Carruthers & Hood, 2007; Davidson et al., 2006; Hood & Carruthers, 2007; 2013).

The co-researchers suggest that leisure engagements can facilitate the creation of safe and inclusive environments that are personally meaningful and provide the opportunity to establish behaviours that support the discovery of one's best self. Through his love for literature, Mark connected to philosophical insights that helped him develop strategies such as journaling, that have promoted new behaviours that he described in chapter 4 as supportive of his ability to live well. Doug iterated similar experiences, for him, painting became a way to connect with emotional expression and discover an artistic side of his personality that he had not previously explored. In addition, painting provided Doug with a sense of connectedness to his deceased mother whom he describes as "*quite an accomplished artist*" (Interview 1). For Donald, music became the conduit between his anxiety and his authentic self. As previously discussed in this chapter, Donald attributes the development of his identity to his found passion for music, suggesting previous to music, he lacked a sense of self which greatly affected his ability to participate in relationships outside of his nuclear family. However, through music, Donald gained a sense of belonging in a particular community that, over time, connected him with others and helped him create new relationships.

For me, authenticity and integrity have been central to my recovery over the past decade. By engaging in activities that support my sense of self, I have been able to narrate a life that is guided by my core values and beliefs and therefore dependable when challenged by the inevitable threats that impact my ability to live well with depression. I align myself with the philosophy that it is through our struggles that we discover our strengths; and through the engagement in leisure experiences that have been personally meaningful and gratifying, I have been able to harness and express my strengths in the face of adversity. For me, the power of leisure in authenticity has further validated how leisure supports living well. Through the establishment of a lifestyle rich in leisure pursuits and positive emotion, the co-researchers have continued to uncover opportunities to elevate their level of resilience, emphasize their own competencies and create spaces that allowed the continuous exploration of their whole-selves. As a result, I believe it would be beneficial for future research to explore whether leisure provides similar experiences for others, as it has for the co-researchers? Or are we, the co-researchers, simply a unique group or does leisure really facilitate opportunities for individuals to connect to their values, goals and aspirations, central to authenticity?

### **The power of leisure in reducing struggle**

Leisure most often existed in a space that highlighted one's best self and gave individuals reasons to get well and stay well. As a result, leisure became central to the process of recovery from and living well with mental illness. In addition, the co-researchers spoke of the many roles leisure played in their lives. It provided distraction from the challenges associated with recurring and chronic symptoms; the opportunity to

connect with and express feelings; the motivation to employ familiar strategies to improve functioning in relapse; and the opportunity for positivity.

Wanda proposed leisure as a distraction from the challenges of everyday life, which includes her chronic symptoms. Though at times her symptoms have kept her from reading, she suggested failed attempts at reading keep her accountable.

*“When I was really, really, ill I couldn't read at all, which was hard. I just couldn't focus. So that's [reading] probably my biggest telltale, if I can sit down and read and actually focus on something and get through a few pages. If I can't then I know there is something going on and I know that I need to do something about that...But I love where reading takes you, and your imagination and also the information about self awareness. It [reading] gives me time not to worry about anything else and kinda just get lost in a book. It takes your mind off of other things. I missed reading, I was a very avid reader and then I couldn't read for a lot of years and that was something I really, really missed. I use to get so, almost depressed, when a book would end because it was like missing a piece of you, I don't know if you read, but I get sucked in and it's like I don't want it to ever be over. And so [when I can't] I miss that piece, I miss just going off into another world and ya!” (Wanda, Interview 2).*

For Wanda, it is evident that reading provides a sense of respite, but also engages her in a way that is personally gratifying and supportive of opportunities to experience positive emotion and stay connected with her self.

As previously discussed, Mark and Sally narrated the ways in which leisure facilitates their connection to and expression of feelings. For them, journaling became a way for them to couple themselves with their internal thoughts and feelings. When asked about the impact of journaling on daily living, both co-researchers suggested it allowed them to express and let go of thoughts, and often provides them with greater insight into their moods and overall mental health. Although I agree that journaling is a positive experience for both of them, I cannot help but question whether this is truly a leisure experience, or rather, a learned exercise with mental health benefits? Although Sally

spoke in chapter 4 of her love for words, and various writing projects she was working on, she also discussed recommending it to others at the local mental health organization where she volunteers. As a result, I find myself wondering if their paralleled interests are once again a product of the organization through which they have ascribed part of their identities?

Donald and I discussed how leisure provides us with motivation to employ known strategies in the face of challenge. For him, music becomes a companion that buffers his perceived isolation and reminds him of his previous successes in overcoming similar experiences. Within this context, Donald suggested music, allows him to accept set backs as part of his journey and over time he has been able to shorten the duration of his depressive episodes by recognizing symptoms as familiar when they arise and maintaining a positive mindset. For me, dogs are a key ingredient in my recipe for staying well. Although I have a cyclical illness, it has been years since I have experienced an episode that has significantly impacted my ability to live well. I attribute much of this to daily routine, but also life choices; I surround myself with opportunities for success and seek out situations that validate my strengths. Though I would hardly suggest I am good at everything, I am a hard worker and continue to learn how to care for myself as much as others. I am also fortunate enough to have a professional life that keeps me connected to current literature, active in thought and engaged with the strategies that work well for me. I am reflexive about my life because I have to be! My sense of agency is not rooted in others, but rather the commitment I have to staying well so I can continue to forge a career that may someday help others to do the same. The way I see it, I have merely been fortunate enough to have the opportunity to connect with myself through

leisure, vocational and academic pursuits in a way that keeps me accountable and prepared for anything.

The co-researchers provided narratives that support how leisure supports positivity in daily living. For me, leisure is central to the experience of positive emotion. Although indeed we can certainly find moments of positivity in our vocational lives, for most, leisure provides an organic context for positive emotion, and is often the motivation behind engagement. Throughout this chapter I have outlined the benefits of leisure in many forms and it's simple, people participate in leisure activities because they enjoy them. The question that remains, is how exactly does leisure facilitate living well with mental illness?

As reviewed in chapter 2, Davidson et al. (2001) examined the impact of leisure engagements on individuals with mental illness and found that ongoing purposive activity in daily living provided participants with a sense of normality within a life that is otherwise dominated by treatment appointments. In addition to respite, this research identified that leisure engagements provide individuals with mental illness the opportunities for connectedness, increased sense of hope and savouring. The co-researchers in this project would agree. For Donald, leisure allows him to develop an identity and through music he has begun to establish relationships he has not previously been able to. For Mark, leisure creates a sense of hope, through his connection to the philosophy of a good life; he envisions a life of great meaning for himself, a life that is defined by helping others. For Sally, leisure provides opportunity for gratitude and appreciation for daily living, through her ability to slow her mind and experience the details in life, she has gained new appreciation for the world around her, which in turn,

supports how she lives well. In chapter 4, Doug also described his practices of mindfulness meditation and yoga; another example of savouring strategies, which he also believes support his efforts in self-care. The findings of this project provide evidence that indeed, leisure is a facet of life through which individuals are best supported in the engagement of a lifestyle that is socially, emotionally and physically healthy and inclusive of community-based networks. However, I cannot help but wonder how individuals find the right space in which to connect with leisure in a supportive manner?

### **Therapeutic Recreation**

This research was designed, in part, to support the practice of Therapeutic Recreation (TR) in mental health settings. Therapeutic recreation is an allied health profession that is particularly useful for supporting individuals in the pursuit of leisure engagements that are personally satisfying and compliment one's strengths and capacities. The findings should therefore be linked back to practical implications for service. As briefly discussed in chapter two, there is a revolving door effect that brings individuals with mental illness in and out of hospital in a cyclical pattern. However, to me, problematizing health care in Canada without proposing change is ineffective and unproductive. Therefore, I put forth the notion that therapeutic recreation practice could work to support the psychological, emotional and social aspects also required in treatment, through the facilitation of services that connect individuals to activities that are personally gratifying and promote internal desires for change.

This work validates the need for practitioners to focus on strengths within the therapeutic setting as means of facilitating positive self-regard in our clients and supporting the development of a therapeutic working relationship that can help clients

begin to connect with their whole-self (Carruthers & Hood, 2007; Davidson et al., 2006; Hood & Carruthers, 2007; 2013). Central to strengths-based practice is the process of helping clients to identify personal aspirations, set related goals and mobilize strengths towards the attainment of such goals. However, I think this project also provides evidence that recovery is an individualized process and therefore, the role of the practitioner would be to encourage autonomy and facilitate opportunities for clients to engage with this process.

The role of the recreation therapist is therefore to assist clients in the establishment of goals that are both measureable and attainable in an effort to structure the process of change in a way that is accessible for clients. Practitioners need to create a dialogue with their clients that provides the opportunity for connectedness and allows clients to feel understood in their current circumstance. By doing this, they can create safe and inclusive environments that include activities that are personally meaningful and provide clients with the opportunity to establish behaviours that could support the discovery of one's best-self. Within this context, it is possible that leisure, well used, could provide similar experiences for clients, as it did for the co-researchers, thus creating opportunities for connection to one's values, goals and aspirations central to living well.

Lastly, the findings of this project are particularly significant in therapeutic recreation practice given that many of our clients are likely to experience elements of struggle in daily living. By developing programs that assist clients with the skills and capacities necessary to engage in leisure, it is possible that clients may discover positive ways to escape from future struggles beyond the provision of TR service. The findings of

this project once again provide evidence that indeed, leisure could be a facet of life through which individuals are best supported in the engagement of a lifestyle that is socially, emotionally and physically healthy and inclusive of community. As a result, I propose that this research assists in affirming the value of Therapeutic Recreation and supports it as an essential service in recovery-oriented care.

### **Conclusions and Implications**

This project sought to gain insight in the lives of individuals who live well with mental illness, with the goal of answering *how do individuals live well with mental illness?* I believe this project is of value to the field of leisure studies, and this work certainly determined the answer to such a complex question is larger than a Master's thesis. What has become evident to me in completing this work, is that living well is truly a process of self development, although thus far, while I have not discovered a particular formula for living well, I have uncovered common strategies that have proven helpful for a particular group of people.

I believe leisure benefits are highly subjective, and therefore entirely dependent on the individual; what is gratifying for me, may bore or frustrate someone else. However, this project certainly supports the contribution leisure could make to the creation of meaningful social networks, community connections and overall sense of enjoyment in life. And therefore, it is certainly possible that leisure could support individuals in the identification and sustainability of a healthy lifestyle that supports living well with mental illness. Within leisure studies there are a number of classic and contemporary works that further intersect with this project and therefore should be briefly discussed.

Kleiber (1999) highlights the developmental capacity of individuals based on their current life stage, and the role of leisure in facilitating continued development across the lifespan. Donald was diagnosed at 21 years of age, at which time he identified a lack of connection to others. Within this context it is possible that he was unable to develop his social capacity prior to adulthood as a result of his social anxiety. According to him, music facilitated a perceived sense of connectedness in an otherwise reclusive life, and over time, helped him create a sense of self that when supported by medication could begin to envision a life that included relationships with others. When asked about the role of medication in his experience he responded “*music was our common interest, it made it easy, the medication just gave me a little extra confidence*” (Interview 1). As a result, Donald validates Kleiber’s (1999) work, and provides evidence that indeed leisure can support development in the presence of underlying capacity.

Brightbill (1960) problematizes leisure and reminds us of the dark or deviant side that exists, a concept that supports what Kleiber (1999) has coined as maladaptive coping. Doug and Sally both exemplified this coping through leisure as evidenced by their history of substance abuse. Both co-researchers described their free time prior to recovery to include alcohol, in an attempt to numb the experience of depression. For Doug, his addiction to alcohol eventually led to his attachment to Alcoholic Anonymous and the sustainable commitment to getting well, however that was not before he sought an early retirement package as a result of years of dysfunctional living. For Sally, self-medicating with alcohol resulted in the loss of her license and a recently expunged criminal record; an event that she found deeply humiliating, but also inspiring of change. Though within western society, alcohol consumption has become a social norm, for

some, it is the free time engagement that supports maladaptive coping and perpetuates years of dysfunctional living.

Veblen (1967) reminds us how conspicuous leisure can be, a concept that illustrates the elitism that can exist within leisure and the exclusion that results from the notion of a leisure class. For many years I took pride in the free leisure I explored with my dogs, until recently, when I was challenged in a graduate class to think about it more critically. All throughout this thesis I have written about the positive experiences I have shared in my life, as a result of their companionship. Yet, I never took the time to acknowledge the privilege associated with pet-ownership, let alone 5 purebred dogs! As a result, I can't help but acknowledge there is likely a common level of affluence among the co-researchers that allows us to afford the things we do in their free time as a means of supporting living well. For me, Veblen's (1967) work further highlights the connection between socioeconomic status and recovery, as discussed in chapter 2, and leads me to suggest that an additional factor to consider in future research is the intersection of leisure and disposable income, as it may have additional influence when it comes to living well with mental illness.

Kleiber (1999) reminds us of the ways in which leisure can help us transcend through negative life events. Meanwhile Griffin (2005) reminds us that leisure, even in it's purest form, can be a space through which individuals reenact negative experiences and relive past trauma. Wanda validates this work as she describes the pleasure from speaking about her recovery, but also the challenges of reliving her past in doing so:

*"[Telling your story] it's a double edged sword, it empowers you cause you've seen where you've come from and where you're going to, it gives you voice to who you are, but on the other hand, I have to relive a lot of that stuff. And there's so many things, a lot of things I do tell and people think they've got an idea, but*

*there are so many things I don't tell, not yet. And who knows whether or not I will, but you have to, you do relive all of those things. I talk about my first suicide [attempt] and I remember being 12 years old and I remember how I felt; that dread inside of me and I remember being a parent and looking at my son at 12 years old and thinking he's just a baby and how could I think such big thoughts at that age. It hurts [to relive it] but it gives you a bit of power to think I've come through that! Mostly it's the feelings you have to go through again, which hurt" (Interview 2).*

Earlier in the chapter, Wanda also described the experience of losing herself in a book, which supports Csikszentmihalyi's (1990) flow theory and illustrates the optimal experience reminding us of the potential role of leisure as a facilitator of this fully immersed mental-state. Finally, the co-researchers of this project illustrated Hood and Carruthers' (2007; 2013) suggestion of the reciprocal relationship between well-used leisure and the attainment of well-being, and further validate the value of the leisure and well-being model as a guide for therapeutic recreation professionals in mental health services.

Although there are many theories outlined in the above-mentioned work, I align myself primarily with the intersection between leisure and a life well lived and highlight the discrepancy between theory and practice that exists within the field of therapeutic recreation. My own professional practice is guided by Hood and Carruthers' (2007; 2013) leisure and well-being model. This model is fueled by positive psychology theory and promotes a strengths based approach to therapeutic recreation practice within which Hood and Carruthers (2007) highlight leisure as a central element to increasing positive emotion and supporting the development of strengths. Through the person-activity fit, leisure professionals can facilitate the potential for an optimal experience between participant and activity and assist individuals in the identification of activities that support their interests and capacities. However, in my opinion, the model provides more

than a framework for practice. It informs us of the benefits of positive psychology and the potential a strengths based perspective brings to the enhancement of health care services. This model also has the potential to inspire a paradigm shift away from the current deficits based biological approach to wellness that is promoted by the medical model.

Positive psychology theory and subsequently the leisure and well-being model guide new-aged thinking that promotes a client centered approach to leisure services and allows practitioners to facilitate the development of skills and capacities necessary for individuals to cope with and recover from adversity. However, within the field of therapeutic recreation, the leisure and well being model remains secondary to previous, deficit-based models (C. Hood, personal communication, 2011). As a result, there is a discrepancy between theory, education and current practice. The leisure and well-being model supports individuals in the acknowledgment of their limitations as a means of measuring personal growth and achievements and approaching well-being with realistic expectations, so too does this project. As a result, it is my belief that research projects such as this one can continue to provide insight into the world of living well with mental illness, and by doing so, further validate the use of a strengths-based approach in mental health research, as endorsed by Hood and Carruthers (2007).

As stated throughout this thesis, leisure, well used, could be a facet of life within which individuals are best supported in the engagement of a lifestyle that is socially, emotionally and physically healthy and inclusive of community-based networks. As such, I propose that my professional practice as well as my research are heavily influenced by the leisure and well being model and the theories embedded within it. As a result, my work seeks to support the examination, conceptualization and development of one's

capacity to engage in a life that is rich with purpose and meaning in an attempt to overcome the constraints of the medical model and inspire a truly client centered approach.

In my experience, leisure often creates a sense of perceived freedom from external pressures, generates positive emotion, and helps people identify personal strengths, interests, and talents (Carruthers & Hood, 2007; Kleiber, 1999). As narrated throughout this project, the co-researchers agree. Leisure was described to support respite and provide escape; for the provision of positivity; and for the ability to promote self-discovery and development. And through their experiences, the co-researchers were able to articulate the strategies that have best supported them in living well with mental illness, all of which were demonstrated to intersect with leisure.

As a Recreation Therapist I acknowledge my natural inclination to assume leisure is good. I believe that leisure has the potential to cultivate pleasure, autonomy, social connections, hope and a sense of identity. However, I also find myself challenged by the conspicuous nature of leisure, as it often exists in a space that is motivated by consumer capitalism; a notion which I myself exemplify in my own free-time engagements. In addition, Wanda (Interview 2) and Griffin (2005) reminded us of our assumption that the facilitation of leisure opportunities within does not always carry over into independent positive functioning.

Finally, I feel it necessary to problematize leisure as it pertains to treatment and suggest that if we assume the perspective that leisure is always good we are simply ignoring the potential harm that leisure can afford. In his first interview Mark discussed his passion for professional sports as something that requires balance:

*“I am big time sports addict, in terms of professional sports, I am a pretty diehard basketball fan and a diehard baseball fan. I’m not sure if it’s always enjoyment, sometimes is a nervous enjoyment or an addiction in a sense where, you know, part of it is like a self-medicating thing. I would say that it’s an escape from whatever other worries I have. But sometimes it’s not, sometimes when I’m watching sports I’m super anxious because I’m very concerned about my team. It is a healthy enjoyment in small doses but sometimes I take it to an extreme where I get a little bit too into it...It can take 2-3 hours of my day, you know, because I’m watching the games, I’m reading the articles, I’m doing my research on the team. I kind of enjoy it, but when it gets to a point where it’s starting to affect my other things or when I’m taking the time to watch the sports rather than hanging out with my friends or work on other things then it becomes detrimental. So it’s enjoyment in small doses but I have to keep a handle on it” (Mark, Interview 1).*

To suggest that leisure is universally good, denies the intimacy of the experience as multifaceted, individualistic and unique. It is quite possible that in leisure individuals may employ negative coping strategies and thus leisure could manifest opportunities to relive or persevere over negative life events (Griffin, 2005), or in the case of Mark, perpetuate the chronic symptoms associated with obsessive-compulsive disorder. Mark’s experience, however, is consistent with the Dualistic Model of Passion (Vallerand et al., 2003; Vallerand, 2008), within which obsessive passion results in an uncontrollable urge to engage in a particular activity.

“Passion is defined as a strong inclination toward an activity that people like, find important and in which they invest time and energy” (Vallerand 2008, p. 1). Accordingly, there are two types of passion- harmonious and obsessive. Harmonious passion involves the engagement in freely chosen activities that support positive experiences and are in harmony with other aspects of the person’s life. In contrast, obsessive passion is the result of the internalization of a particular activity, where the activity is assumed as part of the person’s identity. This assumption of identity in turn, results in a dependency on the passionate activity, often having negative effects on the other aspects of a person’s life.

According to Vallerand (2008), when connected to obsessive passion activities, it is likely that the individuals will struggle to resist the uncontrollable urge to participate and, as a result, begin to experience an internal conflict that can negate positive benefits such as freedom and autonomy, positive emotion and satisfaction that are often associated with freely chosen activities. The work of Vallerand et al. (2003) and Vallerand (2008) supports Mark's discussion of balance, reminding us that passions, unmanaged, can begin to dominate our lives. Although leisure can support living well, it is important to recognize there is always an underlying potential to deter from it.

This research is among the first to approach the problem of mental illness from a strengths-based perspective and evaluate the role of leisure in the lives of individuals who are living well. As a result, each of the findings should be further explored as this project only brushes the surface of the complexity of living well. However, this project demonstrates the wealth of knowledge available that supports new solutions to some of the broader social issues associated with mental illness. By exploring the experiences of individuals living well, this research initiates the foundation of a body of leisure-based literature that is rooted in potential treatment strategies rather than insoluble problems. This work provides evidence for the contribution of leisure in living well with mental illness suggesting that if individuals with mental illness learn to engage in pursuits that inspire development and support positive experiences in daily living, they can begin to foster personal resiliency that buffers the effects of chronic symptoms and begin to envision ways to become more engaged in their communities and in society.

### **Relocating Self**

As a leisure scholar, bracketing my knowledge of leisure, therapeutic recreation and my own experiences remained an ongoing effort. Much of my understanding surrounding my own experience of recovery has been supported by the education I have. Throughout the study I felt a deep connection to the literature and struggled to find my own voice through it. In some respects, university education has framed student research to exclude personal experience and focus on the published work of others. The heuristic process, however, emphasizes the lived experience as the center of the research. As a result, I struggled with the dualistic nature of my position as a participant and a researcher. In this project I was responsible for giving equal voice to my co-researchers and while authoring a thesis that was academically sound. This, for me, remained the most challenging aspect of the project.

Interestingly, as I reviewed my thesis in preparation for defense, it became evident to me that much of the language used by my co-researchers may also have been a product of their learning. Many of the co-researchers spoke of their experiences using clinical language that was likely a product of treatment environments, self-development, or affiliation with local mental health agencies. As a result, I feel there is relevance to expressing the power (and influence) of knowledge, in particular, when it helps us ascribe meaning to our own lives. Although perhaps a limitation of this project may have been my own bias towards living well, I believe my foundational knowledge of leisure and mental health lends strength and relevance to this project. The final section below discusses the implications of my experience as the primary researcher and further explores subsequent tensions that challenged me in this role.

**Limitations, Challenges and Values**

Heuristic research felt especially demanding for me as the primary researcher, as my own perspectives are held as equal in the data set. I found the process of embedding my own voice throughout the project particularly challenging in that it was difficult to decide when to share my perspectives. Journaling throughout the data collection phase helped me to separate my story from the co-researchers, but I had a great deal of difficulty writing up the results. In particular, I seemed to consistently detach myself from the participants and underrepresent my own voice.

This project was rooted in my desire to give voice to others. Unfortunately this other-oriented approach often over-shadowed my desire to share my own story. Although I am proud of the work I have done, if given the opportunity, I am unsure if I would employ a heuristic approach again. This project has left me with a deep sense of vulnerability and an overarching fear of judgment in the academic world. There is nothing safe about sharing your story with others, especially when it involves a subject that is so heavily stigmatized. However, I do know that part of living well is being authentic, so I take solace in the fact that I've completed a project that is truly reflective of my whole self. It is my hope that in allowing myself to be vulnerable, my work will give new meaning to others and create space for others to begin the conversation about their experience with mental illness.

This thesis is based on the primary assumption that leisure is both possible and desired by the participants. However, my graduate courses have broadened my awareness that the lens through which the co-researchers view the world is very westernized and privileged, which is a potential barrier to this work. Although this project is rooted in the

commonality I share with my participants, I feel it's important to acknowledge that the leisure through which I have transformed my life is very much conspicuous.

Before engaging in graduate level studies, I took pride in my accessibility to others, including the clients I have worked with. Yet, as I reflect critically on my ability to recover from mental illness, I recognize that much of my potential stems from my socioeconomic status. As a result, I believe it is necessary to acknowledge that recovery from mental illness may not be universally accessible. In fact, chapter 2 noted current literature that suggested individuals of higher financial means are more likely to recover from and live outside of mental illness.

Aside from the influence of socioeconomic factors, there are additional assumptions with regards to leisure that have resulted from my westernized view and are embedded within this work. First, I assume individuals derive pleasure and gratifications from their leisure and ascribe meaning to such experiences. As a recreation therapist I ascribe meaning and value to my own leisure experience, which may have become a preconception within this research that is not fully representative of my sample. As a result, perhaps it would have been useful to explore the leisure attitudes of my participants in comparison to my own as a means of identifying any discrepancies that exist.

Second, I assume leisure is not entertainment but rather purposeful engagement in free time activities with the intent of a preferred experience. As a leisure scholar, I have a unique view of leisure that is heavily influenced by the world in which I study. However, within the context of this research, it was unrealistic to place labels or parameters on the engagements that participants deem as leisure. In fact, omitting the use of the leisure label

within the work and replacing it with “free time engagements” helped to generate more discussion in the interviews.

Lastly, I assume that leisure provides an opportunity for transcending negative life events through the facilitation of positive emotion and increased resiliency. As well, I assume leisure provides context for freedom of self-expression and self-directed development and facilitates the second two stages of recovery (Kleiber, 1999). However, within this assumption, I have embedded much of my idealistic therapeutic recreation education without acknowledging the simple fact that many individuals who experience a mental illness will not have the immediate capacity to engage in leisure. As a result, perhaps a future project should be to explore how leisure skills are developed within therapeutic recreation practice in order to better understand their evolution.

No research is free from limitation and qualitative research is about uncovering the lived experience as a means of gaining insight into the lives of others. There were an equal number of male and female participants, diversity in age and variability in ethnic and socioeconomic backgrounds. Nevertheless, each of the co-researchers had voluntary attachment to a local mental health organization. As a result, this project represents a particular cohort of people that were targeted to participate as a means of creating a benchmark for how individuals live well with mental illness. When designing a research project, it is often the notion of participant recruitment that poses particular challenge. However, when designing a project that requires individuals to talk about their experience with mental illness, there is additional concern for how one might actually find participants. This project was fortunate enough to receive the support of a local mental health organization and capitalized on the opportunity to work with the

individuals who are members of a local group who speak publically about their experiences with mental illness.

The intention of this project was not to create generalizability, but rather to explore the experiences of others who live well with mental illness to gain insight into any common experiences which might further support implications for future research and/or therapeutic recreation practice. In the case of this research, both were accomplished. Not only has this project provided significant insight into the core strategies that individuals employ in living well, it also has given new thought to how one might support the development of such strategies when supporting individuals receiving therapeutic recreation services in the health care arena. The results of this project will be further explored at the doctoral level, as I continue on in my academic career. It is my belief that this project holds immeasurable value in its demonstration of truth that individuals really can live well with mental illness!

As a result of this project, I find myself thinking critically about the role of leisure in my own life and how my education has influenced the meaning and value I place on such experiences. I continue to align myself with the belief that leisure can be invaluable if well used, but I acknowledge the preconditions that must exist for that to happen. Although I have become mindful of the assumptions I make about leisure, I still believe my efforts towards understanding how people live well with mental illness remain socially and globally relevant. Therefore, not only does my research contribute to the growing body of literature that relates to recovery and leisure, it also has the potential to contribute significantly to the therapeutic recreation profession, recreation service in general, and the quality of life for individuals living with mental illness.

## Appendix A



## Letter of Invitation

March 12, 2012

Project Title: Flourishing in the face of mental illness: A heuristic examination of the contribution of leisure to creating a meaningful life

Faculty Supervisor:  
Dr. Colleen Hood  
Department of Recreation and Leisure Studies  
Brock University  
[chood@brocku.ca](mailto:chood@brocku.ca) (905) 688-5550 Ext. 5120

Student Principal Investigator (SPI):  
Lauren Torok  
Department of Recreation and Leisure Studies  
Brock University  
[Lauren.Torok@brocku.ca](mailto:Lauren.Torok@brocku.ca) 905 401 3636

Dear Participant,

My name is Lauren Torok and I am a graduate student in the department of Recreation and Leisure Studies. I am writing to you to invite you to participate in a research project that I am conducting for my Master's degree at Brock University. The title of the project is: Flourishing in the face of mental illness: A heuristic examination of the contribution of leisure to creating a meaningful life. This project is being supervised by Dr. Colleen Hood, a professor at Brock University.

The purpose of this research is to examine how individuals live well with mental illness. Living well with mental illness is defined in this study as feeling socially connected to others, satisfied with one's life and demonstrating success in educational and/or employment pursuits. If you have received a formal diagnosis from either a family doctor or psychiatrist and feel that you are living well as defined here, then you have important information to share about your experiences that may be used to help others. As a participant, you will be asked to participate in 2 semi-structured interviews where we will discuss your experience with mental illness. You will receive the questions prior to the interview and there are no right or wrong answers. The length of the interviews will be approximately one hour each. Following the completion of the interviews you will receive a summary of your responses to check for accuracy and possibly some other questions for clarification.

Participants will receive a \$10 Tim Horton's gift card as an honorarium for agreeing to participate in this study. As well, this study provides you with a unique opportunity to share your story of recovery in an effort to help us further enhance mental health treatment services. The role of leisure in living well with mental illness has not been examined in academic research, as a result, possible benefits of participation include the de-stigmatization of mental illness and the promotion of improved mental health support services. This research is not intended to be harmful to any of the participants in anyway, however there may be psychological risk associated with discussing your personal experience with mental illness, in an effort to minimize risks the interview questions will be provided to each participant prior to the interview.

Any assistance you can provide me in this process would be greatly appreciated. Should you choose to participate in this research project, please contact me at 905-401-3636 or email [Lauren.Torok@brocku.ca](mailto:Lauren.Torok@brocku.ca) and we will set up a time to meet to discuss the project and the Informed Consent Document that further outlines the purpose of this research and your rights as a participant. Should you require any further information, please do not hesitate to contact me.

I thank you for any assistance you're able to provide me,

Lauren Torok  
Brock University

If you have any questions about this study or require further information, please contact Lauren Torok, principle student investigator ([Lauren.Torok@brocku.ca](mailto:Lauren.Torok@brocku.ca)) or Colleen Hood, faculty advisor ([chood@brocku.ca](mailto:chood@brocku.ca)) using the contact information provided above. This study has been reviewed and received ethics clearance through the Research Ethics Board at Brock University **13-164-Hood**. If you have any comments or concerns about your rights as a research participant, please contact the Research Ethics Office at (905) 688-5550 Ext. 3035, [reb@brocku.ca](mailto:reb@brocku.ca).

**Appendix B****Informed Consent**

March 12, 2012

Project Title: Flourishing in the face of mental illness: A heuristic examination of the contribution of leisure to creating a meaningful life

Faculty Supervisor:  
Dr. Colleen Hood  
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Brock University  
(905) 688-5550 Ext. 5120 chood@brocku.ca

Student Principal Investigator (SPI):  
Lauren Torok  
Department of Recreation and Leisure Studies  
Brock University  
(905) 401 3636 Lauren.Torok@brocku.ca

Dear Participant,

You are invited to participate in a study that involves research. The purpose of this research is to examine how individuals live well with mental illness and seeks to explore what the impact of having a mental illness on daily living and the experience of recovery from and living well with mental illness?

**WHAT'S INVOLVED**

As a participant, you will be asked to participate in two semi-structured interviews regarding your experience with mental illness. Each of the interviews will take approximately one hour of your time, and you will be sent the interview questions ahead of time so you are aware of the general structure of the interview. Each interview will be recorded using a digital audio recording device. You will be asked to bring an artifact to your second interview and a digital photograph of your artifact will be captured. Following the completion of your second interview we may contact you again within 2 weeks to ask you additional questions or seek clarification regarding your responses. You may decide at that time whether or not you wish to participate in that part of the study.

**POTENTIAL BENEFITS AND RISKS**

Participation in this research project provides each participant with a \$10 Tim Horton's gift card as an honourarium for agreeing to participate in this study. The role of leisure in living well with mental illness has not been examined in academic research, as a result, possible benefits of participation include the de-stigmatization of mental illness and the promotion of improved mental health support services. This research is not intended to be harmful to any of the participants in anyway, however there may be psychological risk associated with discussing your personal experience with mental illness, in an effort to minimize risks the interview questions will be provided to each participant prior to the interview.

**CONFIDENTIALITY**

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The information you provide will be kept confidential. Your name will not appear in any thesis or report resulting from this study; however, with your permission, anonymous quotations and a digital photo of your personal artifact may be used, if appropriate.

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Please note: Based on the nature of face-to-face interviews this study cannot be considered anonymous because the researcher is able to identify the participant. Confidentiality, however, can be maintained.

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Data collected during this study will be stored in the locked office of the Primary Student Investigator. Data will be kept for up to two months following your completion of the interview after which time all written information will be shredded using a cross-sectional shredder and all digitally recorded information (ie. Email correspondence and audio recordings) will be deleted.

Access to this data will be restricted to Lauren Torok, principle student investigator and Colleen Hood, faculty advisor.

### **VOLUNTARY PARTICIPATION**

Participation in this study is voluntary. If you wish, you may decline to answer any questions or participate in any component of the study. Further, you may decide to withdraw from this study at any time and may do so without any penalty or loss of benefits to which you are entitled.

### **PUBLICATION OF RESULTS**

Results of this study may be published in professional journals and presented at conferences. Feedback about this study will be available through Lauren Torok, principle student investigator following the completion of this thesis project in or before December, 2014.

### **CONTACT INFORMATION AND ETHICS CLEARANCE**

If you have any questions about this study or require further information, please contact Lauren Torok, principle student investigator (Lauren.Torok@brocku.ca) or Colleen Hood, faculty advisor (chood@brocku.ca) using the contact information provided above. This study has been reviewed and received ethics clearance through the Research Ethics Board at Brock University **13-164-Hood**. If you have any comments or concerns about your rights as a research participant, please contact the Research Ethics Office at (905) 688-5550 Ext. 3035, [reb@brocku.ca](mailto:reb@brocku.ca).

**Thank you for your assistance in this project. Please keep a copy of this form for your records.**

### **CONSENT FORM**

I agree to participate in this study described above. I have made this decision based on the information I have read in the Information-Consent Letter. I have had the opportunity to receive any additional details I wanted about the study and understand that I may ask questions in the future. I understand that I may withdraw this consent at any time.

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Should you feel you require support as a result of participating in this study  
COAST is available for individuals in crisis 24 hours a day at **1-800-263-4944**.  
Alternately, please contact CMHA Niagara at 905-641-5222 to set up an  
appointment with a personal counselor.**

## Appendix C



## Interview Guide

February 7, 2014

Project Title: Flourishing in the face of mental illness: A heuristic examination of the contribution of leisure to creating a meaningful life

**Interview #1 – Living Well with Mental Illness**

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Student Principal Investigator (SPI):  
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Brock University  
(905) 401 3636 Lauren.Torok@brocku.ca

1. Tell me a bit about yourself:
  - a. What is your educational and/or vocational background
  - b. Tell me about your family and your social connections (friendships)
  - c. What is your current relationship status
  - d. How would you describe your health
  - e. What do you do for enjoyment
2. How would you describe who you are as a person?
3. What was it like to be diagnosed with a mental illness?
4. What has it been like to live with a mental illness? Are there certain aspects that stand out to you? What is the impact of having a mental illness on daily living?
5. What has changed in your life since being diagnosed with a mental illness?
  - a. Are there any changes in your vocational life?
  - b. Are there any changes in your relationships with family/friends/significant other?
  - c. Has your health changed?
  - d. Has your mental illness impacted what you do in your free time? Or how much free time you have?
6. How the experience of living with a mental illness changed you? Or has it?
7. When you think of living well with mental illness, what comes to mind?

## Closing Instructions for Interview #2:

Thank you for participating in this interview today, for our next interview I would like to talk with you about further about living well. For our next interview I would like you to bring an item, or picture of the item that is personally meaningful to you. This item will likely represent a turning point for you in your journey of towards recovery.

## Appendix D



## Interview Guide

December 4, 2013

Project Title: Flourishing in the face of mental illness: A heuristic examination of the contribution of leisure to creating a meaningful life

## Interview #2 – Living well and Leisure

Faculty Supervisor:  
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Brock University  
(905) 401 3636 Lauren.Torok@brocku.ca

1. How do you live well with mental illness?
2. Thinking about your own experience with mental illness, what was a turning point for you?
  - a. What was life like before?
  - b. What is life like after?
  - c. What changed?
  - d. You brought in a [artifact] today, tell me about it. Why did you choose this item, what does it represent for you?
3. Are there any aspects of your life that are particularly important to your experience of living well?
4. How have you coped with relapse as part of your recovery?
5. What strategies do you use to support yourself living well?
6. Thinking about the things you do for enjoyment in your free time, how do these experiences affect the way you live with mental illness?
7. What kinds of things do you do in your free time?
  - a. What is important to you about [activity/experience]?
  - b. How does [activity/experience] impact your sense of self?
  - c. How does [activity/experience] affect coping?
  - d. How does [activity/experience] affect living well?
  - e. Was this an engagement that you did prior to diagnosis or that you have added since?  
*[IF NEW ACTIVITY]*
  - f. How did you come to add it?  
*[IF PREVIOUS ACTIVITY]*
  - g. How did you maintain participation (continuity) from diagnosis to recovery? How has the meaning or experience changed for you, or has it?

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