

**The meaning of creative activities in the
lives of people in remission of mental**

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Abstract

Traditionally, creative activities have been used in occupational therapy practice as an intervention with people who have a mental illness. Recent research has explored engagement in creative activities with people living with disabilities, mental illness, retired people and people with cognitive impairment. The findings centred on positive emotions, increase in self-confidence and respite from worrying thoughts. Anecdotal evidence from local occupational therapy practitioners and arts organisations suggested that people in remission of mental illness seemed to use creative activities in their daily lives as a way to keep well, but deeper understanding was missing about this.

The first aim of this study was to gain a deeper understanding of the phenomenon of voluntary participation in creative activities by people in remission of mental illness. The second aim was to explore and provide evidence of any relationship between well-being and creative activities as it was perceived by the participants.

The research utilised a hermeneutic phenomenological approach. Qualitative data were collected through interviews with participants, transcribed verbatim and analysed within the hermeneutic tradition. Ten participants volunteered and were recruited by mental health NHS staff in central England. All participants had a diagnosis of a mental illness but were in remission from between six months and seven years at the time of the interviews. The data were analysed via my own interpretation of Cohen, Kahn and Steeves' (2000) approach to hermeneutic phenomenological data analysis.

The findings revealed that for all participants, engagement in their chosen creative activity evoked enjoyment and was of particular personal significance and meaning. Their subjective experiences highlighted the possible therapeutic potential of creative occupation, in particular, temporary mental relief from self-referential thoughts through deep immersion into the creative process. Deep engagement in creative occupation encompassed different types of optimal experience and might have a soothing effect on the Default Mode Network. The deliberate engagement in creative activities supports Wilcock's theory of the use of occupation for self-restoration and keeping healthy. Additionally, the real contact with people and places facilitated a more active lifestyle which impacted also positively on the participants' sense of well-being. The findings of the study are discussed from an occupational science perspective to extend our

understanding of the solitary and group nature and effects of participation in creative activities.

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Candidate's declaration

Declaration

I declare that the research contained in this thesis, unless otherwise formally indicated within the text, is the original work of the author. The thesis has not been previously submitted to this or any other university for a degree, and does not incorporate any material already submitted for a degree.

Signed

Dated

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CHAPTER 1 Introduction

This chapter starts with the justification for my choice of topic for this doctoral thesis. I will explain to the reader why I regard participation in creative activities as an important research matter for occupational therapy. The historical and philosophical background of the use of creative activities will then be described. I will clarify my understanding of the reasons for the diminished use of creative activities as occupational therapy interventions and how the emergence of occupational science could have generated a renewed interest for them. A summary of existing research literature will lead to a description of my reasons for exploring the topic from the patient's perspective and for choosing people in remission of mental illness as participants. To conclude, I will give a short description of the structure of the whole thesis.

1.1 Rationale for the research

My research problem arose from both my clinical work and professional experience as an occupational therapist in the field of psychiatry. I have used creative activities as an intervention in individual and group work with patients within different settings, including hospitals and community-based venues. A local participatory arts project which involved patients, artists and occupational therapists including myself gained national recognition in 2009, earning an Arts and Health Award from the Royal Society for Public Health. The success of this art project and similar initiatives inspired me to explore patient views on creative activities, to find out what it meant for them to become, and remain, involved in creative pursuits and to potentially understand these matters better from the therapeutic perspective.

It is estimated that one in six adults in the United Kingdom experience mental illness (Royal College of Psychiatrists, 2009), which accounts for 22.8% of the total disease burden over a lifetime (World Health Organisation, 2008) compared with cardiovascular disease at 16.2%. The economic cost of the treatment of mental ill health is anticipated to double in real terms over the next fifteen years (McCrone, Dhanasiri, Patel, Knapp and Lawton-Smith, 2008) as a result of the ongoing social and financial challenges faced by individuals, society and governments. There is no single cause for most mental health problems and usually they are thought to be a result of complex

interactions between biological, psychological, social, economic, genetic (Friedli, 2009) and occupational factors (Wilcock and Hocking, 2015; Wilcock, 2014). Occupational scientists view humans as occupational and creative beings, and if they are unable to fulfil their occupational and creative needs they are susceptible to experience ill health (Wilcock and Hocking, 2015; Blanche, 2007). Mental health treatment needs to take into account the whole person, their context (Slade, 2009; Rethink, 2005) as well as health promoting initiatives that encourage individuals to develop a meaning and purpose in their life through activity (Department of Health, 2010).

The service provision of the organisation which I work, a National Health Service Trust, is influenced by several policies and guidelines (Department of Health, 2010; 2009b, 2009a; 2008b; 2008a; 2006; 2004) as well as regional and local strategies (National Health Service 2009; 2008; National Health Service and County Council, 2007). They emphasise mental health promotion in all aspects of life and encourage the individual to take responsibility, engage in an active life style and participate in meaningful activity in order to stay well (Department of Health, 2014; 2013).

In recent years, mental health services have undergone major changes in both the public (Department of Health, 2014; 2013) and voluntary sector (Mental Health Foundation, 2009; Rethink, 2005; MIND, 2012; 2004). The main impact is noticeable in how services are provided, by whom and in which location. The patient is encouraged to become a more active part of the whole intervention process, thereby challenging traditional service provision on a wide scale (World Health Organisation, 2015; World Health Organisation Euro, 2005). Current government policy emphasises the promotion of mental wellbeing for both the individual and the wider community (Department of Health, 2014; 2013). This requires not only the commitment of those working within the health and social care system, but also wider societal support and engagement. One of the main challenges faced by users of mental health services is re-integration into their local communities (Minato and Zemke, 2004). Rather than keeping patients within the mental health care system, community mental health teams are required to explore conventional public opportunities and facilitate service users' participation in them. At the moment, local providers struggle to attract appropriate funding for creative projects that involve people with mental health needs. The participants of our study, who I will describe in Chapter Four, battled the side effects of medication – including

tiredness and disrupted sleeping patterns – but this did not stop them exploring creative endeavours at local places when encouraged by others, such as family, friends and staff. Several participants received financial support from their families or help from mental health staff with their applications for grants from local charities.

I refer to ‘our’ study throughout the thesis because I want to acknowledge as well as honour the involvement of other people across the study’s various stages. The participants were people in remission of mental illness who volunteered to take part in individual interviews and who shared their experience of creative activities with me as the researcher. At the end of each interview, each participant was also invited to comment on my summary of the initial meanings that emerged during the interview. Members of the Service User Forum helped to formulate the research and later interview questions and contributed to the recruitment of participants. My supervisors and fellow doctoral students provided constructive criticism throughout the study. Their feedback enabled me to really look at the data, to sharpen my awareness of my own knowledge about creative occupation and consider how this might influence the data collection, analysis and findings. Several colleagues from occupational therapy and staff from multidisciplinary community mental health teams across two counties were actively involved in the recruitment of volunteers and data analysis. Together with members of the Service User Forum they assisted with the revision and conceptualisation of themes. The involvement of interested people during question formulation, data collection, analysis and findings added to the rigour of our study and will be discussed in Chapter 3.

1.2 Contemporary occupational therapy practice in mental health within our Trust

Our occupational therapy department has adopted these national initiatives to create several occupation-focused interventions. On one hand, daily professional practice is exposed to ongoing operational changes – such as the re-organisation of in-patient wards and Trust-owned community settings, and the introduction of new information technology for electronic patient data collection or national audit exercises – as well as staff shortages. Only a limited amount of time is available to thoroughly plan and evaluate individual interventions, or systematically record patients’ views on this. On the other hand, these challenges have evoked a creative element in my own clinical

reasoning generating a strong desire to search for alternative, innovative ways when working with patients and their families.

The Trust's artwork coordinator supported my idea to set up participatory creative projects in the art studio of a local community centre. Participants were service users with an interest in arts and crafts, as well as occupational therapists and students. Local artists and the artwork coordinator facilitated the projects and the art-work produced was exhibited not only in buildings owned by our organisation but also in local galleries and museums. I started to understand how difficult it was for some participants to suddenly become the focus of attention when the local media was invited to take photographs of their artwork and wanted their name for the newspaper. The transition from being an anonymous patient to becoming a public person created discomfort amongst patients and a moral dilemma for me and my colleagues. We wanted to celebrate the achievements of our patients and support them in their creative pursuits and return to an active lifestyle. However, we also wanted to respect their right to privacy and anonymity. The participatory creative projects allowed us to emphasise our collective effort as a group of like-minded, local people with a shared interest in arts and craft, and to avoid the use of terms such as 'service users', 'patients' and 'staff'. As a group we decided that the artist of each project would be nominated as a spokesperson to represent us in public with our art work and respond to inquiries from the media, galleries, museums and the general public.

In our organisation, occupational therapists who are members of multi-disciplinary teams aim to enable the participation of patients in meaningful activities both within in-patient wards and after their discharge from hospital in community settings. Currently, they have only gathered anecdotal evidence of how beneficial and enjoyable meaningful activities – amongst them different arts and crafts projects – have been for patients. The Anglia Ruskin/UCLan Research Team (2007) observed the involvement in creative projects which took place in community settings, helped patients to re-familiarise themselves with the community and the people in it. My colleagues and I observed service users' enjoyment during sessions of our participatory creative projects and we were later told by them, that '...time just flies when I work on this painting' or that 'I tend to forget my worries because I have to concentrate on the picture in front of me.' Several of our service users had been successful, over time, in achieving their desired

intervention goal in combination with other supportive interventions: the transition from their perceived role of 'being a patient' to 'becoming a person again', thereby reclaiming their status as a citizen and member of the public. Another encouraging outcome for us as a team was the discharge of patients from the mental health service.

1.3 Participation in creative activities, a contributing factor to wellbeing

Senior managers in our organisation acknowledged the positive feedback of service users as valuable but, as yet, there is insufficient evidence to attract funding for further creative projects with local partner organisations. There is still a lack of local, socially inclusive community settings that offer inspiring and financially affordable arts and craft programmes for this client group. Additionally, participation in creative programmes, with its perceived benefits, is still not accepted as a legitimate and prescribed treatment option, whereas psychological interventions, medication, physical activity and advice on a healthy diet are (National Institute for Clinical Excellence, 2006; 2002). This means that former psychiatric patients have limited opportunities to express their potential creative talent and to lead an active and balanced life with meaningful and personally chosen activities (Cooke, 2014). As a consequence, former patients can become exposed to social exclusion, and in severe cases, to occupational injustice which may result again in a deterioration of their mental health (Wilcock and Hocking, 2015).

I noted in my research diary that members of the Service Users Forum have expressed several factors that constrained the desire to fulfil creative needs in their everyday lives. These are: difficulties in accessing local mainstream art or music classes because of limited financial resources; fear that the side effects of the prescribed medication impact on their dexterity, fine motor skills and concentration, causing them to be left behind in a class of aspiring students; or that they might express themselves in socially unacceptable ways, for example if they respond to voices they are hearing or if they talk to themselves. The fear of not being accepted by other people could impact negatively on their self-confidence and might lead to feelings of loneliness and further withdrawal from others. Additionally, some expressed the wish to be with other 'normal people' but at the same time felt socially awkward and even inadequate in their behaviour, leading them to return to the local day centre to meet fellow service users again.

1.4 Definition of terms in occupational therapy practice

The following definition of terms reflect my current understanding as an occupational therapist working in the field of mental health:

Occupational Therapy

The World Federation of Occupational Therapists (WFOT, 2012) defines occupational therapy as *a client-centred health profession concerned with promoting health and well-being through occupation. The primary goal of occupational therapy is to enable people to participate in the activities of everyday life. Occupational therapists achieve this outcome by working with people and communities to enhance their ability to engage in the occupations they want to, need or are expected to do, or by modifying the occupation or the environment to better support their occupational engagement.*

Occupations

In occupational therapy, occupations refer to *the everyday activities that people do as individuals, in families and with communities to occupy time and bring meaning and purpose to life. Occupations include things that people need to, want to and are expected to do* (WFOT, 2012).

Creative activities

Creative activities include painting, drawing, working with clay or wood, playing a musical instrument, making embroidery, knitting and making a collage (Griffiths, 2008). These are used in our intervention programmes and are provided by local occupational therapy staff in collaboration with artists, people in remission from mental illness, members of the public including families, and students from a variety of disciplines (occupational therapy, nursing, social work, psychology, physiotherapy and theology). Our use of creative activities aims to enable people to express their creative ability through the use of different materials and tools.

1.5 Historical and philosophical background of the use of creative activities in occupational therapy

According to Schwartz (2003), the founders of the moral treatment movement in the 18th century, recognised the health-promoting effects of engagement in a range of everyday occupations. In England, William Tuke established *The Retreat* in York as a refuge for mental health patients, known in those days as lunatics. The patients were involved in the daily running of *The Retreat* and provided with occupation that mostly comprised of manual labour for working class people, whereas the middle classes were engaged in crafts such as embroidery and carpentry.

At the end of the 19th century, several social movements came into existence that were characterised by progressive social activism – the settlement movement, the mental hygiene movement, the philosophy of pragmatism, and the arts and crafts movement – to combat the effects of poverty, industrialisation and immigration. Amongst the activists, there was a strong belief that engagement in art, music, drama, writing and crafts was a powerful tool to address individual and societal problems. During this time, the foundation of occupational therapy as a profession took place.

Advocates of the mental hygiene movement, amongst them Adolf Meyer viewed mental illness as a problem of adaptation (Meyer, 1922). This problem, according to Meyer, could be addressed through occupation and a healthful rhythm of work, play, rest and sleep. Occupation was regarded not only as a tool to organise the time of patients in an institutional setting, but also as a medium to develop life skills. However, Meyer's ideas, although valuable, were opinion-based rather than generated by research findings. The arts and crafts movement embraced humanistic values and focused on the positive effects of creative manual work, which was believed to support patients in the reconstruction of the self after recuperating from ill health (Levine, 1987).

Representatives of this movement expressed interesting views and ideas that again lacked research evidence. The treatment of patients with different social class backgrounds remained divided. Fine arts such as painting and drawing were used as a leisure occupation for patients from the upper and middle classes, while patients from poorer social backgrounds were encouraged to engage in creative activities as a work occupation (Kielhofner and Burke, 1977).

The development of occupational therapy as a profession continued in the field of physical rehabilitation when injured soldiers from World War II were treated through engagement in crafts (Schwartz, 2003). The use of arts and crafts as a mode of treatment continued through the 1960s, 70s and 80s, but its beneficial use for patients remained under-researched (Reilly, 1962). Since then, the focus in occupational therapy practice has shifted to evidence-based interventions, such as certain psychological interventions or engagement in physical activity, that are not unique to occupational therapy (Wilcock and Hocking, 2015; Larson, Wood and Clark, 2003).

The use of creative activities in occupational therapy practice continued to decrease during the last three decades, as the results of a survey in the late 1990s revealed (Craik, Chacksfield and Richards, 1998). The authors noted that the profile of occupational therapists during this time had changed, because their qualifications changed from diploma to degree level. The use of creative activities as a therapeutic intervention remained under-researched despite there being a growing workforce who have gained research skills during their undergraduate training at university. At the same time, this generation of occupational therapists views themselves as inadequately trained to involve patients in creative occupation and take a leading role amongst clinical staff (Griffiths and Corr, 2007). A survey by Griffiths and Corr (2007) found that creative activities were only used as part of the overall 'treatment package' in mental health settings by occupational therapists, but were more often used in clients' homes. Cost implications and the occupational therapists' disinterest or lack of training in creative activities, were identified as the reasons of not using them regularly in clinical practice (Griffiths and Corr, 2007). The lack of an evidence-base for creative activities as a therapeutic intervention had financial implications, as funding was re-allocated to the use of psychological interventions and physical activity which appeared to have a stronger evidence base (National Institute of Clinical Excellence, 2006; 2002).

The need to explore the evidence base for creative activities as an alternative treatment option has become more evident since the development of occupational science as an academic discipline (Wilcock and Hocking, 2015). Occupation has long been regarded as key to recovery from illness and our profession, which was founded by medical doctors was based on occupation (Yerxa, 1993). However, the profession lost this emphasis until the 1980s, when the rise of occupational science created a renewed

interest in the use of creative activities within occupational therapy interventions (Schwartz, 2003).

1.6 Occupational science

Occupational science, according to Elizabeth Yerxa (1993), '*is a new interdisciplinary synthesis of basic knowledge concerning the human as an occupational being*' (p. 3). It is regarded as the rigorous study of humans as occupational beings, and emphasises their strength and potential to pursue occupational and creative needs to maintain a healthy and balanced life style, even when individuals face the challenge of living with physical and mental health problems (Yerxa, 1993). Occupational science also attempts to gain a deeper understanding of the experience of human beings with occupation, their subjective world, and its link to their subjective wellbeing. Ann Wilcock (2014), who has carried out historical studies, extended our understanding of occupation as '*a synthesis of doing, being, belonging and becoming*' (p. 4). There is general consensus in the occupational science literature (Wilcock and Hocking, 2015; Pierce, 2001) that participation in purposeful and meaningful activity or occupation may enhance a person's health and subjective experience of wellbeing, but more empirical evidence is needed.

1.7 Existing research on creative activities

Two literature reviews have focused on creative activities and their impact on people's wellbeing. Leckey (2011) carried out a literature review to investigate the effectiveness of creative activities. The findings indicated that the person's own internal resources were strongly linked to their motivation, desire and determination to get better, as well as the ability to develop trust towards other people who offered genuine support and help. Another literature review by Stuckey and Nobel (2010) revealed that engagement in certain creative activities – music, arts and ceramic – shared the potential to alleviate levels of stress, depression and anxiety. However, the authors of both reviews concluded that the complexities of concepts such as health and wellness made it difficult to identify elements that maintain or enhance a person's perceived health status.

Research papers that emphasised occupation-based interventions described participants with mental health problems who were encouraged to rediscover their creative potential

as members of a community-based group (Griffiths, 2008; Rebeiro and Cook, 1999), a community arts programme (Lloyd, Wong and Petchkovsky, 2007) or as participants of a workshop at a day centre (Mee, Sumsion and Craik, 2004; Mee and Sumsion, 2001). These earlier studies employed qualitative research designs, for example grounded theory (Griffiths, 2008; Rebeiro and Cook, 1999) or ethnography (Mee, Sumsion and Craik, 2004; Mee and Sumsion, 2001). The findings showed that engagement in meaningful activity contributed to the participants' wellbeing (Rebeiro and Cook, 1999), and that the drive to create supported self-identity (Mee, Sumsion and Craik, 2004) and the internal recovery of the individual (Lloyd, Wong and Petchkovsky, 2007). Additional psychosocial benefits included those associated with interacting with other people within a safe environment. The studies that used a grounded theory approach had methodological limitations and the findings had to be interpreted with caution. A small sample size is not unusual for qualitative studies, but for a grounded theory approach it limited data saturation and hindered the development of a sound theoretical framework. The authors of these earlier studies emphasised the importance of engagement in meaningful, as opposed to meaningless, activities because they positively affected the motivation of patients to participate.

The population group in earlier studies was made up of people with severe mental health problems. In our contemporary mental health practice, we also work with people who are in remission of mental illness. They are encouraged to live their lives as independently as possible from services, even though some symptoms of their mental illness might be present at times (College of Occupational Therapists, 2006). To control these remaining symptoms more effectively, service users are taught techniques based on cognitive-behavioural therapy and mindfulness training. Our team was aware that some patients found that engagement in creative activities – such as painting, woodwork and textile art – relaxing, or they enjoyed listening to music or playing a musical instrument in their pastime. There is a lack of studies in the literature that included people living with mental health problems who use creative activities without a therapist.

In the field of physical disability, Frances Reynolds has published several phenomenological studies that underline the importance of engagement in creative leisure occupation as a way to express emotions of loss and grief when facing serious

health problems. Continued engagement was found to instil hope for a positive life style and re-construction of self-identity in individuals who were medically retired due to chronic fatigue syndrome, or myalgic encephalopathy (Reynolds, Vivat and Prior, 2008) and multiple sclerosis (Hunt, Nikopoulou-Smyth and Reynolds, 2014). Women, who were living with cancer (Reynolds and Prior, 2006) experienced several aspects of flow during engagement in visual art-making. Deep immersion and focused attention on the art-work helped to eject intrusive thoughts about cancer. The experience of flow was reported in two other studies that involved people living with long-term physical conditions (Timmons and MacDonald, 2008; Reynolds and Prior, 2003). All of these studies used a phenomenological approach. Timmons and MacDonald as well as Reynolds and her co-authors, used Interpretative Phenomenological Analysis (IPA), a qualitative approach, to explore people's lived experience and the meanings they attribute to those experiences.

The British psychologist Jonathan Smith and colleagues developed Phenomenological Interpretive Analysis in the 1990s (Smith, Flowers and Larkin, 2009). This phenomenological approach includes guiding theoretical principles, research questions and designs, methods of data collection, and analytic procedures. Its popularity has grown over the last two decades, particularly in the field of clinical psychology and health research. A person is viewed as a self-reflective being with experiences, who tries to make sense of them. Researchers also attempt to make sense of the person's experiences and use their own interpretive skills (Braun and Clarke, 2013). Reynolds and colleagues used mostly homogenous samples in their research, for example women with specific health problems who faced significant life events that had implications for their identity. The findings of these studies confirmed those of previous research that had used the same methodological approach, but different population groups.

Two phenomenological studies, Reynolds (2009) and Bedding and Sadlo (2008) focused on older people and explored the factors of taking up visual art making – painting, pottery and textile art – in later life. Both studies found that subjective wellbeing was promoted through participation in creative activity, either as a solitary or group activity. It filled occupational voids (Reynolds, 2009), and attendance of a group facilitated learning from others and social interaction (Bedding and Sadlo, 2008).

A recently published study by researchers at the Mayo clinic in Rochester, Minnesota (Roberts, Cha, Mielke, Geda, Boeve, Machulda, Knopman and Petersen, 2015) has shown that participation in art stimulates the mind, cultivates motor skills and seemingly lowers the risk of developing mild cognitive impairment compared to using a computer, socialising or joining a book club. 256 people who were over 85 years old were followed for four years and reported their participation in arts and craft activities, social activities and using a computer. After four years, the findings indicated that more than 30 percent of the volunteers had developed mild cognitive impairment. The likelihood of developing memory problems was less than 73 percent for people who participated in art compared to 45 percent of those who engaged in crafts, 55 percent for socialising and 53 percent for regular use of a computer. The findings promote engagement in arts and crafts as an important life style factor in keeping mentally and socially active in old age. Craig and Killick (2011) recommended engagement in creative work for people with dementia, because it seems to play an important role in enhancing communication and re-instating personhood and identity. In the absence of research, their book includes examples from practice, but also comments and observations from people with dementia. Even though the authors referred to anecdotal evidence, I liked their effort to give people living with dementia the opportunity to talk about their experiences of creative engagement and to include their stories in the book.

I was interested to learn more about the experiences of people in remission of mental illness, to explore their use of creative activities as a leisure occupation, and to find out what becoming and keeping involved in creative pursuits meant for them. Furthermore, I wanted to engage a sample of participants in our research that would mirror the patient group my colleagues and I encountered in our clinical practice.

1.8 Rationale for researching this topic from the patient's perspective

Reading of these papers, combined with my own clinical experience of facilitating participatory arts and crafts projects with patients, motivated me to consider conducting a study that would focus on patients' experiences with their chosen creative activity.

I wanted to gain a better understanding of individuals' experiences during their engagement in occupations, about the occurrence of any creative processes, why participants felt better during engagement and afterwards, and how these positive emotions may manifest themselves in what people do. My understanding was limited to

what I had read in the research literature, to my own observations, and to what patients told me about the effects of creative engagement. Furthermore, it was unclear how the experience of engaging in occupations within community settings may support people in taking up previous social roles or adopting new ones, how it may show an impact on the engagement of other occupations in their daily life after a period of illness, and how future interventions could be tailored towards a person's individual need of support. I anticipated that the answers to my questions would help our teams to design occupation-focused interventions, that are not only based on research evidence but also create meaningful experiences for patients, thereby embracing the modern care principles of effectiveness, experience and safety (Department of Health 2014). The existing literature on the use of creative activities indicated that the experiences of people in remission of mental illness who used creative activities as a leisure occupation was under-researched.

I feel passionate about the use of arts and crafts in contemporary occupational therapy practice because I have seen the positive effect creative occupation can have on some patients who experience severe intrusive thoughts. I have my own experience of how enjoyable creative activities are, but I also realise that their profile as an occupation-focused intervention needs to be raised through systematic investigation and research studies. As a result, I decided to explore the use of arts and crafts or 'creative activities', as they are called by occupational therapists, in more detail and to choose it as my area of research interest.

The importance of eliciting the views of service users was highlighted in recent policies about mental health service provision (Department of Health, 2014; 2013; 2010) and the importance of learning more about people's own coping strategies during times of wellness and unwellness (Slade, 2009). The Department of Health has emphasised the importance of helping people stay healthy and active, as well as to improve the experiences of patients and their families with services and the outcomes of interventions (Department of Health, 2010; 2009). A person's success in identifying a meaningful activity and participating in it on a regular basis might contribute to their experience of feeling better and livelier.

Patients who access our local mental health service have their own Wellness Recovery Action Plan (WRAP) which includes things that make oneself feel good (Copeland, 1997). Mary Ellen Copeland developed a practical way of turning the principles of hope, personal responsibility, education and support into a structured self-management approach in order to live well after being diagnosed with multiple illnesses such as manic depression, fibromyalgia, chronic myofascial pain syndrome and major depression. Anecdotal evidence was available that for some patients the engagement in painting, drawing, pottery or playing a musical instrument made them feel good, but there was not enough time in my clinical practice to investigate this topic more systematically or in greater detail. Our senior management team encouraged me to explore the area of arts and crafts-based intervention and its possible connection to the health and wellbeing of patients. It was anticipated that the findings of my investigation would enhance our department's understanding, provide a deeper insight into the phenomenon of participation in creative activities and secure funding for future community-based arts and crafts projects for people with mental health needs.

Since our organisation had received foundation status the active involvement of service users was encouraged at all stages of service development initiatives. Interested patients were invited by community mental health teams to take part in my research and talk about their experiences with arts and crafts-based media. The meaning that patients attribute to their experience helps us as professionals to understand the needs they have and how these needs can best be met in their future care (Cohen, Kahn and Steeves, 2000). I firmly believe that a better understanding of service user needs' contributes towards service improvements, with an emphasis on a more personalised and socially inclusive approach for patients who want to express their creative potential. Furthermore, I envisaged that the findings of my systematic investigation might be helpful in the design of further research, perhaps a randomised controlled effectiveness study at a later stage.

The notion of person-centred practice within occupational therapy was also applied to the research method of face-to-face interviews in which my whole attention as the researcher was concentrated on the participant's verbatim account of what was happening during their engagement in creative activities. The study was undertaken for a doctoral award in professional clinical-based research. It was recognised that the

formulated research question had been chosen subjectively and was influenced by my interest in the human expression of creative abilities as well as my professional background as an occupational therapist.

1.9 Potential relevance of my research interest

Despite growing anecdotal evidence of how beneficial participation in meaningful creative activities has been for service users of our organisation, the scientific evidence is still lacking. Additionally, there is a lack of research that explores the experiences of people who are in remission of mental illness and participate in creative activities as a means of achieving a modicum of calmness in their thought processes ‘...to stop worrying and over-thinking’, as well as to experience positive emotional feelings ‘...just to be content to live in the moment’ (research diary, personal notes, B.Ruckli, 2012). Staff in our community-mental health teams work mostly with patients who are in remission of mental ill health. This particular population group is likely to be more vulnerable to mental health problems than the rest of the population, as recent statistics on repeated episodes of mental ill health have shown (Blumberger, Mulsant, Emeremni, Houck, Andreescu, Mazumdar, Whyte, Rothschild, Flint and Meyers, 2011; McCrone, Dhanasiri, Patel, Knapp and Lawton-Smith, 2008). Therefore, it is paramount to find appropriate and meaningful interventions that support people in remission of mental illness and to prevent hospitalisation with further disruption to their life.

As an occupational therapist who has been working in psychiatry for more than twenty years I am still fascinated by how individual patients respond to the use of arts and crafts media, and how a previous unawareness of their creative potential might come to light after they attended a workshop or a class on creative activities. I was particularly interested to learn about patients’ experiences of engaging in chosen creative activities. For my research project, I intended to involve service users who shared my interest in creative activities and who were keen to talk with me about their experiences. Their involvement in the research project was welcomed by members of the Service User Forum from our organisation who contributed with their views to the formulation of the initial research question: *‘What is the experience of creative activities for people in remission of mental illness?’* Several of my colleagues from other community-mental health teams in the region heard about my research interest through members of the Service User Forum. Additionally, occupational therapy colleagues from my own

department showed an interest in becoming involved and offered their help with the recruitment of eligible participants.

1.10 Structure of the thesis

The doctoral thesis consists of six chapters. In Chapter 1, I outlined my reasons for choosing creative activities as the topic of the thesis. The historical background of the use of creative activities, and its relevance to occupational therapy and existing research was described. A tentative research question was formulated and further refined following a systematic literature review.

Chapter 2 describes the process of the systematic literature search and critical appraisal of selected studies. The results of the systematic literature review suggested a lack of research in the use of creative activities with people in remission of mental illness and facilitated the formulation of the final research question.

In Chapter 3, I explain how the final research question led me to choose a qualitative methodology. I outline my position as a researcher for this study, highlight ethical considerations and give a detailed description of the management process.

Chapter 4 introduces the reader to the participants and the findings of the study. Details about the participants' background are given in the participant profile and in individual vignettes. Some participants gave permission to take photographs of their art work which can be found in Appendix 15. This chapter concludes with the findings of the study, which are presented as four themes and four subthemes.

My discussion and interpretation of the findings are presented in Chapter 5. The findings were linked conceptually to different types of optimal experience, mindfulness and the creative process. The strengths and limitations of the study, recommendations for future research and my reflective thoughts complete this chapter. Finally, in Chapter 6, I present the study's conclusion.

CHAPTER 2 Literature review

2.1 Introduction

This literature review was conducted in order to establish the current state of knowledge and understanding about the identified phenomenon of interest, as well as to identify any gaps that would warrant a systematic investigation. Creative activities and their usefulness for occupational therapy practice have generated literature based on observation, opinion or ideas, but only a few research studies were known to me and my colleagues (Lloyd, Wong and Petchkovsky, 2007; Rebeiro and Cook, 1999). I wanted to explore this topic with fresh eyes and conducted a systematic literature search and review. The search for relevant published studies covered the period from 1999-2015. The findings helped refine the initial research question '*What is the experience of creative activities for people in remission of mental illness?*' to the final research question '*What is the experience of participation in creative activities for people in remission of mental illness?*'

2.2 Literature search

An initial literature search was conducted for articles with the combined search terms *occupation, creativity, health, and wellbeing*. Rothstein and Hopewell (2009) suggest that a combination of different information searches such as utilising computerised databases, as well as hand searching, is required to comprehensively identify articles of research studies. Therefore, a wide range of information sources was consulted and different search strategies were systematically utilised throughout the search process. The information sources entailed electronic databases (for example AMED, BNI, CINAHL, Electronic Books, Electronic Journals, EMBASE, PsycINFO, MEDLINE), reference lists from relevant articles and primary studies, hand searching of various occupational therapy journals and accessing relevant websites, as well as personal contact with local, national and international colleagues in the field of occupational therapy. I did not restrict the literature review to any particular year at this stage, but it appeared that abstracts were included from the year 1993 onwards in most commonly used electronic databases. Prior to this cut off point, abstracts could be found manually in printed copies of journals. Each electronic database emphasises different subjects and has some slightly different indexing terms. I did not want to restrict my search terms at this early stage and used the truncation symbol * in relevant search terms such as

*occupation** and *creative** to include as many terms as possible, for example. *occupational therapy, occupational engagement, occupational science, creativity or creative activities*, when accessing electronic databases.

Relevant citations and available abstracts were then scrutinised for inclusion. The number of abstracts on topics focused on *creative**, *occupation, health and wellbeing*. I also located a range of relevant policy papers. The total number of retrieved papers was above 100 and had to be narrowed down due to time constraints. All papers that gave opinions about a certain topic, described programmes, interventions, treatments, concepts, theories, personal accounts, editorials, letters, reviews or policies were excluded at this stage because the aim was to identify research studies.

I attempted to carry out a thorough literature search, but there are already three main limitations when searching databases through the use of controlled vocabulary. Firstly, some authors describe their research methods incompletely, and use synonyms or alternative terms. There is confusion about the use of terms such as *activity* and *occupation*: very often they are used interchangeably, in singular and plural forms. Secondly, the thesaurus may lack the appropriate indexing terms with which to precisely outline the content of the article. The term *old/older* has undergone several changes throughout the last two decades and may not be politically correct any more (such as *elderly, elders*). Thirdly, inaccuracies in assigning indexing terms may occur. The term *mental illness* is now widely used among my colleagues whereas the terms *mentally handicapped* or *psychiatric disability* seem to have disappeared from clinical practice. It is, then, interesting to note that these terms still appear in titles and abstracts of various databases, particularly in MEDLINE. I used the search term *mental disorders* because this term is also used in the International Statistical Classification of Diseases and Related Health Problems (ICD-10, 2010). A summary of the relevant mental disorders can be found in Appendix 1.

Even though further attempts had been made to minimise bias and errors in the search of primary studies, there were two main sources of bias evident at this stage: publication and language bias. I am always very keen to explore the different ways of knowing about a certain topic, what kind of knowledge has been made accessible through publications and the reasons behind it. With the emergence of occupational science, an

academic discipline that focuses on the form, function and meaning of human occupation (Wilcock and Hocking, 2015), and due to increased publication, our knowledge has grown. Professional bodies and associations have identified the need to re-focus the profession's core interests on *occupation*. One journal, *The Occupational Therapy Journal of Research*, was even given a new name *OTJR: Occupation, Participation and Health*, in order to emphasise the role occupation may play in promoting participation and health (Baum, 2003). The College of Occupational Therapists (COT) organised the 29th annual conference in 2005 around *Activity, Participation, Occupation*. Despite these efforts on an international scale, there is still a lack of empirical evidence on how occupational engagement may contribute to a person's remission from ill health. It also means that this drive to publish papers on particular themes may have led to other areas of interest being neglected. Additionally, I did not search grey literature, which includes unpublished masters' and doctoral theses, neither did I access the National Research Register for unpublished studies due to time constraints. Lastly, I decided to focus only on research studies that were published in English. Language bias refers to the exclusion of articles for linguistic reasons.

Eventually, I included only research articles for the critical appraisal process, but felt overwhelmed by the immense scope of the literature which included various population groups (healthy people, patients with disabilities, chronic illness, life-threatening illness, mental ill health) and different areas of clinical practice (physical medicine, psychiatry/mental health, geriatrics, paediatrics). Themes arising from my search were the psychosocial effects of participating in creative group or class activities, beneficial effects on the mind and body, temporary respite from worrying thoughts, and promotion of positive emotion and subjective wellbeing. Valuable feedback was given by one of my supervisors, Dr. Martin. She suggested that the included studies emphasise the engagement of creative activities with people who resemble the population group of my own clinical practice (adult population with mental health and physical health problems, older people). The search strategy was revised, and the inclusion and exclusion criteria both became more focused and relevant to my research question.

The newly devised search strategy included inclusion/exclusion criteria and specific search terms which are described in the next section.

2.3 Comprehensive search of research articles

I applied the following inclusion and exclusion criteria:

Inclusion:

Population: People living in the community with mental health/physical needs, older people

Intervention: Community-based group/solitary, creative occupation/activity, crafts

Exclusion:

Published literature in languages other than English

Unpublished literature such as masters' and doctoral theses, conference proceedings

Population: professional artists, crafts people

Intervention: art therapy, music therapy, any other kind of therapy

The search strategy consisted of the following search terms: *creative occupation*, *occupational therapy*, *mental disorders*, *creativity*, as well as a combination of these search terms. Different electronic databases were utilised and the search strategy and results can be viewed in Appendix 2, including the abstract details of the selected studies.

2.4 Search results

The comprehensive search generated twelve research articles. Different parts of a study by Mee had been published in two articles (Mee, Sumsion and Craik, 2004; Mee and Sumsion, 2001). They were combined and counted as one study. A study by Griffiths consisted of two phases, which were published in different years but only phase two fit the inclusion criteria. Phase one was a survey with occupational therapists and their use of creative activities (Griffiths and Corr, 2007) and mentioned in Chapter 1. Phase two was a qualitative study that emphasised creative activity as a treatment in the field of psychiatry (Griffiths, 2008) and included in the search results. Initially, a study by Reynolds (2003) about textile art-making was also included. However, after reading the full article, I realised that the sample consisted of textile artists as well as hobbyists and rejected the study as it no longer fit the inclusion criteria. A total number of ten studies remained.

Table 1 shows the ten studies from the systematic search of electronic databases, which were initially clustered in three groups. The three groups were: mental health problems (five studies), physical health problems (four studies) and physical/mental/no health problems (one study). A search for research articles from the current year did not produce any studies that fit the inclusion criteria.

Table 1: Identified studies from electronic databases

1.Mental health problems	Lawson, Reynolds, Bryant and Wilson (2014)	Swindells, Lathom, Rowley, Siddiquee, Kilroy and Kagan (2013)	Griffiths (2008)	Mee, Sumsion and Craik (2004) part 2 Mee and Sumsion (2001) part 1	Reynolds (2000)
2.Physical health problems	Timmons and MacDonald (2008)	Reynolds and Prior (2006)	Reynolds (2004)	Reynolds and Prior (2003)	
3.Physical/mental/no health problems	Riley, Corkhill and Morris (2013)				

An additional manual search of occupational therapy journals generated seven more studies that fulfilled the aforementioned inclusion and exclusion criteria. The total number of included studies was seventeen and they were clustered into four groups (Table 2) according to the participants' main common characteristics: group one included people with mental health problems (n=8); group two focused on people with physical health problems (n=6); group three included older people (n=2); and in group four were participants with no or a mixture of self-reported health conditions (n=1).

Table 2: Identified studies from electronic databases and manual search

1.Mental health problems	Horghagen Fostfedt and Alsaker (2014)	Lawson, Reynolds, Bryant and Wilson (2014)	Swindells, Lathom, Rowley, Siddiquee, Kilroy and Kagan (2013)	Griffiths (2008)	Lloyd, Wong and Petchkovsky (2007)	Mee, Sumsion and Craik (2004) part 2 Mee and Sumsion (2001) part 1	Reynolds (2000)	Rebeiro and Cook (1999)
2.Physical health problems	Hunt, Nikopoulo-Smyrn and Reynolds (2014)	Timmons & MacDonald (2008)	Reynolds, Vivat and Prior (2008)	Reynolds and Prior (2006)	Reynolds (2004)	Reynolds and Prior (2003)		
3.Older people	Reynolds (2009)	Bedding & Sadlo (2008)						
4.Physical/mental/no health problems	Riley Corkhill and Morris (2013)							

2.5 Critical appraisal of studies

Seventeen studies were critically appraised following the principles of the Critical Appraisal Skills Programme (CASP, 2014). Tables 3-5 show the four groups of studies and details of the authors' names, the year of publication, the country where the study took place, participants' gender and age, the intervention and setting, and methodology, as well as the participants' perceived effects on their subjective wellbeing. Each study is presented individually and summarises its significant findings, strengths and limitations.

2.5.1 Participants with mental health problems

The first group of studies involved participants living with mental health problems (Table 3).

Table 3: Participants with mental health problems

Author(s)	Participants	Intervention Setting	Methodology	Perceived effects
2015 –				
Horghagen Fostfedt and Alsaker (2014) Norway	n=12 long-lasting illness 9 women, 3 men 45-75 years Group	Engagement in craft activities Textiles, Woodwork, Paintings, Glasswork, Ceramics	Ethnography, field notes about conversations Participant observation Meaningful occupation	Traditional familiar crafts Low-risk threshold predictable Personal process of craft making Positive emotions: joy, hope Psychosocial benefits: group routines, skills, peer support
Lawson, Reynolds, Bryant and Wilson (2014) UK	n=8 living with long-term mental health problems 3 women, 5 men 39-65 years Group	Engagement in community-arts project (2 years) Art-making experience	Phenomenology Meaningful occupation	Immersion in creative process – temporary respite Forming identity beyond illness, >self-worth Sense of belonging Acquisition of creative skills Self-management of mental health Ending provoked anxiety
Swindells, Lathom, Rowley, Siddiquee, Kilroy and Kagan (2013) UK	n=21 interviews with adults and older people with a mental health diagnosis 18-85 years (no details about women: men ratio)	<i>Invest to Save</i> arts projects (n=4) Painting, Craft, Music, Ceramics, Woodwork, Textiles, Group	Mixed method design Standardised measures Interviews Purposeful occupation	Purposeful occupation, Eudaimonic themes of autonomy Self-expression/intrinsic motivation, Development of innate creative potential. Cognitive and creative challenge Heightened concentration (flow). Sustained engagement for continued psychological well-being.
Griffiths (2008) UK (Phase 2)	n=8 people with mental health problems 6 women, 2 men	Creative activities as a treatment medium	Grounded theory Interviews Observations Focus groups	Non-threatening, fun, purpose Different levels of engagement Skills-challenge (flow) Occupational gains: confidence,

	20-59 years n=5 occupational therapists 3 women, 2 men	4 creative activity groups Multiple use: 1:1/group		>Intrapersonal, relational skills, Personal growth Functional performance, Restoring balance between work/leisure Choice to participate, safe environment Group: friendship, affirmation,
Lloyd, Wong and Petchkovsky (2007) Australia	n=8 consumers with serious mental illness women/men – not known 20-59 years	Engagement in community arts programme (<i>Girrebala</i>) Various media and techniques Group	Qualitative Interviews Meaning and purposeful activity Meaning and experiences of recovery	Self-expression/-discovery Changes in internal conditions: Spirituality, empowerment, self-validation Creation of art facilitated individuals' internal recovery; Linked to conceptual model of recovery (Jacobsen & Greenley, 2001) Creative environment Group: Supportive relationships
Mee, Sumsion and Craik (2004) UK Part 2 Mee and Sumsion (2001) UK Part 1	n=6 people with enduring mental health problems, living in the community 2 women, 1men from each setting 36-61 years	Workshop (wood work) drop-in-facility engagement in Group/solitary	Ethnographic approach Interviews Observations engagement in meaningful occupation personal meaning	Self-identity through the drive to create, Acquisition of skills/competence Feelings of usefulness, purpose Intrinsic motivation generated by occupation Time structure within an empowering environment
Reynolds (2000) UK	n=39 women living with mental health problems (depression) in the community subscribers of needlecraft journal 18-70 years	Personal meanings of creative art activities Solitary	Qualitative Written narratives complimented by few interviews	Meaningful occupation in later life Process/product of creative activity Pride, evidence of skills Sense of autonomy, self-worth Therapeutic value: hope for future Mental/emotional relaxation >perceived control Time management Self-management of depression
Rebeiro and Cook (1999) Canada	n=8 women with severe mental health problems	quilt making experience Women's group Out-patient Group	Grounded theory Participant observation Meaning Occupation-based	Personal experience of occupational engagement conceptualised as 'occupational spin off' process model' with affirmation, confirmation, actualisation and anticipation Contributes to mental wellbeing

The qualitative study by Horghagen, Fostfedt and Alsaker (2014) involved twelve people – nine women and three men – with long-lasting mental health problems who engaged in group craft activities at a Norwegian mental health centre called the *Meeting Place*. An ethnographic approach was utilised and included participant observation and

the collection of field notes which were analysed and interpreted. The findings revealed that making craft activities in a group facilitated stability, routines, skills, abilities and peer support. It strengthened the participants' self-identity as an artisan and maker, and they experienced a sense of everyday occupation as well as a sense of accomplishment for making products that could be sold. Being part of a group helped participants to socialise and use collaborative skills to complete products together. The strength of this study was the offered programme: voluntary engagement in familiar crafts as a group activity, which facilitated the participation of people who had experienced severe disruptions in daily routines, occupations and loneliness due to their mental illness. A methodological weakness was the data collection and sample method. Data collection was carried out by one person who had the dual role of participant-observer, collecting field notes and asking questions whilst participating in group crafts activities. The accuracy of the conversations could have been increased by recording them. The sample consisted of individuals who attended the craft group regularly and were appreciative of craft activities.

The psychosocial benefits for eight people – three women and five – men living with long-term mental health problems, who participated in a two-year community arts project, were explored in a phenomenological study (Lawson, Reynolds, Bryant and Wilson, 2014). Interpretative Phenomenological Analysis was used as a methodology and to analyse the interview data. The findings indicated that participants valued the project experience, which encompassed the personal process of art making and the social context. Art making and the recognition of artistic abilities through visual self-expression contributed to participants' subjective wellbeing by boosting confidence and self-worth. Community venues were the social context and they facilitated the forming of new relationships with members of the public – teachers, staff at museums and galleries, and artists – and a new identity away from the illness. Immersion in the creative process gave participants temporary respite from troubling thoughts and the pleasure of deep concentration which was linked to a flow-like state.

Regular attendance provided structure to their lives but some participants expressed fear and anxiety for ending the project. Negative emotions were produced by internal and external pressure to make high-quality artwork, physical disabilities that limited full engagement and a perceived loss of creative ownership when teachers became overly

involved in the participants' art-making. The study confirms previous research on how art-making in a socially affirmative environment enables positive identity transformation. The strength of this study is the reporting of participants' positive and negative experiences. The authors also acknowledged the help of a steering group with administrative aspects of the study, for example the finalisation of interview questions and dealing with participants' correspondence. A limitation of the study was the self-referred sample. All participants were thought to have mental health problems, however four participants had acquired brain injury and their experiences might have been different to those with anxiety, depression or schizophrenia.

Swindells, Lathom, Rowley, Siddiquee, Kilroy and Kagan (2013) re-analysed the qualitative data of twenty-one participants with mental health problems who were previously collected in the *Invest to Save* arts projects. As a three-year research project it employed a mixed-method design with standardised measures and semi-structured interviews. Participants showed significant improvement in eudaimonic well-being (Ryff, 1989) but it was unclear how this change had happened. The eudaimonic perspective on well-being emphasises meaningful engagement, relationships with others and personal growth, which includes ideas of self-actualisation, realisation of inner potential and authentic self, and the expression of positive and negative emotion as a healthy reaction to challenging circumstances (Waterman, Schwartz and Conti, 2008). The interview data underwent a secondary thematic analysis and the authors placed the findings within the context of eudaimonic models of wellbeing thereby identifying eudaimonic themes of autonomy (opportunities for autonomous self-expression), intrinsic motivation, challenge (creative, cognitive) and heightened concentration, all of which can be linked to the concept of flow.

The study highlighted the importance of skilled facilitation – the flexibility of creative activity which was adaptable to the skills of participants and provided a meaningful experience. A limitation of the study was the lack of a qualitative methodology that justified the method of data collection (semi-structured interviews), analysis and interpretation of data. However, the authors made an effort to understand the participants' intrinsic interest for creative engagement and the human need for creative expression as a means of enhancing subjective well-being from the eudaimonic perspective.

The grounded theory project by Griffiths (2008) included observations and interviews with five occupational therapists and eight clients to explore the use of creative group activities as a treatment intervention. Engagement in creative group activities was voluntary and offered opportunities for participants to learn new skills, enhance previous skills and make choices through the use of different techniques and media. Positive emotions such as pleasure were reported during occupational engagement and a sense of pride after completing a project. The participants viewed friendship, support, and affirmation as important elements of working in a group. Furthermore, positive experiences of engagement gave meaning and purpose to their life and motivation for continued engagement. Griffiths also discovered that the experience of engagement was linked to different levels of consciousness which influenced the thought process. Deeper levels of engagement were linked to flow-like states. A limitation of this study was the small number of participants, which meant that data saturation could not be reached. Therefore, the findings should be viewed with as preliminary findings.

Lloyd, Wong and Petchkovsky (2007) explored the involvement of eight participants with mental illness in an Australian community arts programme, *Girrebala*, and its contribution to their internal recovery. A qualitative method was used with interviews, field notes and thematic data analysis. The findings comprised the following themes: ‘the creation of art’ was viewed as a medium for expression and discovery and ‘changes in internal conditions’ – spirituality, empowerment and self-validation – were linked to a conceptual model of recovery (Jacobsen and Greenley, 2001). The participants were able to express through their art not only their thoughts, emotions and struggles with their illness, but also their dreams and aspirations. Creative problem-solving skills were developed through experimenting with materials. Participants gained insight about themselves, their relationships and the illness through art-making in a safe and creative environment.

Art-making helped participants to create a new identity that incorporated their illness as a manageable rather than an overwhelming part of their lives. Accomplishments with their produced artwork increased the participants’ sense of worth and self-confidence, and facilitated a new lifestyle with new goals and life roles. A limitation of the study was the sampling strategy, which involved participants appreciative of the programme and an unclear data analysis method that produced fifteen subthemes. The number of

subthemes was possibly generated by the uniquely individual, but also favourable accounts, of participants about the benefits of the community arts programme. A qualitative study about engagement in meaningful occupation was published in two separate articles by Mee and her colleagues (Mee, Sumsion and Craik, 2004; Mee and Sumsion, 2001). The study focused on six people with enduring mental health problems, with three of them attending a drop-in-facility and the other three a workshop at day services. Involvement in productive occupation, the opportunity to socialise in an encouraging environment and the useful organisation of time motivated participants to attend the day services. The ethnographic approach employed interviews and participant observations. Occupation was experienced by the participants as a conduit for generating motivation, building competence and developing self-identity. Participants appreciated the voluntary participation and the autonomy to decide their level of occupational engagement. It helped them to combat boredom, which they had previously experienced at home. Competence building was facilitated through skill acquisition, the ability to cope with challenges during the creative process and the experience of positive emotions through achievements.

Three factors appeared to play a central role in the development of self-identity: the drive of participants to create, feelings of usefulness and the construction of an integrated sense of self through object making. The authors explained the findings from an occupational science perspective that emphasised the human need for occupation. Limitations of the study were related to methodological issues. The sample consisted of the first eight individuals who agreed to participate with the likelihood of being appreciative of the benefits. The position of the researcher was controversial because she was also a trustee of the charity that provided the workshop setting. She acknowledged her subjective bias in the research process and its potential influence upon the findings.

Reynolds (2000) explored the experiences of thirty-nine women who were managing depression through their engagement in needlecraft. The qualitative study employed written narratives, supplemented by four verbatim transcribed interviews and a template approach to data analysis. This approach is characterised by the use of categories that are summarised from existing theories. The researcher looked for these themes within the data and for additional themes generated by the participants. The sample was

recruited through the readership of national needlecrafts magazines and self-selected. The findings indicated that the majority of respondents had taken up needlecraft as a leisure occupation in adulthood or later life. As a creative leisure activity it offered psychological benefits. It helped participants to cope with stressful life events because their engagement not only offered an escape from worrying thoughts but also relaxation (mental/emotional/physical), intense concentration and enjoyment. Mental relaxation was experienced through the physical act of sewing and through related activities, for example reading needlecrafts literature or planning future designs. The visible process of engagement and the visible products of needlecraft offered an opportunity for self-expression and the use of creative abilities as well as public and private acknowledgment.

As a leisure pursuit, needlecraft offered autonomy, choice and control for the participants whose life was very often restricted by the symptoms of their illness. It supported an active lifestyle and brought structure and meaning to their lives. The limitations of the study were the self-selected sample and the absence of an independent diagnosis of depression. The use of written narratives has advantages and disadvantages. Written material cannot be probed or extended, but it can offer participants subjective insight about their experiences without prompts by the researcher. Lastly, the template approach to data analysis is open to influences by the researcher's theoretical and practical knowledge which can be reflected in the findings.

Rebeiro and Cook (1999) explored, in a grounded theory study, the experiences of eight women living with severe mental health problems who were members of an out-patient quilting group. The qualitative design included interviews and participant observation. Engagement in creative occupation was presented in a conceptual model which the authors called 'occupational spin-off'. The Model of Occupational-Spin-Off consists of four stages. The first two stages are affirmation and confirmation. Affirmation by group members enabled individual occupational engagement. Confirmation of individual competency was received through direct involvement in the occupation and feedback from others. The interaction of social environment and occupation characterises the last two stages of actualisation and anticipation.

The authors stressed the importance of the therapeutic effects of creative occupations and hypothesised that on-going occupational engagement can contribute to subjective well-being and a sense of self-actualisation over time. The findings of the study provide scientific evidence about the use of creative occupation as a treatment intervention. Although not explicitly expressed by the authors, the study confirmed the value of occupational engagement for subjective wellbeing from an occupational science perspective. The group was developed for women who had a history of re-admission to hospital and did not seem to benefit from traditional, verbal-based therapies. The limitations of the study were the lack of data saturation; a sample that was restricted to members of the women's group who might have responded favourably to the research questions, and the role of the first author in her dual role as researcher and staff member of the out-patient department.

2.5.2 Participants with physical health problems

Studies that involved people with physical health problems are presented in Table 4.

Table 4: Participants with physical health problems

Author(s)	Participants	Intervention Setting	Methodology	Perceived effects
2015 –				
Hunt, Nikopoulo-Smymi and Reynolds (2014) Ireland	n=5 people living with multiple sclerosis medically retired 2 males, 3 females 40-64years	Engagement in leisure-based visual art making Process/products Solitary/group	Phenomenology (IPA) Interviews	Deep immersion-respite from worry about illness; >Emotional well-being, Art-making process/products: >Affirmative Multi-faceted means of supporting identity, self-worth Filling occupational voids: time use Creative classes-social camaraderie, Opportunities for learning /development
Timmons and MacDonald (2008) UK	n=6 people living with long-term physical health problems 5 women, 1 men 27-73 years	Ceramics Ceramic process	Phenomenology (IPA) Interviews (face-to-face; telephone) Written narratives Meaningful creative leisure pursuits	Promoting wellbeing - physical, emotional Creative process/product: sense of achievement/self-worth Expression about feelings (loss) Facilitating adaptation to ill health Flow, control, choice, creative adventure (except clear goals) Social contact/interaction
Reynolds, Vivat and Prior (2008)	n=10 women with chronic fatigue syndrome/myalgic	Art-making leisure activity	Phenomenology (IPA) 10 interviews	Taking up of art familiarity with craft skills

UK	encephalopathy (CFS/ME) Medically retired 34-62 years Readership of creative arts magazine	Solitary/group		Positive self-image, hope Expressions of emotions-grief, loss Contact with outside world Manageable within illness constraints Shared interest with family
Reynolds and Prior (2006) UK	n=10 women living with cancer medically retired 23-66 years Readership of arts magazines	Visual art-making experiences Textile art Pottery Painting Collage making Solitary	Qualitative (Template approach) Interviews Aspects of creative process/ flow-like?	Art-making, multiple purposes Promoting wellbeing Banish intrusive thoughts about illness Flow present except clear goals Creative process linked to flow-like states Valued experiences of mastery and control Positive journeys into the unknown
Reynolds (2004) UK	n=7 people living with long-term health problems medically retired 6 women, 1 men 39-58 years	Textile art-making - Multi-dimensional experience Reflections on creative process	Qualitative (IPA) Interviews Meanings of textile art making	Engagement in textile art-making Meanings six distinctive features: Highly accessible/diverse art form Time-consuming; Traditional among some social groups Use of assistive technology absorption into family life
Reynolds and Prior (2003) UK	n=35 women living with disabling chronic illness 29-72years Textile art magazines local adult education centres, craft web-sites	Textile art freestyle Embroidery Tapestry Applique Quilting Mixed media work Solitary/groups	Phenomenology (IPA) 30 interviews, (face-to-face/ 3 telephone) 5 written narratives Meanings and functions of textile art	Promoting wellbeing, positive identity Distracted thoughts away from illness, Expression of grief, Experience of flow, spontaneity, filled occupational voids, Extended social networks; Value conceptualised as 'lifestyle coat-hanger'; Further purposeful roles/ activities; Overcoming restrictions imposed by illness on self and lifestyle

A recent phenomenological study by Hunt, Nikopoulo-Smyi and Reynolds (2014) explored the meanings of leisure based visual art-making for five people living with multiple sclerosis. The study followed principles of Interpretative Phenomenological Analysis (IPA) and used individual face-to-face interviews with a topic guide, and examples or photographs of participants' artwork to stimulate discussion of their experiences of art-making and its meanings. Art-making held many meanings for the participants and added value to their lives. It filled occupational voids and gave them the opportunity to use time productively. Deep immersion in the creative process offered respite from worries about the illness. The participants experienced art-making

as a solitary and group activity and a way for self-expression. The attendance of classes offered social contact and opportunities for learning and development.

Art-making processes and products impacted positively on the emotional wellbeing of participants, promoted their self-worth and preserved their self-identity. The findings of this study confirmed previous research on the positive experience of creative leisure occupations that involved participants living with complex physical health problems. The limitation of the study was the sample which consisted of people with similar demographics and who had a well-developed social network that facilitated access to creative occupation in the community. The researchers' knowledge about the phenomenon might have influenced data collection and analysis. However, all three researchers maintained an awareness of their possible influence on data and subsequent findings throughout the study.

Timmons and MacDonald (2008) conducted a phenomenological study with six people living with long-term physical health problems who engaged in ceramics as a creative leisure occupation. Data collection and analysis were guided by Interpretative Phenomenological Analysis. Methods for data collection included telephone or face-to-face interview, and written accounts of participants' experiences. Engagement in ceramics promoted personal wellbeing (physical/psychological) and successful adaptation to illness. It was linked to the following experiences: 'being productive and creating', 'enhancing opportunities for social interaction' and 'alchemy and magic'. For a few participants, the engagement with clay enabled self-expression about negative feelings (loss). The ceramic process offered an opportunity for deep immersion, and to experience flow with a reduced awareness and less focus on distracting thoughts about the illness.

Furthermore, 'creative adventure', an element of the art making process and perhaps part of the flow state according to Reynolds and Prior (2006) was also experienced by participants. 'Creative adventure' refers to unexpected discoveries during the creative process which were enjoyable for the participants but were not compatible with Csikszentmihalyi's (1990) flow state and the occurrence of clear goals. The positive social value of ceramics gave participants status and supported the reconstruction of self-identity. The process of making and the production of an end product evoked feelings of enjoyment, satisfaction, a sense of achievement and personal worth.

Ceramics was predominantly perceived as a leisure occupation, but for a few it had become a paid work occupation after the onset of illness. The limitation of the study was the recruitment of participants from one international ceramic journal with the likelihood of attracting interested, dedicated and experienced potters who worked in studios. In-depth interviews with a larger sample from different sources might have generated richer data than the combination of three data collection methods and recruitment from one international journal of ceramic art.

Another phenomenological study by Reynolds, Vivat and Prior (2008) focused on the meanings of art-making for ten women living with chronic fatigue syndrome/myalgic encephalopathy (CFS/ME). The sample was recruited from the readership of creative arts magazines and from a local CFS/ME support group. The study followed the principles of Interpretative Phenomenological Analysis. The data contained verbatim transcribed interviews and three written accounts to the interview questions. Art-making as a creative leisure occupation was taken up after the onset of the illness which had led to medical retirement. The loss of roles created occupational voids. Achievements in manageable arts and craft projects helped participants to adapt to a new positive lifestyle that included the management of their illness. Regular engagement in art-making was viewed as a meaningful experience that impacted positively on subjective wellbeing, which included increased self-confidence, affirmed identity, sense of achievement, development of creative skills and hope for future projects.

Creative leisure occupation facilitated social contacts and moved participants' attention away from the illness. For a few, art-making provided a means of cathartic self-expression of negative emotions. Limitations of the study were a self-selected sample without the independent confirmation of a diagnosis, and the possible influence of the researcher on the data analysis and findings. This study generated similar findings as previous phenomenological research that explored the experiences of people with other physical health problems.

A qualitative study by Reynolds and Prior (2006) focused on the experience of visual art-making of ten women living with cancer. The purpose of the study was to find out if the participants mentioned flow experiences in their account. Verbatim transcribed interview data were analysed by using the template approach. All participants were

medically retired and had encountered loss of roles, social contacts, self-confidence and self-worth in the early stages of cancer. They expressed a need for occupations to fill the available time and occupational voids. Art-making was used to normalise their everyday life and to cope with the problems of the illness. Features of the creative process were linked to flow-like states: art-making demanded intense concentration which helped to eject worrying thoughts about cancer. Reduced awareness of the environment and self, for example being less aware of health problems, happened during their engagement in art-making. Regular creative occupation facilitated skills development and personal designs, thereby increasing feelings of self-confidence, self-worth and achievement, which enhanced subjective wellbeing. Artistic challenges could be mastered through personal effort and the interest to learn new skills. But clear goals were absent in art-making and replaced by creative adventures.

Three other aspects of the art-making experience with a possible link to the flow state were described: sensuous vitality – feeling alive during the engagement of art-making due the sensual and aesthetic aspect of art; flexible responsiveness or intuitive ability to the evolving art creation; and creative adventure or journey into the unknown. A limitation of the study was the self-selected sample from the readership of national arts magazines who also self-reported a diagnosis of cancer. This could be improved by choosing a purposive sample with the independent confirmation of a diagnosis. The limitations of the template approach were mentioned earlier (p. 29).

Reynolds (2004) conducted a qualitative study with seven people living with long-term physical health problems to explore the meanings of textile art-making. Interviews were verbatim transcribed and data analysis followed the guidelines of Interpretative Phenomenological Analysis (IPA). Six distinctive features of textile art emerged. Textile art-making was described as a highly accessible and diverse art form. Engagement in textile art facilitated skills development, competence and confidence building. The diverse range of techniques and projects gave participants autonomy and choice to select a project that suited their current circumstances (mood, time, energy, dexterity). The time-consuming nature of textile art demanded commitment and future orientation, and gave structure to daily life after retirement. Textile art-making facilitated social contacts with like-minded people to share ideas and techniques.

The use of assistive technology helped participants to adapt their artwork to current levels of functioning without feeling disadvantaged from other members of society. The integration of textile art-making into family life was possible and produced artwork that was visible to others. A limitation of the study was the involvement of the small homogenous sample from one ethnic group which could have precluded cultural dimensions of textile art-making. Reynolds (2004) recommended further research into the distinctive features of other creative activities, such as painting and playing a musical instrument.

In a phenomenological study with thirty-five women living with long-term illness, Reynolds and Prior (2003) explored the meanings of textile art work. The study followed guidelines of Interpretative Phenomenological Analysis (IPA), and verbatim transcribed interviews as well as narratives were analysed. Engagement in textile artwork held different meanings for participants. For some participants it was a way to cope with negative emotions (loss, grief, anger, sadness) through self-expression. Focusing attention on the artwork and deep absorption in the creative process provided distraction from worrying thoughts. For other participants it was a means to rebuild a life around the illness with a new and positive identity. Retirement due to illness had created occupational voids for the participants, which were filled meaningfully with the production of textile artwork. Deep immersion in creative occupation appeared to develop participants' aesthetic awareness for colours and designs, as well as an appreciation for their natural surroundings. Some participants described flow-like experiences during deep immersion, particularly when clear goals and creative challenges were skilfully mastered.

Engagement in artwork produced positive emotions (pleasure, joy) which motivated participants to seek out other related activities (classes, exhibitions), form new relationships, and develop new skills and plans for the future, all of which supported a positive identity transformation. The central theme of the meaning of art-work was summarised as a 'lifestyle coat-hanger'. This study was important because it explored the experiences of participants with textile art as a valued leisure occupation and confirmed findings from a previous study, but provided richer descriptions (Reynolds, 2000). A limitation of the study was the sample which was self-selected from the readership of textile art magazines, craft web-sites and local adult education centres. It

consisted of women with a privileged cultural background and a range of different health problems that were self-reported. Purposive sampling might have increased the involvement of participants from a wider social background with varied experiences to produce rich data.

2.5.3 Older people

Table 5 shows two studies that were conducted with older people as participants. Participants in both groups were retired, except one participant in the study by Reynolds (2009) who was a home maker and, when time had become available for her due to diminished family responsibilities in later life, became interested in visual art-making as a leisure pursuit.

Table 5: Older people

Author(s)	Participants	Intervention Setting	Methodology	Perceived effects
2015 –				
Reynolds (2009) UK	n=12 women 61-80 years older readership of a national magazine	Visual art- making Painting, Pottery, Textile art Solitary/group	Phenomenology Interviews	Take up of art-making Promoting subjective wellbeing Distal factors: pre-existing craft skills, Positive attitudes towards change Proximal factors: filling occupational voids Encouragement from family/friends Serendipitous events
Bedding and Sadlo (2008) UK	n=6 older, retired people living in the community 65-84 years 4 women, 2 men	Art class activity Painting Group	Phenomenology	Important aspects: activity and socialising, positive emotions contribute to health, productivity, sense of achievement >Confidence, wellbeing, challenge satisfaction, time transformation. Group: actual attendance valuable, Inspiration, encouraged by/learn from other

The study by Reynolds (2009) aimed to explore the reasons why older women took up creative occupations during later life, or increased their participation. Participants were recruited through a magazine for older people. Interpretative Phenomenological Analysis methodology was employed and face-to-face/telephone interviews were verbatim transcribed and analysed. Distal and proximal factors as well as serendipitous

events facilitated participation. Distal factors included personal resources: pre-existing craft skills, aesthetic awareness, role models within the family, interest for learning and personal development. Proximal factors focused on the need to fill occupational voids in a meaningful way and overcome restrictions, very often through the support of family and friends. The findings revealed a combination of factors that had encouraged participants to engage in creative occupation after retirement or the onset of illness. A limitation of the study was the sample which represented women from socially advantaged backgrounds with similar lifestyles and a supportive social network. They reported to be either in good health or that they lived with a chronic health condition. The study is important because the participants addressed creative needs through their own resources and not through formal therapy or with the help of a therapist. The creative needs of other social groups remained under-researched.

A phenomenological study by Bedding and Sadlo (2008) explored the experiences of six retired people – four women and two men – without previous experience in painting, who participated in community-based painting classes. The experience of art-making and the social aspect of attending classes evoked positive emotions (enjoyment, fun, sense of achievement) but also presented cognitive challenges (learning new skills and knowledge about material/techniques). The attendance of art classes was valuable because the social environment inspired the participants to engage in art, but none of them continued with painting outside the class. Meeting like-minded people created a sense of belonging from an occupational science perspective. A limitation of the study was its focus on art classes. It was unclear whether the engagement in painting created meaningful experiences in the lives of the participants and long-term effects on wellbeing, because participation appeared to be happening only in the class environment. The sample consisted of a socially advantaged group of retirees (healthy, independently living) and confirmed findings from previous research about the psychosocial effects of working with like-minded people in an affirmative environment.

2.5.4 Participants with no, or a mixture of, self-reported health problems

Table 6 shows an online survey that used a mixed methodology and involved participants who reported to having no health concerns or a mixture of physical and mental health problems.

Table 6: Participants with no, or a mixture of self-reported health problems

Author(s)	Participants	Intervention Setting	Methodology	Perceived effects
2015 –				
Riley, Corkhill and Morris (2013) Internet knitting site	n=3,545 knitters worldwide 3,458 women, 42 men <20-60 years	Engagement in knitting Solitary/ group/ virtual	Online survey questionnaire Skilled, creative occupation	Promoting wellbeing, quality of life Knitting frequency - feeling calm, happy (significant relationship) Relaxation, stress relief, creativity. Psychosocial benefits group: > social contact, communication

Riley, Corkhill and Morris (2013) conducted an online survey with 3,545 knitters worldwide to identify the benefits of knitting and its therapeutic use. The survey instrument was a questionnaire that produced quantitative and qualitative data. Two different software programmes (SPSS 16 and NVivo 8) were used for data analysis. Respondents appreciated the psychological benefits of knitting (relaxation, calmness) and its therapeutic value, which were associated with the repetitive and rhythmic nature of hands-on physical, tactile engagement. Knitting impacted positively on the cognitive abilities of respondents (concentration, thinking, short-term memory), evoked positive emotions (happiness), made use of respondents' creative abilities and helped as a diversion from negative thoughts. Some respondents perceived knitting as stressful, particularly the process of learning new, complex knitting skills.

For members of both virtual (internet) and real time groups, knitting was viewed as a means of socialising and facilitated learning. A strength of the study was the discovery of a significant relationship between frequency of knitting and feelings of calmness and happiness. The skilled process of knitting provided cognitive challenges and might have produced flow-like states in some respondents. The findings of this study confirmed previous research on textile art-making. A limitation of the study was the sample which was self-selected (keen and interested knitters), age (younger age groups), and that it only included English speakers. The authors themselves acknowledged that a revision of the questionnaire was necessary, as some questions produced descriptive answers and could not be used for statistical analysis.

2.6 Summary of the critical appraisal

The majority of studies utilised a qualitative design which was appropriate because they emphasised the exploration of experiences in creative activities. All four groups consisted of samples with predominantly female participants and contributed to gender bias. Several studies reported different levels consciousness through engagement combined with cognitive and creative challenges, skills acquisition and autotelic motivation which were linked to flow-like states (Csikszentmihalyi, 1990). They all referred to earlier research on flow by Mihaly Csikszentmihalyi, but did not take into account recent developments on flow as a complex construct that still lacks a universally agreed definition. Three studies discussed the findings from an occupational science perspective and linked individual determinants of occupation –doing, being, becoming and belonging (Wilcock, 2014) – to the subjective well-being of participants. The critical appraisal of the literature also brought to light the importance of meaningfulness for the chosen activity as a source of motivation. Meaningful engagement produced meaningful experiences that impacted positively on the way people felt about themselves.

In the group that involved participants with mental health problems all but one study (Reynolds, 2000) involved people with severe mental illness. They were living in the community and attended creative activity programmes at day service settings or community centres. The samples consisted of volunteers who also participated in the programmes. Given the lack of community-based resources for this population group, it is not surprising that the findings generated a more positive outlook on the programmes offered. Only one study (Reynolds, 2000) explored a creative activity (needlecraft) as a leisure pursuit. Limitations of the studies were methodological weaknesses such as sample bias, lack of data saturation in grounded theory studies, unclear descriptions of data analysis methods and researcher bias. Engagement in creative leisure occupation as a means to promote subjective wellbeing for people in remission of mental illness remains under-researched and warrants attention. Future research requires the use of different sampling methods, for example purposive sampling, an independent diagnosis of participants' mental health problems, and the inclusion of various social and ethnic groups to capture differing views and experiences about the phenomenon of creative occupation.

The leading researcher in the group with participants living with physical health problems is Frances Reynolds, who contributed her work to all studies except one by Timmons and MacDonald (2008) either as the principal investigator or as co- author.

Five studies employed the same methodological approach – Interpretative Phenomenological Analysis (Smith, Flowers and Larkin, 2009) – but used different population groups. These studies generated similar findings and emphasised textile and visual art-making as a means for positive identity transformation. Participants of all studies were self-selected and recruited through arts and crafts magazines or support groups. The possibility of biased data due to self-selection is likely to occur, with the overrepresentation of certain themes and under-presentation of others. The findings comprised therapeutic effects of occupational engagement such as different types of relaxation (mental/emotional/physical), competence building through skill acquisition (creative and cognitive) and a sense of achievement. Continued occupational engagement showed long-term effects on subjective wellbeing, and supported the re-building of a self-identity beyond the illness through creative self-expression, making inanimate objects and feeling useful. Psychosocial benefits for groups were reported in all studies. One study used a template approach (Reynolds and Prior, 2006) with the likelihood that the authors’ pre-knowledge about the research area influenced data analysis and findings of the study.

The systematic literature revealed gaps in our knowledge and understanding of creative activities and their link to subjective wellbeing. In mental health, previous research involved mainly people with severe mental health problems who used creative group programmes at community-based venues. An under-researched area remains the use of creative activities as leisure occupation and how this affects people in remission of mental illness. Increased understanding and knowledge of this topic would be of pivotal importance for our clinical practice to address the unmet creative needs of service users in an evidence-based effective way.

2.7 Final summary

There were several key or shared points across the 17 reviewed studies. Creative activities, for example making art or working with clay, were carried out as either a solitary or group activity. A socially affirmative environment encouraged creative

occupation and social interaction with others. Deep concentration in the creative process facilitated temporary respite from worrying thoughts and the experience of flow, but it was unclear how flow started and ended. Additionally, clear goals appeared to be absent during the flow experience, but not unexpected discoveries, which Reynolds termed 'creative adventures'. The group format created opportunities for learning and creative self-expression as well as the productive use of time. Creative occupation supported positive identity transformation, for example, to become an artist or maker. The visible process of engagement and the visible product were regarded as opportunities for self-expression and were acknowledged by family members or like-minded people. The psychological benefits included the experience of positive emotions (enjoyment, pleasure), and feelings of relaxation and calmness. Participants described a sense of accomplishment and feelings of pride when they were able to make a piece of artwork. When an arts project reached completion, participants experienced negative emotions (anxiety, distress). Creative leisure occupation was usually described as a solitary activity that filled occupational voids after medical retirement and after the onset of an illness.

The next chapter discusses my methodology and methods which were guided by the refined research question '*What is the lived experience of participation in creative activities for people in remission of mental illness?*' The choice of a qualitative approach seemed appropriate because I was interested to learn more about the subjective experiences of individuals and their views on how their engagement in particular creative activities had helped or hindered them in their remission.

CHAPTER 3 Methodology and Method

3.1 Introduction

In this chapter I will present my chosen methodology for the study. Methodology is concerned with both the philosophical tradition upon which the data collection and analysis are based, and the detailed research methods through which data collection occurs (Haralambos and Holborn, 2013). The chapter starts with the research purpose and question, and continues with my search for an appropriate research paradigm. My interest to explore the subjective experiences of individuals directed me to a qualitative methodology.

3.2. Research purpose and question

In the previous chapter I established the need to investigate the phenomenon of participation in creative activity in a more systematic way. The aim of our study was to explore the experience of participation in purposeful creative activities for people in remission of mental illness, their feelings and reactions towards creative experiences and thus to advance occupational therapists' understanding of the therapeutic potential of certain creative activities. The term 'experience' is referred to as the process of gaining knowledge or skill over a period of time through seeing (observing) or doing things rather than through studying (Crowther, Oxford Advanced Learner's Dictionary, 1995, p. 404).

3.2.1 Research paradigms

My search for a suitable methodology was guided by the research question '*What is the experience of participation in creative activities for people who are in remission of mental illness?*' The research question was developed from my professional and personal interest in the use of creative activities. I was keen to explore this experience from the patients' point of view, because this was thought to be most relevant for our own clinical practice. In order to aptly address the research question, I examined research frameworks or paradigms that would support suitable sampling, data collection and data analysis methods. A worldview or paradigm is a comprehensive belief framework which guides research and practice in the field (Willis, 2007). The systematic literature review revealed a predominant use of qualitative methodologies –

phenomenology, ethnography and grounded theory – with interviews as a frequent data collection method.

In my own clinical practice, the positivist paradigm is the dominant worldview. The emphasis is placed on the diagnosis of a disease and identification of symptoms which allows the clinician to choose from available, scientifically proven, cost-effective treatment options (National Institute of Clinical Excellence, 2006; 2002). Even though the introduction of national initiatives (Department of Health, 2010; National Institute for Mental Health England, 2005; National Institute for Mental Health England and Care Services Improvement Partnership, 2005) places its emphasis on patients' experiences, the current economic climate, with cuts in mental health services compromises this encouraging development (Department of Health, 2014; 2013). In previous years, occupational therapy staff had the financial resources to purchase material and to rent community-based venues to provide solitary and group creative activities for service users.

Despite supporting, yet anecdotal, evidence from local service evaluations, the occupational therapy department no longer has its own budget for meaningful patient interventions. The medical model of disease and the phenomenological approach to personal illness experience are both evident in my clinical work. The patient's illness experience, perceptions and understanding of their mental health problems are currently not completely ignored, but their accounts are viewed by some members of the multidisciplinary team as less reliable information compared to facts which have been obtained with the help of diagnostic instruments, laboratory and standardised tests. The traditional medical view favours physical manifestations of disability and disease whereas Benner (1994), a prominent nurse theorist, regards illness as a human-lived experience of loss and dysfunction which has a reality of its own.

There is a strong belief among qualitative researchers that people give meaning to their unique experiences throughout their life and within their life context, which entails personal stories, relationships, social roles, goals, interests and dynamic interactions with the environment (Nieswiadomy, 2008; Streubert Speziale and Rinaldi Carpenter, 2007; Patton, 2002; LoBiondo-Wood and Haber, 1998). Each person's experience of

health or illness is viewed as unique and of personal significance for her or him (Mattingly and Fleming, 1994; Benner, 1994).

3.2.2 My ontological and epistemological position as a researcher for this study

My ontological position influenced my research question which reflects my epistemology or my beliefs about the relationship between the researcher and the known (Denzin and Lincoln, 2008). Illuminating personal assumptions verbally in discussions with my supervisory team and colleagues, and as written accounts in my research diary, guided me towards the constructivist paradigm which informed the methodology of the research study. Ontology is a branch of thought concerned with the nature and relations of *being* and the question ‘What is reality’ whereas epistemology is a branch of philosophy concerned with the nature and scope as well as limitations of knowledge, and addresses questions such as ‘What is knowledge?’, ‘How is knowledge acquired?’, ‘How do I know?’ (Gerrish and Lacey, 2010; Bauer and Gaskell, 2000; Morse, 1994). Grbich (1999) emphasized the importance of making one’s philosophical assumptions explicit, because they determine the essential difference between quantitative and qualitative research approaches, with data collection and analytic processes following as a logical consequence of these assumptions.

The two main research strategies - naturalistic enquiry and experimental-type research - are underpinned by distinct philosophical traditions. Each of them follows different forms of human reasoning and each of them defines and generates knowledge differently. While some researchers still hold the so-called separatist position (Murphy and Digwall, 2001) with the firm belief that the main research strategies are incompatible, others support the notion that both strategies are equally important and complement each other in health and social sciences research (Cupchik, 2001).

In my research question ‘What is the lived experience of participation in creative activities for people in remission of mental illness’, I view myself situated within constructivism, a qualitative, interpretative paradigm, and to have a relativist ontology, a subjectivist epistemology and a hermeneutic, dialectical methodology (Denzin and Lincoln, 2008). I believe that all points of view regarding this phenomenon are equally valid. Individual participants will bring unique perspectives to the investigation depending on their background and illness experience, but they will all be true and valid

to them. Reality presents itself in a personal and subjective way to individuals, and not just only as a direct experience. Their subjective experience has already been shaped by their interpretation of it and what it means to them. The same phenomenon might hold different meanings for individual participants. A limitation of this position is that each experience is unique for the individual but not representative for the general population. Thinking and reflecting are important elements to gain a deeper understanding of the phenomenon by listening to the participants' experiences, reading and re-reading their verbatim descriptions, and interpreting them through my lens as researcher.

By contrast, logical positivism supports a realist ontology, which assumes that reality exists out there driven by immutable laws (Denzin and Lincoln, 2008). The remit of the researcher is to discover the true nature of reality through the prediction and control of natural phenomena (Norcross, Beutler and Levant, 2007). The positivist epistemology takes an objectivist stance or etic perspective (Patton, 2002; Guba, 1990). The reductionist nature of positivism embraces the notion of a single reality that can be discovered by reducing it into parts (Norcross, Beutler and Levant, 2007). The attempt is made to discover the truth about how things really work through the identification of the cause-effect relationship with clearly defined hypotheses, which are posed and tested under carefully controlled conditions (Niewiadomy, 2008). Karl Popper and other authors criticised the assumption that well-designed experiments could lead to the truth of a specific investigated area because the collected data might not represent reality (West, 1997).

I hold the ontological view that multiple realities of the world exist for patients, staff and others that are relative to their background (Barbour, 2008; Lechte, 1994). I believe that a person interacts with the environment and the people in it, and that a person's experience of the world may contribute towards their mental health problems. When people experience mental ill health, it is pivotal to consider influences of their social context too, for example their lifestyle, their engagement in daily routines and any long-term goals, all of which give meaning to their lives and a sense of personal identity (Abrahams, 2008; Clark and Lawlor, 2008; Christiansen and Matuschka, 2006; Haralambos & Holborn, 2013). Additionally, my professional practice has been influenced by conceptual models of my discipline in which the environment, amongst other factors, can have an influence upon a person's motivational (Kielhofner, 2007)

and spiritual state (Polatatkjo, 2008) as well as occupational performance and occupational engagement.

My own viewpoint has been formed and shaped by my personal and professional background, my experiences with the complexities of life and my interaction in the field of psychiatry. As an occupational therapist, I bring to the patient-therapist relationship my own understanding of the world in which knowledge is constructed from both my own background in society and my professional life. The constructivist ontology strongly supports that reality is socially constructed through interaction with other people (Denzin and Lincoln, 2008). Researchers who share this worldview are committed to study the world from the viewpoint of the individual they are interacting with (Patton, 2002). They aspire to gain a deeper understanding and knowledge of phenomena that create and shape human experiences and are meaningful to individuals, societies and cultures (Patton, 2002).

I believe that an experience will come into existence as a phenomenon of people's outspoken expressed thoughts and beliefs when they describe this experience to me in my role as a researcher. Knowledge about the meaning of this particular phenomenon derives from the person's oral account and my own interpretative capabilities. This form of knowledge acquisition, which creates understanding, is also evident in my clinical practice. Patients who experience an acute mental health problem often display disturbed behaviour that can be observed by staff and measured through the use of rating scores, based on a positivist epistemology. However, to genuinely understand the patient's behaviour as a consequence of their experiences in the world, it is pivotal to interact with the patient through a dialogue and establish a therapeutic relationship in order to get to the patient as a person (Scholes, 1998). The dialogue can help to create a mutual understanding, but I have to acknowledge that I might never be able to fully understand the other person. However, my aspiration for my research was to use my best effort and try to understand the other person's viewpoint as much as possible within a certain time frame. My clinical work as an occupational therapist brings me in contact with psychiatric patients and I am attentive to the meaning of patients' real life interpretations.

My position within the organisation gave me access to patients with mental health needs. In this study, I was interested to explore the lived experiences of patients who were in remission of mental illness, such as depression, anxiety disorder, schizophrenia and bipolar disorder to name a few. The term ‘remission’ for this study was defined as ‘the time that follows an episode of a formally diagnosed mental illness – the full criteria were previously met – in which currently only some of the signs and symptoms remain but less in number and intensity. The presence of a few symptoms may result in a minor impairment of a person’s occupational and social functioning (Ruckli, 2011, letter to colleagues, Rec No: 11/NW/0715, Appendix 3). I anticipated unique but subjectively meaningful experiences of participants that would give us a richer understanding of their engagement in creative activities.

3.3 Phenomenology

My search for a suitable methodology that would fit with the constructivist paradigm led me to phenomenology, which has been described as a philosophy and a research method (Van Manen, 2014; Spiegelberg, 1975; Merleau-Ponty, 1962). The philosophic movement consisted of three phases – the preparatory, German and French phase. In the first or preparatory phase, the concept of intentionality was defined and refined by Franz Brentano (1838-1917) and Carl Stumpf (1948-1936), and later in the German phase by Edmund Husserl (1857-1938). Intentionality describes the inward consciousness and outward appearance of an experience based on memory, image and meaning (West, 1997).

The second or German phase was dominated by Edmund Husserl (1857-1938) and Martin Heidegger (1889-1976). Husserl believed that consciousness needs to be examined as it appears or as pure phenomenon (Annells, 1996), but at the same time he encouraged bracketing or epoche of the natural attitude. This means to set aside or suspend any assumptions about existence or causality of phenomena. The existence or reality of a phenomenon is only perceived within the meaning of an individual’s experience. The search for the essence – the central underlying meaning of an experience or the basic units of common understanding of a phenomenon – is carried out through the method of phenomenological intuition. Husserl believed that experience implies a relationship with something real whereas intuition might also happen in a person’s imagination or memory. Thus mental phenomena have no existence, only an

essence, in Husserl's transcendental phenomenology. The engagement in creative activities was a real, hands-on, meaningful experience for participants, which offered respite from overwhelming and disturbing thoughts.

Two other notions of phenomenology – intersubjectivity and lifeworld – were developed by Husserl's colleagues and students. The former is accessible through empathy and refers to the existence of subjectivities, which are shared by a community – individuals who share a common lifeworld – whereas the latter focuses on the lived experience, which can be examined and described through phenomenological inquiry. Martin Heidegger was interested in ontological ideas, and he developed the notion of 'being' by explaining its nature – being-in-the world and being-with-others – for the human existence. It became a concept of personhood and was linked to temporality. Temporality is different to time and expresses a novel way of perceiving time as now, no longer and not yet. A Heideggerian interpretive phenomenology explores the meaning of being a person in the world and therefore moves beyond a description of a phenomenon into an interpretation of it. The world is described as it is experienced, and preconceptions and presupposition are acknowledged.

Heidegger also elaborated on common phenomenological concepts and developed the interpretive strand of phenomenology, which influenced the emergence of hermeneutics, the theory of interpretation and meaning. The meaningfulness of experience was highlighted by Husserl and Heidegger. In our study, the engagement in creative occupation was meaningful for the individual participant but also for me from a personal and professional perspective (Dreyfus and Wrathall, 2009). The interview was an opportunity for me, the researcher, to get to know the participants' experiences with and interpretations of this phenomenon. I learned about the participants' similar and shared meanings of participation in creative activities, and my chosen method of data analysis, which is based on ideas from Cohen, Kahn and Steeves (2000), was a meaningful way to interpret the collected data.

One of Heidegger's students, Hannah Arendt (1906-1976), was particularly interested in political theory and distinguished between *vita activa*, which consists of labour, work and action - and *vita contemplativa* – the realm of thought or realm of contemplation of the eternal. In her view both are equal in human life. Arendt assumed that work involves

the integrity of fabrication – the process of making which produces an end product that is owned by the maker (creative ownership) and is an expression of oneself (Arendt, 1958). Labour is regarded as a kind of activity that lacks this integrity. Arendt's assumption resembles the notion of work as a therapeutic medium for the treatment of patients in occupational therapy at the beginning of the 20th century. It is interesting to note that the majority of patients who are referred to our occupational therapy department at present regard their engagement in a creative project as 'work' and not as 'therapy' and they express pride when referring to the produced inanimate object as 'artwork' or 'a piece of work'.

Heidegger also became a mentor for Hans-Georg Gadamer (1900-2002) who developed Heidegger's conception of hermeneutics, which is the art of interpretation or understanding. Gadamer viewed phenomenology as a suitable way to access an experience and to illuminate it through conversation between two people. For Gadamer, the essential matters of a phenomenon would come to light through dialogue and mutually created understanding. Gadamer's notion of understanding is called 'fusion of horizon', an emphatic view that human beings are able to reach mutual understanding through consensus. Furthermore, he applied the notion of the 'hermeneutic circle' to texts, in which the reader has an ongoing dialogue with the text of the author to reach a mutual and new understanding of a topic. Contemporary philosophers, amongst them Jurgen Habermas, have criticised Gadamer's hermeneutics because there is a belief that complete understanding through dialogue, either verbal or written, is not possible because one's fore-understanding remains mostly hidden from the other person (Dreyfuss and Wrathall, 2009).

Heidegger also had some influence on the philosophers of the third or French phase, Gabriel Marcel (1889-1973), Jean-Paul Sartre (1905-1980), Gabriel Merleau-Ponty (1908-1961) and Simone de Beauvoir (1908-1986). The concepts of embodiment and being-in-the world were refined and based on the assumption that all human actions (acts) are constructed through the actor's perception or their original awareness of a phenomenon. Sartre's precept that existence precedes essence – existence happens before essence – was also accepted by Beauvoir, who as a feminist existentialist presented ideas around the social construction of 'Woman' or 'the Other' (the Second sex) which she identified as pivotal to women's oppression. In our study, the

engagement in creative occupation was experienced and viewed as a real, being-in-the world phenomenon which offered for some participants an awareness of the present moment with positive emotions, and a connection to reality (Moran, 2008). The awareness of being-in-the world, being in contact with real materials and tools, grounded participants of our study in reality.

Phenomenology is viewed as an approach within continental philosophy (Van Manen, 2014). The philosophical beliefs on which phenomenology is built upon are complex and have been refined over time according to Van Manen (2014). He pointed out that the methodological applications of phenomenology in research remain dynamic and unfolding, and they are the main reasons that different interpretations of phenomenology as a philosophy and research method continue to exist.

Cohen and Omery (1994) outlined different schools of thought in phenomenology, which guide research that aims to gain knowledge about the lived experience of phenomena. There are three major schools: the Dusquesne school focuses on Husserl's eidetic structure and description of phenomena; the second school has an emphasis on the interpretation of phenomena (Heideggerian hermeneutics); and the Dutch school is a combination of both.

The phenomenological method has been described as a systematic, critical and rigorous investigation of phenomena (Streubert Speciale and Rinaldi Carpenter, 2007) that are important to allied health disciplines such as nursing, midwifery, psychology, physiotherapy and occupational therapy (LoBiondo-Wood and Haber, 1998). It investigates subjective phenomena, believing that the essence of reality is rooted in the person's lived experience (Todres and Wheeler, 2001). It does not attempt to provide a causal explanation for the experience, but searches for unity of meaning revealed through language (Lawler, 1998). Phenomenology supports constructivist beliefs that a person's subjective experience is pivotal to revealing reality as well as the existence of multiple realities (Bolton, 1987). Todres and Wheeler (2001) discuss the application of the various concepts of phenomenology in research such as grounding – the lived experience in the lifeworld as the starting point of inquiry, reflexivity – human beings are viewed as self-reflective persons of everyday life with personal relationships and experience within a temporal and historical context (body, time, space) as well as their

own position being-in-the-world. In our study, some participants had experience of creative occupation prior to the onset of the illness whereas others were introduced to it during a hospital stay. The relationship with others supported participants to become initially involved and encouragement by others was valued, particularly after episodes of illness with severe disruptions to people's lives. The actual experience of creative occupation was not only described but also interpreted and reflected upon, and generated personal knowledge and understanding for the individual. For one participant, creative engagement was a means for reflection on meaningful events that had happened to him and had evoked positive or negative emotions.

The original works of Husserl and Heidegger are intellectually challenging to read but the exploration of the original work contributes towards rigour in the chosen methodology (Koch and Harrington, 1998). Husserl's phenomenology represents a mechanistic view of the person, known as Cartesian duality or mind-body split (West, 1997) and it describes the study of the phenomena as they appear in our mind through consciousness (Koch, 1995). Husserl's viewpoint suggests that the self as subject passively observes the world as an object and understands the world as cognitions developed in the mind (Leonard 1994). It takes an epistemological stance and determines experience expressed through human consciousness as the ultimate meaning of knowledge (Moran, 2008). Additionally, this epistemological view ignores the impact of culture and history on how a person comes to know the world and it does not correspond with my beliefs about the uniqueness and diversity of people and the contribution of a person's background to their experience. Husserl suggested that the concept of lifeworld is not easily available to human beings because it consists of what we take for granted (Rose, Beeby and Parker, 1995). His intention was to reveal essences, thoughts, feelings and perceptions of a phenomenon through an accurate description of the participant's everyday lived experience. Essences are elements that give true meaning and common understanding of the phenomenon (Streubert Speziale and Rinaldi Carpenter, 2007).

Husserl demands that the researcher employs a process of bracketing in order to reveal only the participants' essential knowledge about the phenomenon. He supports the notion that it is possible to detail a pure description of the phenomenon through this reductive process. I found it very difficult to adhere to the notion of reduction, because

my mind would just wander off and find all kinds of associations. However, the more I immersed myself in data, the better I was able to focus my attention to the text. Keeping a research journal made me aware of my fore-knowledge and regular meetings with my supervisory team and feedback from them, helped me to be careful and avoid imposing my fore-knowledge onto the data.

Heidegger reacted against Husserl's epistemological stance from an ontological position (Koch, 1995) and was primarily concerned with what it means to be a person and how human beings come to understand the world (Moran, 2008). He took a philosophical turn from consciousness to existence and influenced the French philosophers and existentialists Sartre and Beauvoir. Heidegger employed a way of thinking about nature that remained faithful to the historical, lived, practical nature of human experience and introduced two essential notions, the historicity of understanding and the hermeneutic circle (Koch, 1995). He believed that the world is encountered, questioned and interpreted based upon one's historicity, or forestructure, and the social situation of the experience (Draucker, 1999), shaping one's experience of the world. Time is considered to be dimensional rather than a linear concept in Heidegger's viewpoint and he refers to temporality, which he describes as being-in-time (Leonard, 1994). A person's past (having-been-ness) and their expected future (being expectant) contribute to their current existence (Koch, 1995). In hermeneutic phenomenology, a person is seen as trying to gain an understanding from their past experience of the world and a projection of their future in the world (Cohen, Kahn and Steeves, 2000). This means that the person is constructing and is being constructed by their world through interaction with it (Koch, 1995).

Hermeneutic phenomenology supports my belief that people living with mental health problems use their historicity to engage in creative activities. Two notions, the 'fusion of horizon' and the 'hermeneutic circle' appeared relevant for my research question. Fusion of horizon is relevant for the dialogue between people through both verbal words and written accounts, and the hermeneutic circle is applicable to reading and interpreting a text. I felt comfortable to acknowledge my subjectivity and fore-understanding and employ strategies to make them transparent not just to myself but also to others through writing about it and verbal exchange. Overall, it was important for me to maintain the authenticity of the participants' verbatim transcribed accounts

and I used the following strategies: I kept a research diary, arranged regular meetings with my supervisory team, produced meeting reports with reflective accounts, had regular discussions with members of the Service User Forum, presented findings of my data analysis to a team of occupational therapists and answered their questions about my research in open forums at my workplace. Hermeneutic phenomenology holds a relativist ontology. Being-in-the world is constructed by human actions and how the individual person perceives these actions as experiences. It embraces the view that different people's backgrounds produce different, but equally valid knowledge about how to become engaged in creative activities and therefore fits the constructivist paradigm (Dezin and Lincoln, 2008).

3.4 Ethical considerations

It is important to consider ethical principles in any type of research. These principles are summarised by Beauchamp and Childress (2009) as follows: the respect of autonomy, non-maleficence, beneficence and justice.

The principle of respect for autonomy obligates the researcher to ensure confidentiality. Any information that may reveal the identity of participants was removed from the transcript. The only people who had access to the data were my supervisory team, the person who transcribed the interviews and myself. The interviews were digitally recorded and then transferred and stored on a password protected USB drive in a safe place in my office at the research unit.

The principle of non-maleficence is the researcher's obligation not to act in ways that may harm others. Ethical conduct aims to maximise participants' well-being whilst minimising discomfort. The information sheet that was given to participants detailed the time commitment and the location of the interview. I had to take into consideration the psychological protection of the participants. The care-coordinator of each participant was on site when the interview took place at Trust premises (workshop, out-patient department, my office). Three participants preferred to be interviewed at home and we arranged for the care coordinator to be available by telephone for the time of the interview and afterwards. All interviews were carried out without causing any distress to the participants.

My professional background underpins the communication and interactive skills essential to the research interview method. Poor interview techniques may evoke discomfort in participants. I felt obliged to offer an empathetic, non-judgemental approach for the interview and debriefing for participants after completing the interview. Debriefing entails the provision of time and space to answer questions about the research process and reassurance for participants that they had control over what will be included in the study. I found the experience of interviewing as an occupational therapist and researcher different. As a researcher, I had to learn to demonstrate patience and hold back prompting questions when a participant required more time to complete a sentence, or was still thinking about what had been said. I learned to really listen to people and give them the time they deserved to being listened to. In my clinical practice, I have to think and react quickly and there is always the pressure of time to see as many patients as possible. I believe that my research experience has made me more attentive and a better listener in my clinical practice.

Beneficence is a moral obligation to act in ways that promote the well-being of others. The anticipated benefits of my study were predominantly for patients and professionals, and therefore for the greater good. No financial incentives were driving the study. I was encouraged by my employer to maintain an open and curious attitude throughout the conduct of the study and to safeguard the wellbeing of all participants.

Justice means to treat others in fairness. Any potential feelings of coercion had to be addressed and minimised prior to the conduct of the study. Staff from community teams approached volunteers providing them with invitation letters with an enclosed information sheet of details about the study. They were asked to contact me directly if they required further details. This process ensured voluntary participation and promoted feelings of safety. Written consent was obtained prior to the interviews and a copy provided for the participant. Informed consent in qualitative research is of eminent importance because the conduct of an interview might bring to light personal and upsetting details which cannot be predicted beforehand (Kvale and Brinkmann, 2009). Safeguarding procedures were put in place in order to avoid any potential harm to participants. We arranged for the care coordinator to be present on site or to be available on the telephone during the interview and afterwards. Participants were reassured that they had the right to withdraw from the study at any point without fearing any impact

on their treatment because their participation in the research study remained on a voluntary basis.

Our study received ethical approval from three ethics committees, the Faculty of Health and Social Science Research Ethics and Governance Committee (FREGC), University of Brighton; the National Research Ethics Service (NRES) Committee North West – Greater Manchester North and the local Research and Development Committee, Department of Psychiatry, University of Oxford. Ethical approval for a study that involves human beings is pivotal to protect their rights, safety, dignity and wellbeing. The aim of ethics committees is to facilitate ethical research that is of potential benefit to study participants, science and society.

3.5 Rigour

The term ‘rigour’ in qualitative studies is often used to describe the quality of the research process and the relevance of the research (Braun and Clarke, 2013; Finlay, 2006). While Tobin and Begley (2004) propose that the presentation of rigour in research determines integrity and competence, Whittlemore, Chase and Mandle (2001) argue the need for maintaining a balance between the researcher’s creative ability to gain new insights and her or his accomplishment of a rigorous research approach.

Four considerations for rigour were suggested by Ballinger (2006): coherence between the study’s aim and design; systematic and careful research conduct within the chosen methodology; relevant and convincing interpretation, and the researcher’s role. Another way to appraise the quality in naturalistic research is the use of Lincoln and Guba’s concept of trustworthiness (1985). The concept includes credibility, dependability, transferability, confirmability and authenticity (Guba and Lincoln, 1989), which I will discuss in the following paragraphs.

Credibility in our study was demonstrated by the way the research problem, the setting, the participants and complexities of interactions were described and how they generated findings that made sense to an immediate audience that consisted of the participants, members of the Service User Forum, colleagues, my supervisory team and me, the researcher. The thoroughness of my recruitment approach was evidenced by the approved research proposal and its inclusion and exclusion criteria for a purposive

sample. A confirmed diagnosis of mental illness for each participant contributed to the rigour. The research proposal was accepted by three research ethics committees and actively involved colleagues from community mental health teams across two counties who recruited volunteers into the study. The findings of the study consisted of four main themes and four subthemes that underwent numerous revisions through an iterative process that I employed in the data analysis with members of the Service User Forum and colleagues. Furthermore, the revisions of themes were discussed and further refined in meetings with my academic supervisors.

Dependability refers to the conduct of the study and the way I documented in my research diary the decision making throughout the research process. I had the opportunity to discuss areas of concern in supervision and enhance the credibility of the study by a refined understanding of the phenomenon. Transferability describes the usefulness of the study's findings to others in similar situations who might ask similar research questions. Vignettes of the participants provided a rich description of their individual circumstances, interests and roles without compromising their anonymity. A description of the participants' engagement in individually chosen creative activities also included the setting – home, studio, community setting – in which creative occupation took place. The participants were volunteers who were assured prior to, and at the beginning of, each interview that they were under no obligation to take part in the study and that if they felt uncomfortable they could leave the interview without reason or fear that their care would be compromised. All three ethics committees approved the Participant Information Sheet (Appendix 5) which explains the study, the interview questions and any impact on the participants.

Confirmability includes my own position and influence on the research process which I documented in my research diary and discussed in supervision with my supervisory team. I will discuss reflexivity in more detail in the next section. Authenticity is concerned with fairness and requires that the research will lead to an increased understanding of the phenomenon as well as action, for example the application of the findings to clinical practice. My use of the iterative process in the analysis of data with members of the Service User Forum and colleagues ensured that my interpretation of the data was scrutinised and refined.

3.6 Reflexivity

3.6.1 Pre-knowledge of the research topic

I have been working as an occupational therapist in the field of psychiatry for more than 20 years and have acquired what is called in the phenomenological tradition ‘pre-knowledge’ that relates to my clinical practice. I am aware that this type of knowledge can influence the way I interpret my research findings. The importance of addressing pre-knowledge was highlighted by nursing researchers (Giorgi, 2000) and it means that I am required to lay open to the reader my own assumptions, biases and beliefs of the phenomenon under investigation. The focus of my research was to bring to light participants’ lived experiences of participation in creative activities. The inclusion criteria ascertained that participants took part in creative activities prior to the interview. My pre-knowledge of participation included my experience of participating in a community-based arts group with patients, staff and artists. I had knowledge of some articles about participation but I did not know what meaning the research participants had attached to their experience of participating in creative activities.

My own experiences of working with clay, drawing or making a collage, facilitated the acquisition of personal knowledge about their relaxing effect, an understanding of the reasons why I like doing it and continue to do so, what it means for me if I don’t have time to take part in it, what alternatives I have to being creatively active and the reasons why this is important for me to know. Sharing my experiences and insight with family and friends means that they learn more about me and it helps them to understand me a little better as an individual, but it also defines me as an individual person within my social network. If I am unable to take part in any of my preferred creative activities I find something else to do, usually a physical activity such as running, swimming or cycling. These are my favourite activities because I find that they help me to concentrate on the present moment and become more attentive to the natural environment around me. It is important to make my personal knowledge, my assumptions, observations and biases known to the reader so they can judge if this pre-knowledge has influenced the research findings. My awareness of the present moment or the ‘here and now’ could have influenced the way I looked at the data, perhaps to find similar accounts in them. The lengthy time I spent immersing myself in the data, the application of the hermeneutic circle, and the discussions with my supervisory team,

members of the Service Forum and colleagues, helped me to be aware of them and keep a written account in my research diary.

Gadamer's notion of 'Fusion of Horizon' (Cohen, Kahn and Steeves, 2000) was relevant in the direct verbal interaction during the interview between me and the participant and I, as well as later during textual analysis. My interaction with the written text happened through reading, re-reading, interpreting and revising my interpretations several times. The notion of the hermeneutic circle (Moran, 2008) was another theoretical concept that became important for the research process. In order to understand a text hermeneutically, I had to develop an understanding of the text as a whole by referring back to the individual parts of the text and *vice versa* (understanding each individual part of the text by reference to the whole). This circular movement between the whole text and parts of the text might be an ongoing process without a definite ending. However, I found that placing the text within its historical and cultural context restricts the hermeneutical circular movement. It made me aware that my findings are only a snapshot of what can be known at a certain time and that I had to consider the concept of temporality as another important element in my research findings.

In my clinical role, it is not often possible to set aside time to discuss with service users their preferences or alternative treatment options, such as occupational and creative interventions. Additionally, funding for these interventions remains limited. Our team has been working alongside artists with patients who are in remission of mental illness for nearly a decade. It is fascinating to observe the change in patients' behaviour, and the re-emergence of their social skills and creative abilities when they are able to make something during a creative group activity. Even small achievements are expressed with pride and enjoyment. I was interested to investigate the phenomenon of participation in creative activities as part of my professional doctoral course with the aim to gain a better understanding of it and to share my findings with colleagues, patients and the wider public. I developed a professional interest in learning more about the therapeutic use of creative activities, particularly the reasons why, for some patients, certain creative activities have played a major role in their remission from mental illness but not for others. I think it depends on the individual interest what kind of self-expression they are drawn to and select to use.

Furthermore, I hold a personal interest in certain creative activities such as ceramic work, drawing and painting, and take part in them in my pastime as often as I can. I like the physical aspect of it, the different techniques I can use to produce a piece of work on paper, on a canvas, or in clay. Sometimes, I do a painting and sometimes I just experiment with colours, because I want to know what the colours look like when mixed together. Getting involved in any of these creative activities helps me to relax, I enjoy doing it and I feel pleased if I can produce something that looks good. Even if a piece of work turns out differently as I imagined, I still have a good feeling about it and I either leave it as it is, or I try to change it and use it for something else the next time. Over time, my preferences changed and if I am not able to pursue any of these creative activities actively, I still make the time and visit galleries and museums in order to see other people's work. If I don't pursue any of these occupational and creative opportunities for a longer period of time, I know something important is missing in my life. I would make the conscious effort to find time because I know that neglecting my creative needs would show a negative impact on the way I feel (under pressure, tense) and I would make a conscious effort to rectify this imbalance in my life.

3.6.2 Relationship participant-researcher

Another influencing factor upon the research process, which I had to be aware of, was my dual position as a therapist and a researcher during the interview with participants. I was encouraged by my supervisory team to balance the possible effect of a power relationship with participants by making it absolutely clear that their rights of anonymity and withdrawing from the study at any point were secured without having an impact on future statutory service provision. By contrast, my interviewees held the power in the research partnership because they were the only people who knew the world they were living in and experiencing.

3.7 Management of the research process

I had regular supervision meetings with my academic supervisors in order to discuss difficult issues with them, report on my progress and ask for their advice if I experienced obstacles to move forward in my work. Additionally, the involvement of members of the Service User Forum helped to refine the research question and the findings of my research. We held regular meetings at a local community centre and the members of the Forum commented on my research proposal, gave me feedback on the

presentations I had prepared for the Annual Doctoral Conference at the university or for trust-wide study days for allied health professions. Feedback from people who were interested in my work was invaluable and generated stimulating discussions throughout my doctoral course. I received feedback on the progress of my research from colleagues and students through informal discussions, from the Trust Lead Occupational Therapist in my professional supervision, and from my family and friends.

Furthermore, I kept a reflective diary and notes; I produced several concept maps which were regularly refined as the work on my doctoral thesis progressed. I could see how my understanding of the phenomenon kept changing over time. I also had to keep in mind that there was a definite end point of this process which was determined by the submission date of the thesis in June 2015. The interview data were stored electronically and as printouts, and I always made electronic copies of my written account as a precaution in case the computer system or the electricity went down.

3.7.1 Sampling method

The process of selecting representative units of a population for a study is called sampling (Cresswell, 2014; LoBiondo-Wood and Haber, 1998). I considered my chosen population group as ideal to produce rich data because they had first-hand experience and knowledge of the phenomenon of interest (purposeful sampling). Sample size is a common concern for researchers especially for those following a positivist research tradition (Silvermann, 2014). Phenomenological researchers view a sample size of ten to fifteen as adequate, in particular if the informants have lived the phenomenon and can articulate their experiences (Lawler, 1998; Ray, 1994). I aimed for a minimum of ten participants in order to ensure that the breadth of the collected data for analysis was not compromised (Cohen, Kahn and Steeves, 2000). In hermeneutic studies, the temporality of truth is emphasised (Moran, 2008) and regarded as always incomplete (Lechte, 1994). Phenomenological studies are very time consuming; it is therefore important to acknowledge the need for a balance between the practicalities of conducting the study and adequate representation of informants with the lived experience.

Mental health staff in central England were asked in a letter (Appendix 3) written by me, the researcher, to offer their help as recruiters and invite interested volunteers to consider taking part in the proposed study. Staff had been chosen because they worked

closely with potential research participants in the community and had acquired in-depth knowledge about them through their regular encounters such as follow up appointments at clinics or community-based settings. Furthermore, they had access to patient-related information – such as personal details, diagnosis, mental illness history, test results and so forth – through electronic databases and they also contributed through progress notes about their patient-related work. The letter indicated how to invite interested volunteers who fit the inclusion criteria for the study. The inclusion criteria had been developed in collaboration with members of a local Service User Forum through several discussions:

3.7.2 Inclusion criteria

Individuals

- Who were aged 18 years and older.
- Were in remission from an episode of a formally diagnosed mental illness (full ICD-10 diagnosis criteria applied) such as depression (F32), bipolar affective disorder (F31), anxiety disorder (F411), mixed anxiety and depression (F412), adjustment disorder (F432), panic disorder (F410), phobic disorder (F40), bereavement disorder (Z63), reaction to severe stress (F431) including those who had had an admission to a mental health unit due to a formally diagnosed mental illness (full ICD-10 diagnosis criteria applied).
- Were living in the community.
- Were known to community mental health staff such as nurses, occupational therapists, social workers, consultant psychiatrists, junior doctors, and clinical psychologists, who monitor their mental health through mental health assessments and outcome measures (for example the Mental Health Clustering Tool) at regular follow up visits, and were judged by them as having the mental capacity to give informed consent to research participation. The researcher was informed immediately if a volunteer was no longer able to participate due to relapse symptoms or an overall deterioration in their mental health.
- Were actively participating in meaningful creative activities.

3.7.3 Exclusion criteria:

1. Individuals who did not have the mental capacity to give informed consent for study participation as judged by mental health staff.
2. Individuals who had been living in the community after being discharged from a mental health unit less than three months ago.
3. Individuals with palliative care needs.
4. Individuals with complex co-morbidity.
5. Individuals for whom the researcher in her clinical specialist role had current /had clinical responsibility.
6. Individuals who were professional artists/crafts practitioners, who earned a living by selling their arts and/or crafts products and were viewed as having highly developed skills and expert practice in comparison to individuals who engaged in purposeful creative activities for recreation.

Interested volunteers who met the inclusion criteria were given a participant invitation form (Appendix 4), a participant information sheet (Appendix 5), and a participant consent form (Appendix 6) by community-based mental health staff. If they agreed to take part, or wanted further information, they could get in contact with the occupational therapy team secretary after a maximum two-week period of considering their options, to leave their contact details. I, as the researcher, would return their call within a week of their contact and provide further information. Consent was obtained verbally and by means of a written consent form signed by both the participant and myself, the researcher, to ensure understanding as well as a record of consent. Participants were assured of confidentiality and no participants' names were recorded or used verbally during the study. Participants recruited to the study were interviewed once (minimum of one hour, maximum duration of two hours) and at the end of each interview the participant was offered a summary of what was being said and was asked to add their comments, if they wished, to the summary. Each interview session ended with the participant sharing her or his artwork with me. I was allowed to take photographs of some artwork but I had to respect each participant's right to decline the offer for photographs to be taken.

3.7.4 Data collection

Interviews and research diaries (Streubert Speziale and Rinaldi Carpenter, 2007) were used as data collection methods. Additionally, I had regular meetings with my supervisory team as well as with members of the Service User Forum in order to discuss my progress and to review my growing knowledge and understanding of the phenomenon under investigation. Interviewing is in concordance with constructivism because the researcher and participant mutually engage in constructing meaning (Silvermann, 2014), and the participants can provide in-depth and rich data about their lived experience through stories (Cresswell, 2014; O’Leary, 2009; Plager, 1994). A basic belief of the hermeneutic phenomenological method is that consciousness directs us towards understanding our experience (Moran, 2008) and the lived experience itself is viewed as the participant’s ontological self-interpretation (Burch, 1989), followed by the researcher’s systematic interpretations about the phenomenon (Bolton, 1987), with the anticipated outcome being to create a mutual understanding of it (Gadamer, 1990).

Open-ended interviews with an interview guide were employed to gather information from the informants. Each participant was asked to describe a relevant experience of participation in a creative activity as fully as possible. The nature of the interview was conversational and based on reciprocity to develop trust which is essential to collect closely held, tacit information (Kvale & Brinkmann, 2009). Digital recording provided an accurate record of conversation, but I also made observer notes to capture non-verbal details (Priebe and Slade, 2002; Summerskill, 2001). Two hours were set aside to allow participants plenty of time to share their experience. The interview schedule was designed to follow a supportive interview process (Kvale and Brinkmann, 2009) and the interview style was one of a guided conversation about a topic of mutual interest. My engagement in the same interview schedule supported an empathic approach to an interview with participants who were still regarded as being vulnerable in their remission of mental illness. As an experienced clinician working in the field of psychiatry and trained in interpersonal psychotherapy, I had a range of interview skills which I was able to use adequately.

The lived experience of participants was studied in retrospect and still held meaning for the person (Moran, 2008; Munhall, 1994). A retrospective approach asked for verbal

accounts of events to be told (Patton, 2002) about what the participants had already interpreted (Giorgi, 2000; Annells, 1996). Verbal responses were told as a spoken account of events and an opportunity to live through an experience again especially in one's imagination and to recreate the feelings from this particular situation. I accepted help from administrative staff for the verbatim transcription of all audio-taped interviews, but I always checked the transcriptions for accuracy. All interviews were done together without analysing them one by one. In order to improve the accuracy, authenticity and trustworthiness of the data collected through interviews and remain true to their content, I checked the transcriptions several times by listening to the audiotapes and reading the transcriptions. This process also facilitated my immersion into the data.

3.7.5 Hermeneutic phenomenological approach to data analysis

The data analysis of my hermeneutic phenomenological study followed the approach set out by Marlene Z. Cohen, David L. Kahn and Richard H. Steeves (2000, p. 76-82) who provide guidance on the process of hermeneutic phenomenological analysis. This was helpful for me as a researcher and I decided to use the authors' guidance for the analysis of my data.

I decided to use Cohen, Kahn and Steeves' hermeneutic phenomenological approach because I was convinced that the application of the hermeneutic circle would produce findings that made sense to my audience and would be relevant to my clinical practice. To achieve these two aims, I employed an iterative process with the participants, members of the Service User Forum and colleagues. I received feedback on the early meanings from the participants themselves at the end of each interview, and thereafter from the others in meetings and presentations over a prolonged period of time. I learned to use words carefully and attempted not to impose my own knowledge and understanding onto the data. The process of being reflective and using reflexivity at all stages of the research process contributed to the rigour of our study.

I considered utilising another interpretive approach to data analysis – Interpretative Phenomenological Analysis (IPA) – which was devised by Smith, Flowers and Larkin (2009). This approach emphasises the pivotal role of the researcher in the interpretation of data and her or his prior knowledge of the phenomenon to allow a higher theoretical data interpretation. I aimed to employ a collaborative style in the data analysis with

participants, members of the Service User Form and colleagues, who gave constructive feedback and challenged the use of jargon throughout the research process and decided against the use of Interpretative Phenomenological Analysis. The findings of our study were refined several times and reflected a mutual understanding of the phenomenon under investigation. I used my own theoretical knowledge in the discussion chapter where concept maps were produced that contained a form of higher conceptualisation of the themes.

Cohen, Kahn and Steeves (2000) describe a non-linear, iterative analytic process that starts with data collection. The researcher constructs a so-called field text through the activities of data collection, for example interviews and observation, and starts reading the text which, according to the authors, stimulates early analysis and interpretation of its meaning. The analysis ends with the construction of a text, which is '*understood as tentative and historically bound*' (p. 71). The text represents the findings of the hermeneutic phenomenological study and puts into words the researcher's present understanding and interpretation of the data to the reader. The analytic process, according to Cohen, Kahn and Steeves (2000) consists of a loose order of phases:

- Start of analysis during interviews.
- Immersing oneself in the data.
- Data transformation.
- Thematic analysis.
- Writing and re-writing of a logical text that represents the findings of the hermeneutic phenomenological study.

The loose order of phases reflects the idea of the hermeneutic circle as a way to interpret the data. The hermeneutic circle is viewed as a dialectical process (Gadamer, 1990) that creates understanding by reading the whole text, followed by parts of the text and *vice versa*. Furthermore, the individual texts are understood in relation to all texts and *vice versa*.

Cohen, Kahn and Steeves (2000) add some details to the description of each phase with examples from their own research work. However, they are keen to point out that their approach to conducting analysis is '*not the only way*' to do it, '*as individualised styles are developed with experience*' (p. 72). I found this statement encouraging, because it

suggested a flexibility to adapt their process of data analysis to my own individual style if required. I found it helpful to use concept maps because this gave me an opportunity to see how my understanding of the phenomenon developed over time. I started with terms from my clinical practice such as ‘participation’ or ‘creative activities’ but realised that participants used ‘involvement’ and the actual activity by name instead – painting, drawing, working with clay, making woodwork, playing a musical instrument. According to Cohen, Kahn and Steeves (2000), analysis of the participants’ meaning begins during the interview as the researcher listens to the accounts of their experience, thinks about the meaning of what is being said and begins to orientate to the interpretation. The authors suggest that possible labels for these early meanings are constructed during this phase as well as labels that result from the multiple readings of all transcripts. These labels can be validated with the help of others.

The next phase entails reading and re-reading the transcripts numerous times. This helps to immerse the researcher in the data and orientate to the essential characteristics of each transcript, which are immediate and drive later coding. Data transformation or data reduction (p. 76) occurs during the next phase. The researcher edits the transcripts as she simplifies the spoken language of the participants, and removes digressions and verbal ticks. After editing is completed, each transcript is subject to line-by-line coding. The researcher attempts to gain an understanding of the whole text, underlines phrases in the text and writes theme labels in the margin of the text. The data are then examined line-by-line. The researcher extracts passages with similar themes and looks at them together and alongside passages with the same theme label that are separated from the rest of the text. Finally, the reflective process of writing and re-writing is fundamental when conducting a hermeneutic phenomenological research project. Gaining insight and a tentative understanding of the meaning of the participants’ experience can be explained through exemplars – *‘textual data in the language of the participant that capture essential meanings of themes’* (p. 80).

3.7.6 My approach to data analysis

In our study, participants were asked to talk about their experience of participation in creative activities. Each interview with participants was centred on three questions and was held in a dialogical manner, with prompts provided by me if necessary. Participants knew these questions in advance because they were mentioned in the participant

information sheet they had received (Appendix 5). The hermeneutic circle was used during every phase of the process of data analysis and when I started moving from the whole text to the individual parts of the text and *vice versa*, I brought my fore-understanding to it. I had written my fore-understanding of creative activities prior to the beginning of the study and soon began to understand that this account was only a snapshot of my understanding about the phenomenon at this particular point in time. The dual role of researcher and occupational therapist made it a challenge to label themes with the use of participants' words rather than imposing my professional terminology onto them.

Our study encouraged participants to bring to the interview an object – or photograph of an object – that they made during a specific time of their remission and talk about the feelings they were experiencing whilst making the object. Individual participants did not want to interpret their work or add any explanations to it. For one participant, Nick, drawing was a way that enabled him to deal with his worries because he could just *'put it down on paper and forget about them and come back to them and they're still there, once they're on paper they're one step away from your head aren't they?'* I wanted to acknowledge the participants' artwork as a contribution to our research because it helped participants relax and they were able to share their accomplishments with me as the researcher. I accepted that Emma, Peter and Charlotte regarded their artwork as personal property which they did not want to share with the wider public. However, they gave me permission to use a photographic image of their artwork and I included their contribution with the artwork of other participants in the appendices of the thesis. I wanted to protect the participants' anonymity and I only offer a general description of the artwork without the name of the individual artist (Appendix 16).

During the first three interviews all of my attention was turned towards what the participants said and how I could keep the conversation going. After finishing each interview, I set aside time to document my impressions and thoughts of what had happened (Appendix 7). Sometimes, I was able to think about the meaning of what was being said during the interview, and wrote a few words down – I called them possible labels – for example 'struggle', 'expression of feelings, thoughts, ideas' and 'support by others'.

The next phase had an emphasis on reading and re-reading the transcripts several times. A staff member of the administrative team transcribed each interview, usually within three days of completion of the interview. An example of a transcript can be found in Appendix 8. I always checked the accuracy of each transcript by listening to each interview several times and comparing it to the text in front of me. This helped me to familiarise myself with the data and facilitate immersion.

During the data transformation phase, verbal ticks, *ehms*, and *mhms* were removed. The data were carefully edited this way, because it was important to present the fullness of the spoken work. I did not remove 'you knows' because they appeared to be an expression of the participant's sense of shared understanding with me, the researcher. I removed names of towns and villages, and the names of day centres, hospitals and museums to protect the confidentiality of participants. I interpreted the term 'essential characteristics' as important features within a text (Appendix 9) and put them into red ink. Overall, only a minimal amount of each participant's accounts was removed, usually when they seemed to move slowly away from the main topic of conversation. An example of a digression can be found in Table 7 (Appendix 10). I kept copies from each unedited transcript so that I could refer back to the whole text if necessary.

Eventually, the text was ready for line-by-line coding and thematic analysis. Each transcript was numbered (1-10) and pseudonyms were given to protect the participants' confidentiality. The transcripts were then line-numbered. Each transcript was subject to line-by-line coding. I interpreted the descriptive features of the analysis as the participants' descriptions, containing phrases and specific words, which I highlighted. The interpretive features were my interpretations of the participants' experiences and captured as theme labels which I wrote in the margin of the text. Revision of codes and labels took place many times through an iterative process. It reflected my changing understanding of the individual lived experience in the context of the wider lived experience and *vice versa*.

Table 8 (Appendix 10) shows an example of early coding in which the textual data had been split into small meaning units and coded. In this narrative account, I first understood that Peter, one of the voluntary participants of our study, had a likeness for particular drawing materials, techniques and types of drawing. Table 9 (Appendix 10)

shows how my interpretation changed over time, set within the context of his experience with creative activities.

The final code had changed to 'preferred style' which included Peter's liking of the techniques and material. It was combined with the code 'your own style' that appeared later in the text and I wrote the theme label 'preferred personal style' in the margin. The codes were revised several times until I thought that they reflected the experience of the participants. I copied each interview onto a different coloured paper and cut out of the text individual statements and paragraphs of meaning. I placed the cut-outs with similar themes together on a large desk, compared them and labelled them by writing possible theme labels beside the cut-outs. Sometimes there was a mismatch between the coded meaning and the theme labels. This meant that I had to re-examine the coding, as well as the other theme labels, until I thought that the theme label reflected the meaning. Whenever I moved pieces of text between theme labels I recorded the movements on the text to keep a visible evidence of my decisions (Table 10, Appendix 10). The individual text was located against the theme label 'Afterwards' during early coding. As thematic analysis continued, the text was moved to the theme label 'Effect of engagement', which had developed over time and now contained the effect during and after participation. Individual statements of meaning were put together under the theme labels. The theme labels were reviewed for similarity and shared meaning and movements of theme labels were documented. Overlapping theme labels were condensed until the final understanding emerged as themes and subthemes. I took photographs during the process of data analysis and examples of photographic images can be seen in Appendix 11.

I began to understand, during the process of writing and re-writing, that certain words held different meanings for the participants of the study and me. By conducting the study, I learned that the participants used 'doing' instead of 'participating' and the terms 'to get involved', 'to become absorbed', 'to become immersed' referred to the level of engagement. I also noted that participants did not use the word 'creativity' or 'creative activity' but referred instead to creative ability and painting, drawing and making a piece of artwork.

During the early phases of data analysis, I had identified sixteen tentative theme labels, which were refined as my understanding of the meaning of the whole data and parts of the data deepened. Members of the Service User Forum and occupational therapy colleagues commented on the tentative themes and made suggestions how they could be fine-tuned. Discussions with my supervisory team: Professor Sadlo, Dr. Martin and Dr. Wright led to further refinement. Table 11 shows the refinement of the sixteen tentative theme labels into twelve theme labels.

Table 11: Refinement of theme labels

Theme label	Tentative theme label
From non-action to action	Getting started
Having something to do	Doing something
While doing	Stopped doing it
Really making something	Finished piece of work
	Turning out differently
Working with others	Contact with services
Support from others	At home on her//his own
Working at home	Going to the studio, centre
Going to places	Sharing with others
Overcoming struggle	Preferred style
Personal preferred style	Difficult to get started
	Learning to do it
	Interest
Effect of engagement over time	Beliefs about self
Personal significance and meaning	Personal meaning
	Routine

The twelve theme labels led to the construction of four themes and initially six subthemes (Table 12).

Table 12: Construction of themes and subthemes

Theme	Subtheme
Engagement in a creative activity	Action of doing Being in the moment of making
Engagement with people and places	Being with people Being at places
The need to express oneself and be known	The need and struggle for self-expression
The significance of continued engagement	New experiences

Finally, the latter themes and subthemes were revisited after discussion with the examiners in my viva. The subtheme ‘The need and struggle for self-expression’ was merged with the third theme and the subtheme ‘New experiences’ was combined with the fourth theme. The final four themes and subthemes will be presented in Chapter 4.

The final phase focused on writing and re-writing the whole text (Cohen, Kahn and Steeves, 2000). The text contained individual pieces of data that captured the essential meaning of the themes. The findings were presented in the theme and quote method (Cohen, Kahn and Steeves, 2000, p. 96), meaning that the themes were stated and, under each theme, subtheme names were presented. The first few introductory paragraphs name the themes and sub-theme and start with a topic sentence, followed by a quote that illustrates the data.

3.8 The strengths and difficulties associated with phenomenology

Phenomenology is the study of phenomena as they present themselves in direct human experience and in an individual’s direct awareness, or consciousness (Moran, 2008). As a method it is most useful when the focus of the proposed investigation is to understand an experience from the viewpoint of people who are living this experience (Cohen, Kahn and Steeves, 2000). People are viewed as creative agents in constructing a social world in which they intersubjectively experience with and through others (O’Leary, 2009).

The main strength of phenomenology is believed to be the exploration of day-to-day phenomena of our social world (Todres and Wheeler, 2001). It is crucial for professionals working in health or social care to understand the lived experience of a particular illness and what this experience means to a concerned person, how they make sense of it, how it impacts on the way people live their lives, on their relationships and their plans for a future. An understanding of these areas is an important pre-requisite to support the individual patient in the formulation of recovery goals that are meaningful and of personal significance.

The available literature on phenomenology, however, is often difficult to read. It is not easily understandable due to its philosophical underpinnings and very often does not offer much guidance on methods. As my understanding grew, I became aware of how often only parts of important concepts are described in research method books or how Husserlian and Heideggerian phenomenology are put together without explanation of the distinctive differences (Patton, 1990). Hermeneutic phenomenology as a research method is highly dependable on individuals who respond either through interviews or cultural products – writing, painting and photographing and so forth – to questions about their experiences of a particular phenomenon (O’Leary, 2009). It is also dependent on constructs – in hermeneutic phenomenology they need to be made explicit by the researcher whereas in Husserlian phenomenology they are bracketed (Cresswell, 2014).

3.9 Summary

This chapter discussed my chosen methodology and method. I described how the research question guided me towards a phenomenological, hermeneutic approach as a suitable methodology. The sampling method included inclusion and exclusion criteria. I used reflexivity to discover how my position as a researcher and occupational therapist might have impacted on the research process. The data were analysed by using my own interpretation of Cohen, Kahn and Steeves’ (2000) approach to hermeneutic phenomenological data analysis. The findings, four themes and four sub-themes will be presented in Chapter four.

CHAPTER 4 FINDINGS

4.1 Introduction

This chapter presents the findings of the study. Interviews were conducted with ten participants, who provided information about their personal background and descriptions of their experiences of engagement in creative activities as they were lived, interpreted and understood by them. The transcribed interviews were analysed using my adapted version of hermeneutic, phenomenological analysis described by Cohen, Kahn and Steeves (2000). The chapter begins by profiling the ten participants and continues by describing the participants' current and past engagement in creative activities, which are presented as vignettes to the reader. Finally, the themes and subthemes are presented in the theme and quote method (Cohen, Kahn and Steeves, 2000, p. 96), enriched the participants' own words.

4.2 Characteristics of participants

The participants were four women and six men with an age range from 19 of 87 years. Pseudonyms have been used to protect the participants' anonymity. All participants lived in the community and were known to have some experience of engagement in creative activities. They were in remission from mental illness and supported by mental health staff in their efforts to adjust to daily life in the community. The term 'remission' has been defined for this study as the time that followed an episode of a formally diagnosed mental illness – the full ICD-10 diagnosis criteria were previously met – in which only some of the signs and symptoms remained, but lower in number and intensity. For example, minor impairment in occupational and social functioning. The duration of remission ranged from 4 months (Peter, George) to 84 months (Lisa).

In my clinical practice, the presence of the positivist paradigm is impossible to ignore. The ICD-10 code is commonly used and refers to the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (2010). It is a medical classification list published by the World Health Organisation (WHO) and contains codes for diseases, signs and symptoms. Each participant had a formally diagnosed mental illness with an ICD-10 code from Chapter Five which focuses on the classification of mental and behavioural disorders, for example Schizophrenia (F20.0),

Mood disorders (F31.0, F32.0, F33.0), and Neurotic, stress-related and somatoform disorders (F41.2, F42). A detailed description of the participants' ICD-10 codes can be found in Appendix 1. Additionally, all participants had remained in contact with psychiatric services for ongoing monitoring of their mental health and continued to take prescribed psychotropic medication. Psychotropic medication is a term used for psychiatric medicines that modify chemical levels in the brain, impacting upon mood and behaviour (British National Formulary 66, 2013). Commonly, the psychotropic drugs the participants took anti-depressants, anti-psychotics or anti-anxiety medications.

4.3 Participant profile

The participant profile in Table 13 gives the reader a description of their personal background which includes age, gender, ICD-10 code, the duration of remission, education, social network, roles and work. The word 'work' was used by participants to express their achievements from their engagement in creative activities. I viewed this expression as significant because I recalled Hannah Arendt's distinction of three fundamental levels of human activity – 'work', 'labour' and 'action' – from her book 'The Human Condition' (1958). Arendt defined work as a specifically human activity, a creative endeavour in which the end product displays and confirms the creative ability of the person who made it.

Three participants – Ann, Gareth and George – were retired from their formally paid jobs. The onset of mental illness disrupted the life plans of the other seven participants – Lisa, Emma, Peter, Martyn, Finn, Charlotte and Nick – who had wanted to complete their A-levels, or continue with a university course.

Table 13: Participant profile

Name	Age Gender	ICD-10 code	Duration of remission	Education, social network, perceived roles, work
Ann	78 years Female	F41.2	12 months	Enjoyed life in a bigger city in her twenties but disliked the move to a small rural community at the beginning of her marriage; owned a knitting business with a friend for several years; taught knitting; retired; two children, three grandchildren; wife, mother, grand-mother, friend. 'My work, my piece of knitting'
Gareth	72 years Male	F33.0 F42.0	26 months	Trained as a carpenter, worked on locks and weirs for more than 40 years until his retirement; works as a volunteer for a

				local charity in a garden centre and workshop; views himself as an inventor; volunteer, brother, friend. 'My work, my models'
George	>60years Male	F32	4 months	retired; works as a volunteer for local charities; lives in his own flat;; socialises with friends from university; volunteer, friend, member of an art class. 'My art work'
Lisa	39 years Female	F41.2	84 months	Studied dance at university but stopped university course due to illness; lives with her parents; friends from ceramic studio; daughter, friend, artist. 'My ceramic work'
Emma	87 years Female	F31.0	24 months	Went to school until age 16; was married for more than 50 years; lives in her own house; two adult children, one grand-daughter; friends who share interest in embroidery; friends from church; mother, grand-mother, friend. 'My embroidery, my piece of work'
Peter	32 years Male	F31.0	4 months	School years disrupted by illness; unable to complete A-levels; owns his own flat; father of a three years old daughter; good relationship with mother and late father; former patients who share his interest in art or are artists became his friends; son, father, friend. 'My art work' (drawing and pottery)
Martyn	19 years Male	F20.0	4 months	School years disrupted by illness; did not complete A-levels; lives with parents and his younger brother at the family home; son, brother, patient. 'My art work'
Finn	38 years Male	F20.0	48 months	Opted out of A-levels due to illness; unable to go to university or start a job; started playing the guitar as a hobby prior to onset of mental illness, now recreation; took private lessons; good relationship with his parents; son, friend. 'My song, my music'
Charlotte	38 years Female	F33	36 months	Discontinued A-levels due to onset of illness; took art lessons; lives with her partner in their own home; partner, friend. 'My art, my art work'
Nick	25 years Male	F20.0 F42.0	6 months	School years disrupted by illness; lost mother three years ago; lives in a homeless shelter for young people; attends their art centre for drawing classes, writes stories about illness and other people; service user. 'My art work'

4.4 Participants' engagement in creative activities

All ten participants were actively engaged in creative activities when they were accepted into the study. Table 14.1 and 14.2 show the participants' engagement in creative activities. Both tables include past engagement prior to the onset of the illness, past engagement during episodes of illness and remission, and current engagement.

Four participants – Peter, George, Ann and Nick – were not interested in participating in creative activities prior to the onset of their illness (Table 14.1). Ann had a busy life style, George was discouraged by others earlier in his life, Peter had other interests and Nick's general lack of interest in anything resulted in a state of in-action. However, all four participants had similar experiences as in-patients of psychiatric services. When they became unwell and had to be admitted to a hospital, occupational therapy staff introduced them to creative activities. This was perceived as a helpful and enjoyable intervention. The artwork room was usually easily accessible for patients, well equipped with a range of different materials and tools, and free to use.

Table 14.1: Participants with no past engagement in creative activities

Name	No past engagement in creative activities	Past engagement in creative activities during episodes of illness and remission	Current engagement
Peter	No interest Reading as a hobby instead	Drawing Pottery	Drawing Pottery
George	No interest Family and teachers regarded him as a person with no creative ability	Drawing	Drawing
Ann	No interest Busy professional and private life, several interests and hobbies	Knitting Crochet	Knitting, Craftwork (jewellery)
Nick	No interest which resulted in 'nothing to do'	Writing Drawing	Writing Drawing

Six participants – Martyn, Lisa, Emma, Gareth, Charlotte, and Finn described themselves as always being interested in creative activities since their childhood and prior to the onset of their mental illness (Table 14.2). The participants chose particular creative activities as hobbies during their childhood which they continued to engage in, although perhaps to a lesser extent during episodes of illness and the early days of remission. Sometimes, engagement in their favourite creative activity came to a complete standstill during the acute phase of their illness.

Table 14.2: Participants with past engagement in creative activities

Name	Past engagement in creative activities	Past engagement in creative activities during episodes of illness and remission	Current engagement in creative activities
Lisa	Dance	Drawing Pottery	Ceramic work Lino printing Stone carving
Emma	Stitching	Stitching Embroidery	Embroidery
Gareth	Making objects Woodwork	Woodwork Making objects Gardening	Woodwork Making objects
Martyn	Sketching Drawing Arts and Crafts activities	Sketching Drawing Drawing 'angry stuff' (art therapy)	Sketching Drawing
Finn	Playing the guitar	Playing the guitar	Playing the guitar
Charlotte	Arts and Crafts activities Drawing	Arts and Crafts activities Drawing	Drawing Craftwork (jewellery)

Each participant shared her/his experiences with me during the interview. For ethical reasons, I was not allowed to access the participants' personal and clinical data through an electronic patient data base (RIO Mental Health). Therefore, the information I collected regarding their mental illness and the possible struggles they faced during remission was gleaned solely from what they were willing to disclose to me during the interview. I summarised the salient points of each individual transcript as vignettes and they are presented next.

4.5 Vignettes

The vignette of each participant gives the reader information about her and his familial background, interest in creative activities and reasons why particular creative activities became personally significant and meaningful in her and his life. The participants are presented in the order of their interviews. Lisa was the first one I interviewed, followed by Emma and so forth and my last interview was with Nick. This order helped me turn my attention to one particular person at the time and to record ideas and thoughts in my research diary whilst writing a vignette. Over the course of writing the vignettes, I noted my growing understanding about the participants' experiences of participation in creative activities.

Lisa 'making ceramic sculptures and portraits'

Lisa always had a fascination with the human figure, but she found her attempts at drawing human faces inadequate and started working with clay as a way to express her creative ability during one of her previous hospital admissions. It was not until the closure of a local day hospital that Lisa became aware of the fact that her life revolved around being part of the hospital scene, only allowing her to interact with a small social network away from the hospital. During this time, Lisa suffered from distressing thoughts and stayed at home with nothing to do. She became fearful of having a relapse and made the decision to explore alternative creative opportunities in her local community. She responded to an advert that announced the opening of a new ceramic studio. Lisa disclosed her mental health problems to the owner of the ceramic studio on the telephone whose encouraging attitude made Lisa feel welcomed as a new group member.

Lisa has remained in remission for seven years and out of hospital since then. She continues to take her psychotropic medication to balance her mood swings and she sees the psychiatrist for a review every three weeks. There are some days when Lisa feels unwell, when her thinking becomes negatively coloured and she struggles to leave the house to go to the studio and engage in her work with clay. However, she has learned to successfully use cognitive behavioural therapy based techniques to overcome this struggle because she knows from her personal experience that doing ceramic work makes her feel better. Lisa regards herself as being very fortunate because the

psychiatrist and his department pay all invoices for all her privately arranged ceramic sessions.

Emma ‘making a piece of embroidery’

Emma is in her eighties, a widow with two adult children. She lives independently in her own house. During childhood, Emma had been physically unwell and spent a lot of time on medical wards. She missed school and her friends, and did not have anything interesting to do. Her parents brought small cloths with patterns stamped on them and some thread to the hospital, and she used them to learn and practise stitching. It helped occupy her time on the ward and she found it enjoyable.

Emma developed a life-long interest for embroidery, which she shared with her late husband. Both became members of a local embroidery guild and attended classes to learn more about the different techniques, styles and material. Their shared interest in embroidery let them to visit arts and crafts shows across the country. During adulthood, Emma was diagnosed with a mood disorder, which could be triggered by stressful life events. Her mood would dip further and further, and she would not want to leave her room or look after herself. During her hospital stays, Emma usually started doing a small piece of embroidery, but her bigger projects were only initiated once she returned home.

Emma recalled the time when her children were still living at home and expected her, as their mother, to prepare supper after returning from school. On several occasions, Emma became so engrossed in her embroidery that her children had to take over the cooking responsibilities. Emma is very proud of the treasure trove that she keeps in the sewing room at home. It contains a range of different threads in every colour one could possibly wish for. As Emma became older, her fine motor skills deteriorated and she developed a subtle tremor, which might be a side effect of her long-term antidepressant use. She was unable to use small needles and threads, but rather than becoming depressed about her ailing physical health, she invented a different kind of embroidery with thicker threads and bigger needles to use. Furthermore, Emma never wanted to exhibit her work, but was always keen to give her artwork to relatives or friends. Emma and three of her best friends, whom she met when they were school children and who share her interest in embroidery, still meet every week at Emma’s home. Each of them

works on their own piece of embroidery and they share stories about people and events of the previous week.

Peter ‘making sketches, making a piece of clay’

Peter is in his early thirties and has a three-year-old daughter. He owns a flat, but he prefers to spend time at his parents’ home. He experienced mental health problems as a teenager, had several hospital admissions and was later diagnosed with a mood disorder. During one hospital admission, he was introduced to occupational therapy and participated with other patients in creative activity groups. He was encouraged to try working with clay and liked the physical element of it. Additionally, he started to learn to sketch little scenes of his hospital stay and he had individual sessions with the art therapist. Peter discovered that participation in creative activities, in addition to other interventions, had a relaxing effect on his agitated state.

After his discharge, Peter searched for creative opportunities in his local community. He found this helpful and a good way to reflect on situations or things that had happened to him. He tried several art classes, but he enjoyed neither the set exercises nor the pace of these sessions. Peter’s interest in art brought him in contact with other artistic people in his local community, at the hospital or at day centres, and in other geographical areas of the country. Talking about art with other like-minded people, showing them his drawings and being shown certain techniques, helped Peter find his own preferred style of sketching and drawing.

Peter is currently in remission but on some days he still experiences a few symptoms of his illness, particularly mood swings. He does all his sketches quickly, and they are usually about things that bother him at the time. Afterwards he feels more relaxed and his mind is at ease. Peter views his sketches and drawings as a private matter that holds a personal and emotional value. He is not interested in exhibiting them and only keeps a few of them at home. The rest of his sketches are disposed of. At home, Peter keeps pencils and paper in his room, ready for him to use whenever he wants to doodle or produce a few sketches.

George ‘making a drawing’

George is in his sixties and a retired academic. He lives in his own flat and after retiring from a demanding job at university, George started working as a volunteer for a local charity organisation.

After being on the ward for several months and recovering from his mental illness, the ward-based occupational therapist invited him to visit an art group at a local community centre. George was never encouraged as a child to pursue any creative activities. In fact, he was viewed as the only one in his family without any creative ability. His teachers at school supported this view and, as a consequence, he never developed an interest for artwork.

Despite being nervous at his first visit and having thoughts about failure – for example, his believed inability to produce a worthwhile piece of artwork – George soon discovered that the atmosphere was very encouraging and the artists appeared supportive. The artists teach participants different styles and techniques, and their encouragement to try out new ways made George feel welcome and awakened his interest in art. Nowadays, George visits galleries and museums, and looks at drawings and paintings in more detail. George described his regret that he was unable to develop an interest in artwork earlier in life and that he might have missed out on opportunities to just visit the countryside and draw the surroundings. However, he was grateful that he had been able to develop his skills and knowledge about art later in his life, because this new interest has enriched his existence.

Anne ‘making a piece of knitting’

Anne is seventy-five years old, she is married and she lives with her husband, a retired policeman, at their home in a small, rural town. Anne experienced her first nervous breakdown in her mid-twenties, when her husband was transferred to a small village and they had to leave a bigger city and their glamorous lifestyle. Anne used to enjoy her life and the easy access she had to cinemas and theatres. After Anne moved, she remembered being rather shocked to find herself in an environment without a cultural scene. Anne felt socially isolated and experienced increased marital problems with her husband. Her mental health deteriorated and she had to be admitted to a psychiatric hospital to receive treatment. When she felt better, she started to attend occupational

therapy-led groups and was introduced to knitting and crochet. She was fascinated by the different patterns and ways to use them, and adopted knitting and crochet as a hobby.

Over the years her hobby developed into an ‘addiction’. She recalled moments at home where she was desperate to start a new pattern but was held back by awful household chores that had to be completed first. She set up a small knitting business with a friend and together they sold pieces of their work at a local shop, and at regional and national arts and crafts events. Later in her life, Ann taught knitting and crochet to students for eight years, and she was proud that she earned the reputation of being an excellent tutor with the skills to develop her students’ talents to a high level.

A recent unexpected hospital admission to treat complex physical health problems has stopped Anne’s participation in knitting and crochet temporarily. Currently, both her concentration and motivation seem to have disappeared and she is unsure why this has happened. Anne feels powerless and frustrated that she cannot concentrate on the patterns, start a new piece of work, or continue with her most recent project despite the support of a close neighbour. Because knitting and crochet have always played such an important part in her life, Anne has accumulated lots of boxes of wool and books of patterns at her home. Her former passion for this particular creative activity has now been overtaken by worries about all the boxes that litter her family home. She believes that her brain is unable to take in new information and to concentrate on the task. This new situation has left her mystified and unhappy, as she is unable to find an explanation for it.

Gareth ‘making a piece of woodwork, making an object from thrown away material’

Gareth is in his seventies and lives in his own flat at an assisted retirement home that he shares with thirty other residents. Gareth trained as a carpenter and he worked for forty years repairing weirs and locks until he retired ten years ago.

Gareth has experienced several admissions to psychiatric in-patient wards for the treatment of a mood disorder. Additionally, he has been battling an addiction to alcohol for several decades. He recalls the lowest point of his entire existence when he lost his

job, his home and contact with friends and family. He is currently in remission and he works as a volunteer at a local rehabilitation centre three days a week. When he attends the centre he mostly does gardening with a fellow volunteer but also does woodwork at the centre's workshop. He also adapts discarded material to make objects of his interest, such as a shopping trolley.

His current living arrangement restricts his desire to collect thrown away material and store it at home. Gareth admits to being a hoarder and acknowledges that his behaviour causes tension with other residents, particularly if he stores material in the communal areas. When he was younger he had a garage and his own workshop available where he could retreat and create objects without annoying anybody. Gareth particularly likes to take objects to pieces and then put them together again to make a new creation. He expresses pride in having created innovative pieces out of thrown away material.

While working as a carpenter, Gareth discovered his fascination with mobile cranes and dumper trucks, sparking a desire to recreate them in model form. He never uses plans or drawings. Instead he thinks the idea over and proudly points out that he sees the finished article like a photographic image in his head. As much as it gives him satisfaction to create a mobile crane or dumpster truck, he experiences a terrible drop in his mood after the completion of a project. He resents becoming inactive again, and having to wait until another object catches his attention and ignites in him the desire to create something from it.

Martyn 'making a drawing, making a sketch'

Martyn is nineteen years old and has only recently been diagnosed with schizophrenia. He lives with his parents and a younger brother at their family home in a small rural town. A year ago, Martyn experienced low mood, a disrupted sleeping pattern and had difficulties concentrating and interacting with his family and friends in a socially appropriate way. His parents became desperate looking after him at home and, when they asked for help from psychiatric services, he was admitted to a mental health unit.

While in hospital, Martyn attempted some small sketches, but the thought disorder, which was still the most prominent feature of his illness, meant he did not succeed in this. Additionally, he was on a high dosage of sedating medication and would spend

most of the daytime asleep in his bedroom. Due to his illness, Martyn lost the ability to concentrate on text and to read books. However, he is still able to listen to stories from video games if they are simple in content and the storyline is easy to follow. Martyn used to do a lot of drawing and created comics from the age of three to nine. He vividly recalled his creative efforts that included making up little characters for his comics, or thinking about making a book and then really making one. Additionally, he enjoyed crafts and made statues from old boxes and paper cups. When his attempt to make a cuddly toy during a textile lesson did not work out, he quickly used the remaining time to make flying eyeballs instead.

When he returned home after his hospital stay, he was reminded by his parents that he always enjoyed creative activities, that he had made the front cover of a book and wrote a story with pictures all by himself when he was little. His family encouraged him to take up his previous interest and Martyn re-organised his room in such a way that he now always has easy access to pencils and paper for his sketches.

Currently, Martyn is in remission from his mental health problems and has slowly started to introduce changes in his life with the support of his family. He attended an evening class for drawing a while ago, but even though he enjoyed the session and learned several things he was unable to retain the new information. Martyn is mostly self-taught and he learns new things by trying them out. Even though he likes drawing, he feels overwhelmed by thoughts running through his head most of the time. It takes time and effort for Martyn to concentrate, to sit down and draw. Despite positive comments from other people about his art, he remains highly self-critical, and he does not believe that his art is good enough or of a certain standard. It is Martyn's long-term ambition to enrol in a life drawing course at the local art centre, once he has returned to a proper sleeping pattern.

Finn ‘playing the guitar’

Finn is 38 years old and a musician. He started playing the guitar when he was sixteen years old and only severe episodes of ill health stopped him from playing. He owns a flat and has maintained a good relationship with his parents who live nearby. Finn receives benefits due to his illness, but his aim is to eventually get paid as a session musician.

When Finn started his A-levels he became aware of small changes in his personality. For example, he noticed difficulties concentrating, retaining information or reading a text. He became self-conscious and he stopped talking to friends. Additionally, he started to experiment with drugs, and his thoughts became disorganised and his behaviour erratic. During this time he liked to socialise with friends and playing the guitar became a hobby. He was admitted to a psychiatric hospital when he experienced a severe psychotic episode with distressing thoughts and hallucinations,. His family brought the guitar to the in-patient ward and they encouraged him to play it, particularly when he felt unhappy or when he just wanted to occupy his time rather than doing nothing. The action of just playing the guitar, playing a familiar song, helped to make him feel better about himself.

After his discharge from hospital, he was unsure what to do with his life and he decided to take guitar lessons to improve his playing. Finn had private tutorials, attended guitar lessons at an institute and he started playing with friends in small bands. Finn believes that medication and guitar playing work well together. He has found that the medication, which he has to take for life, suppresses his distressing thoughts and makes him more focused, whereas playing the guitar counteracts the sedating effect of the medication and stimulates him to become more energetic. Furthermore, playing the guitar helps Finn draw his attention to the here and now, and to ignore any auditory hallucinations that are troubling him outside his head.

Nowadays, he engages in a routine of playing three hours every day and he views himself as a musician rather than a patient. He absolutely loves the instrument and expresses pride that he is able to recognise a distinct idea in other people’s songs and that his understanding of the guitar as a musical instrument has grown over the years.

Charlotte 'making a drawing, making jewellery'

Charlotte is in her late thirties and she lives with her partner in their own home in a small village. She has had several hospital admissions spread over twenty-five years and was diagnosed with a mood disorder as a young person. When unwell, Charlotte's mood becomes low and she experiences distressing thoughts about herself. During her last hospital admission, the ward-based occupational therapist encouraged Charlotte to join in the creative activity group and Charlotte's partner brought her own art materials to the hospital.

Charlotte has always liked drawing and painting. At an early age she discovered that doing a painting or a drawing helped her to release some of the feelings, thoughts and ideas she kept locked inside. One particular type of creative art – drawing with pencils in her favourite colours black, red and white – has become Charlotte's unique way of expressing herself. Her preferred style of producing her artwork is to do it very quickly. She is able to produce twelve pieces of drawing during a day when she feels well and less than ten when she is unwell.

Charlotte also produces self-made jewellery from buttons and other material. She has started to experiment with three-dimensional images at the day centre, which she attends once a week and she contributes to the creation of a mosaic garden path. Overall, Charlotte enjoys the action of creating her artwork and she says that getting involved in this particular activity evokes a feeling of happiness in her.

Nick 'writing, drawing'

Nick is in his mid-twenties and currently lives in a shelter for homeless young people. Three years ago, his mother and main carer died of cancer and Nick became homeless because his family home had to be sold. He has a diagnosis of schizophrenia and experiences hallucinations. During one dark moment of his life, Nick injured his right hand. He still has difficulties with drawing accurately because of this. However, he believes that the injury freed him up to do creative things and he started drawing as a way to capture heightened emotions and thoughts on paper in an uncensored way. After his mother passed away, he visited the day centre in town every day and started drawing with pencils.

Currently, Nick is in remission of his mental health problems. This means that he still has visual hallucinations but they are less frightening for him. He is able to find explanations himself and make sense of any worrying or frightening thoughts. As soon as he feels better again, he wants to continue attending a creative writing course at the Open University. Nick also writes stories, mostly about his illness, and he is strongly influenced by the author R D Laing who viewed the experience of psychosis as a cathartic journey for the individual.

Nick has a strong desire to work as a writer on a part-time basis with the aim of earning an income from his writing. Writing about his illness is a constructive way for Nick to come to terms with his feelings of regret that he will never be able to reach his full potential as a human being due to his psychiatric illness. Nick believes that the illness will stay with him indefinitely, but drawing has made him aware of his feelings and thoughts. He is serious about his artwork and he expresses a genuine interest to invest more time and effort to develop his skills in drawing, a creative activity he thoroughly enjoys. Over time, Nick has learnt that it is important to continue drawing and writing, to set up a routine and to keep up these two creative activities even though it might only be for half an hour per day. He believes that drawing his feelings and thoughts, getting them out from his head and putting them on paper, has made him happier and calmer.

The next section presents the themes and subthemes. The reflective process of writing and re-writing about my understanding of the meaning of the participants' experience was initially expressed in four themes and six subthemes (Table 12.2) which originated from twelve theme labels (Table 12.1) and were presented in Chapter 3. Theme labels can be understood as preliminary themes that developed from important phrases and specific words the participants said during the interviews (Cohen, Kahn and Steeves, 2000), and my interpretation of the participants' experiences. They were revised in discussions with members of the Service User Forum, colleagues and my supervisory team. My engagement in the iterative process facilitated the refinement of theme labels over time and led to the construction of themes and subthemes.

In the light of discussion with the examiners in my viva a further refinement of the latter themes and subthemes resulted in the final four themes and subthemes which can be seen in Table 15.

Table 15: Themes, subthemes and theme labels

Theme	Subtheme	Theme label
Engagement in a creative activity	Action of doing	From non-action to action Having something to do
	Being in the moment of making	While doing Really making something
Engagement with people and places	Being with people	Working with others Support from others
	Being at places	Working at home Going to places
The need to express oneself and be known		Overcoming struggle Personal preferred style
The significance of continued engagement		Effect of engagement over time Personal significance and meaning

Themes and subthemes were revised several times during the thematic analysis and reflected my altered interpretation and understanding of the individual participant experience within the context of the whole experience for all participants and *vice versa*.

My interpretation of the data was guided by the use of the hermeneutic circle. This meant that the smallest statements were understood in terms of the whole text, and placed within the context of the individual and their community life including people (family, friends, neighbours, service users, staff, artists and the wider public) and places (home, studio, day centre, music room at day centre, workshop, garden centre, gallery, museum, location for festivals, art exhibitions, arts and crafts shows).

4.6. First theme: Engagement in a creative activity

Participants of this study who were in remission from mental illness were asked to describe their experience of participation in creative activities. One of the prominent features of remission was the participants’ efforts to cope with distracting and sometimes distressing thoughts in their daily life. Engagement in personally significant creative activities created opportunities for the participants to manage these thoughts more effectively. The involvement of body, senses and a focused mind during the action

of doing a creative activity – for example drawing, painting, working with clay, playing the guitar – helped participants to turn their attention away from their overactive mind and towards the creation of a piece of work or music instead. Engagement with the material or instrument meant that the quality of the experience was real and true for the person who lived, interpreted and attempted to understand it. The lived experience of engagement in a personally significant creative activity was an opportunity for the participants to connect themselves to reality by really making something, and to acknowledge their thoughts and feelings at this present moment in time and place.

The experience of engagement in a creative activity encompassed two subthemes: 'The action of doing' and 'being in the moment of making'. Both subthemes are presented in the next section.

4.6.1 Subtheme: Action of doing

The first subtheme, 'The action of doing', was described as becoming active and getting involved in a creative activity because of the pure pleasure or enjoyment it generated. Sometimes it was difficult for the participants to get started with a creative activity, particularly in the presence of emerging health problems; fluctuations in their mental health status, which included a lack of motivation and concentration; during times when they felt unwell due to the side effects of medication and would socially withdraw from other people; during a hospital admission; and shortly after being discharged from hospital. Several participants had learned strategies to overcome these initial obstacles because the action of enjoying in a favourite creative activity helped them to make themselves feel better. The need to do something stimulated participants to actively search for creative opportunities and re-emerged when their mental health improved.

'The good thing about the guitar is, because I've known how to play it, when I do pick it up and I begin a song or something I can.... that it's helping me; I feel better just by the action of doing it. I wasn't thinking about how to open a business or how to, you know, do anything really complicated, it was just the action of it.'

(Finn, playing the guitar, line 321-323, 346-349)

After returning home, Finn noticed that *'because of the illness, I became self-conscious, you know, and not as confident as I used to be.'* The prescribed medication made him

feel lethargic and tired, and he had stopped going out with his friends because he could not tolerate people around him: *'I sat around, and when my confidence was low, I felt sensitive and I couldn't be around people that much.'*

The action of doing meant that Finn started to feel the need to pick up his guitar and he *'turned to the guitar to console myself and make myself feel better. I mean, you've heard of the blues. The blues is where people console themselves with music in a way, so I carried on playing. I played the guitar on my own and I found the guitar became my friend or something.'* His concentration was still poor, so he tried to start playing a song, he knew he could play. He recognised the importance of this, even though it was a small achievement. The guitar became a tool, something reliable he could return to when he felt unwell or ill. It enabled Finn to focus on what he was doing rather than on what he was thinking.

Lisa experienced days when *'it doesn't matter how low I am feeling or how well'* but it would still be difficult for her to leave the house and go to the studio to work with clay. She knew from previous experiences that it was important *'to get myself to the studio'* because she had learnt *'that I am going to feel better as a result of the process of getting my hands on the clay and just looking at a form or something that's in my head and trying to re-create it, and it just takes away all the bad thoughts'*. The action of doing meant that she was working the clay with her hands, thereby feeling the texture of the material and beginning to see the shape of the form she was creating. She always *'had a fascination with the human figure'* and she found *'that I can recreate a very face-like face in clay and it comes to life as I'm working on it, as I make the strokes into the clay.'* The physical component of the action of doing, and the involvement of her senses and a focused mind turned Lisa's attention to the task at hand, and away from distressing thoughts. Two other participants enjoyed working with clay too. Peter liked it, because *'you have a sort of tactile element to do it, where you're really making something, and you get your hands dirty'*. Martyn liked *'the cakey feeling of it'*.

Each acute phase of mental illness disrupted the participants' lives, their relationships with other people, and their engagement in daily routines and creative activities. Finn wasn't *'going out with the friends I had, because of my illness. I couldn't go to university and I didn't have any A-levels or anything, so, you know, I couldn't think of*

what jobs to get, I couldn't get a job either. So I was staying at my parents and playing the guitar was a hobby'.

All participants have had experience with hospital admissions. During the acute stages of mental illness they described an absence of interest and motivation. Lisa *'just sat here and did nothing'*, and Finn was *'lethargic'* with much time spent on concentrating on himself rather than on his surroundings or other people. *'I've been through various stages of psychosis as well, it's interesting, I've had numbers of delusions, I've had voices outside the head, I had paranoid conspiracies'*. Both, Lisa and Finn noticed how they had started to drift into a state of in-action. Participating in creative activities at a designated place in the hospital or a day centre offered patients a short break away from the clinical setting and its routines.

For Peter, participation in creative activities was linked to his hospital stays, because it *'was something you are often encouraged to do if you are in a hospital or a day centre or something like that'*. Participation in creative activities gave patients something to do with access to materials and tools. They had the opportunity to try out different techniques, make a piece of work, and meet other people within an encouraging, non-clinical environment. Within the hospital environment, encouragement by staff facilitated participation in creative activities and the participants' move from a state of non-action with *'nothing to do'* to state of action with *'something to do'*. For Peter, working with clay became very important when he realised that he *'enjoyed it and found it helpful'* and he has *'done pottery but since then in my adult life, I have looked out for it. I would search it out and would try and find different places to do it, and asking people, whether I could do this and use the artwork room and things like that'*. It also provided an opportunity to meet people *'who enjoy doing pottery and clay'*.

The need to do something, to become active and take up a creative activity was the driving force behind Lisa. Whereas Martyn struggled with his memory, motivation and concentration to engage in the action of doing *'yeah, I've kind of got schizophrenia, so it's a bit difficult to concentrate on stuff and drawing does quieten it down quite a lot. I do it when I remember to do it and when I can be motivated enough to do it. Very often, Martyn would want to start with a drawing, but for him there 'are a lot of distractions for doing it, mainly, because I've got to think about something, that will*

make me think about something else and I'll just be sat there for like half an hour, just thinking of stuff and not actually touch pen to paper.'

Lisa could not wait to get started, to leave the house and walk to the studio in order to work with clay and *'get totally absorbed in what I'm doing, in the process of doing the sculpture itself.'* On a few days during a year, Lisa was known to experience a drop in her mood, and not wanting to leave the house. She used *'cognitive behavioural therapy'*-based strategies to combat her anxiety, saying *'I would have to try and overcome that with CBT techniques and stuff, and to try and talk myself out of it.'* Lisa also kept a positive diary *'and I write in there any comments that people made about me or my work that were beneficial, and so I could look back at that and say to myself "Look, that's what people really think not what's in my head" and that would help me get to the sessions.'* Looking at the written comments in front of her and reading them out helped Lisa to focus her attention on the written word, rather than to succumb to any negative thoughts in her mind.

Finn did not need to motivate himself, because playing the guitar *'in a way, it's almost my job. If it wasn't to get out of bed, and have a fag and that and pick up the guitar, if I wasn't to do that, "what else would I do?" I'd have nothing in my life.'* For Martyn, the action of doing a creative activity was very often made difficult by his overactive mind that distracted him from other things. He found his own way to overcome this difficulty because he always made sure *'that it's as easy as possible to get to the drawing. I sit at my desk quite a lot, so I've got it in the drawer and I can just get it out, and the pencils and paper and everything.'*

Martyn also tried to *'schedule in a time of day, where my alarm would go off and I would stop everything I was doing and go and draw.'* But this strategy was not helpful and he had to discontinue because, *'I stopped being able to draw on impulse, just being able to sit down and draw rubbish'* which he disliked.

When Emma realised that she was again all on her own over a weekend – *'I dread Bank holidays, because I'm here alone'* – she pointed out that she needed *'something to do'*. The lack of company over the weekend – *'Nobody comes on Bank Holiday, my family never comes at weekends, unless, you never know, somebody might think of it'* – meant

for Emma that she had time and could start working on a new piece of embroidery or continue her work on the most recent one. Above all, she expressed the desire and the need that *'I need something to do'*.

Through the action of doing a drawing or a piece of pottery, Peter learnt that he was able to direct his attention to the artwork and away from distracting thoughts because he had to focus *'on what I'm doing. I try and think about what I'm doing really, and concentrate'*. Both Ann and George included the time factor in their experience. George realised that his *'whole attention is focused on the art work. I don't have time to think about anything else'*. Ann always followed instructions for her knitting work and she turned her full attention to the instructions in order to *'get it right'* which did not leave her *'an awful lot of time'* to think about other things.

During one of the darker moments in his life, Nick had injured his hand. This impairment seemed to have freed him up to start drawing, a creative activity he had not done previously. Even though he lost the ability to draw accurately, he thoroughly enjoyed the action of doing it, because he gained the opportunity to *'Just experiment. Just think what would it be? Just see what happens really'*. Gareth viewed the action of doing something as an important aspect in his life, because when *'I'm doing something, anything else is out of my head'*. If the participants were unable to do their favourite activity they would look for something else to do. Emma, Ann and Gareth would engage in gardening, although for both women physical health problems had limited or stopped this leisure occupation.

All participants enjoyed the action of doing their favourite creative activity but they also found it helpful during times when being unwell. Finn summarised the enjoyment he experienced during creative occupation *'It makes me happy, I don't know, it's like just, it's just the way it is.'* He was fascinated by the guitar as a tool and he absolutely adored his musical instrument: *'It is the guitar, you know, the sound, the vibration. How does it make me feel? It makes me feel good, it makes me feel motivated, it makes me feel stronger, it makes me feel mentally well, you know. If I start to get a few symptoms, when I'm playing, like I'm hearing something, I'll be able to ignore it by playing the guitar.'*

Emma was very fond of her embroidery and she loved doing it because it was *'very satisfying'* when she found different techniques, but also because it *'was a way of getting out of a down, when I am down. I think you can often do a few stitches on something and spark yourself off on something else.'* Emma referred to a play mat she had made for the small child of a couple *'which was fun to do'*. Nick would do some drawing *'when I am unwell'*, similar to Charlotte, who found *'that drawing is like a safety valve and a relief'* to turn to instead of engaging in self-harming behaviour when negative thoughts interfered with her thinking.

For two participants, the action of drawing or painting had a relaxing and calming quality. Peter found that drawing *'is a bit of a stress relief, it can relieve a bit of stress'*. He liked drawing because he viewed it as a matter of *'trying to clear the mind a bit for me, because there are often worries and thoughts going through my mind that are troubling me at the time or things that I am thinking about.'* Peter thought it was relaxing, because he tended *'to try and enjoy just for doing something'* and because *'it takes your mind away from worries while you are doing it'*. George, who only recently discovered his creative ability, liked the exercises at the art class, which involved *'very careful, geometric designs and so when you were painting you had to be very, very careful to keep the shape of the design you were doing. So again, you really had to concentrate and focus, but it was also a very calming experience, because it was no good being agitated and this sort of thing, because your brush would shake, so you really had to be very, very calm in order to get the lines straight and to produce something that looks, satisfactory at the end.'*

Ann, who loved knitting and crochet because *'it was always a great source of joy and pleasure'*, recalled having *'happy thoughts, I suppose really'* but then corrected herself: *'I mean I suppose I didn't have a lot of thoughts except what I was concentrating on, you know, yes I would say, I just immersed myself in what I was actually doing. You have to think quite a bit, and you have to get it right and you have to follow instructions, so I suppose, you haven't got an awful lot of time.'* Recently, she lost *'all interest in doing it'*, *'had no motivation'* and remained perplexed why this had happened.

4.6.2 Subtheme: Being in the moment of making

Participation in creative activities offered an opportunity for individuals in this study to become actively involved in the process of doing, making and experiencing a sense of achievement as they made a piece of work, be that a drawing, a ceramic sculpture, a dumpster truck, a sketch or a song. The participant's physical contact with the material (clay, wool, threads) and the tool (embroidery or knitting needle, brush, pencil, guitar) was experienced through the senses, mainly through sight whereas thoughts, feelings and ideas were perceived through the mind.

All participants mentioned the importance of the process of making something. The evidence of a finished piece of work which could be seen or listened to meant that the participants could connect with reality, with the 'here' – the present moment and 'there' – the place where they produced it. Particularly during times when distressing thoughts seemed to overwhelm a participant's life, creating or making something that could be seen or listened to, was viewed as an achievement. The achievement gave participants a feeling of satisfaction and it made them 'feel good'. Illness or unwellness also showed an impact on the participants' concentration. The produced piece of work generated mostly positive feelings in participants. Frustration, as a negative feeling, was reported by some participants and one participant felt bereaved after the completion of his creative project.

The participants described different levels of engagement through the use of adjectives (full, complete) and verbs (absorbed, involved, engaged, immersed). They wanted to perform the creative activity as best as they could, but this demanded intensive concentration on the work, the material and the physical movement of drawing, playing the guitar and working the clay. Some participants had their own ideas which they wanted to recreate in the material they were working on, and others worked on careful geometrical designs which they wanted to reproduce. The creative desire to produce something, to feel a sense of achievement, seemed to facilitate the participants' engagement in their chosen creative activity.

'I find I'm completely in the moment of making, and I don't worry about what people are thinking of my work, and I don't worry what they are doing, and I don't worry

about if somebody is looking at me in a peculiar way. I just get on with what I'm doing and focus on that, and try to make it to the best of my ability.'

(Lisa, making ceramic work, line 102-108)

When Lisa started to attend the first few sessions at the ceramic studio, her self-confidence was still low and her concentration poor. Her mind was occupied with distracting thoughts about other people, and what they might think about her and her work *'I was also still very aware of people around me, what so and so is doing and is mine as good as that person's, and all kind of normal thinking I'm sure, but distracting at the same time.'* Nowadays, she felt *'rapt by it, you know. I have, I know, I have to make creative decisions as well so that engages in my mind on a different level to what it would normally being used on, so I think about the aesthetic of the piece, but...it's really hard to describe.* Several participants experienced difficulties in describing exactly what happened while they were making a piece of work. However, all agreed that attention towards the creative task, concentrating on the process of making was important because this made them forget their worrying and troubling thoughts. Attending an art class evoked feelings of nervousness in George who grew up in the belief of *'not having any creative ability whatsoever'*. The encouraging atmosphere at the community centre's studio and the idea that people were *'free to express themselves in different ways'* were crucial for George to overcome any previously experienced negative feelings.

Being in the moment of making meant, that the participants brought their whole being into the action of making or creating a piece of work, or song. Lisa was proud of her acquired skills to transform images and ideas from her head into ceramic portraits: *'This piece was working from my head and it just sort of grows organically, it happens and I can feel myself, I can feel all the tension going away from me, and I can feel all the negative thoughts that I might have about where I am or what I'm doing or just go, because I'm absorbed in something that I have to do, because I have to produce it.'* Lisa made something out of clay that was part of her doing and part of the material's quality of allowing her to form and shape it: *'I just get involved in the form and the texture of it and the overall look of the piece, and my mind is just, before I know it, is just focused on that and not on anything else.'*

Another participant, Gareth, also had to respond to his creative desire to make model dumpster trucks and cranes. He explained that he got *'the inspiration and then I think it over in my head'*. Gareth would *'see something'* – discarded material of all sorts – and if he thought he could use it, he would see *'the finished article like a photograph in my head and I think that is possibly the way that I am able to do it. The article or the object is in my head, so I can see it, so I work with that, the I work on , then I just adapt I think to myself, well, that's not going to work like that but it will work like that, so I can put the bits together.'*

Emma worked on a new piece of embroidery and was inspired by a book with catkins and leaves. Her attention was focused *'on getting the catkins to dangle, getting them to hang, making them fluffy, making them heavy enough to hold down'*. During this creative process, Emma let the material guide her: *'I think it comes from itself, it changes as you work.'* She particularly enjoyed the process of thinking about how to position individual items and trying them out *'then you are thinking, perhaps that would look better that way; and let's try and sometimes it works and sometimes it doesn't.'* Similarly to Gareth, Emma would leave the project for some time then return, and if it works *'you build it up and see if it generates anything more of itself'*. She would start a conversation with herself and ask *'How many of those wire branches might I have? How many little green leaves? That makes a difference.'*

During the process of making creative decisions, Emma would look for visual clues in her home environment, for example a picture in a book *'and then I looked at this, it's a very interesting colour and it's shiny; therefore it will make a beautiful contrast to the yellow , fluffy catkins and I thought "what can it be?" And I thought "what about a dragonfly, when I have finished the fluffy catkins, perhaps an insect of some sort?"'*

The personality appeared to play a role by evoking feelings about their produced work and how they dealt with it. Martyn's drawing efforts were disrupted when his concentration was poor and diminished his level of accuracy in his drawing style. Even though he felt *'good a lot of the time, while I am making a drawing'*, because it took effort to get started, he felt proud of what he had achieved. However, he always took *'a couple of minutes to critique what I have done, yeah, you know, if the arm is too thin or*

if it is out of perspective, but because it's so difficult to get going, I feel really good about having done it, even if it's absolutely terrible.'

Peter sometimes had an idea that *'will pop in my head and I will try and draw it'*. He acknowledged his feeling of being frustrated when a drawing did not work out the way he thought it would. He *'threw it out in the bin, it's a bit frustrating for a minute but I'll try to start another one or try not let it bother me too much, I mean I am not too much of a perfectionist.'*

Nick's previous hand injury made his drawings *'messy and scrappy'* but he did not place too much importance on this. He and Peter tended to value their efforts to produce their own drawings and sketches more than worrying about their drawing styles. Nick would get an *'idea in my head that was something interests me and the rest I just experiment, just think what would it be. I just see what happens really.'*

Finn viewed his guitar playing skills as a *'natural progression'*, and he liked that *'much with the guitar is inventive and of meditation quality. If you are playing something and you want to get it right and because timings involve, it's not just about playing the guitar, it's about getting in time with something else like a drum machine or another instrument, so there are other aspects to it to create a sound that is listenable to somebody else, basically you've got to play it without any mistakes and so there is timing involved.'*

Having acquired the skills *'to do sometimes really wacky things, because I've dreamt them or I just had this vision in my head of something that I want to create, and I can do it now, I have the skills to do it to create it as I saw it in my head, and that is thrilling, really'* had generated feelings of pride in Lisa. Similarly, Gareth experienced *'a wonderful feeling of satisfaction when I get things done and they are going right, you know, suddenly everything will come together, and I will think wow that's good, you know. And it's a warm feeling inside, you know, you've created something and there is nothing like that, that anybody else has done or you're thinking you are the only person who has done it. Well it's a kind of a high, you think wow this is the only one ever done, the only one here.'*

Gareth used all his skills and his whole being to produce a unique piece of work which evoked a positive feeling inside him as he was making it. However, after he finished it he felt bereft in what he described as *'a really strange feeling, because when I finished something, I feel really high, but I suppose it's like everything, like the drug and the drink and all that, it wears off and I think what can I do with it now, I've done it, you understand? Well I got pride in what I've done and I've had amazing thoughts about doing it and it's involved me and I think now, I can't do anything with that now, that's done'*. Gareth was the only participant who felt this way. He had to wait until something else caught his interest and filled the time by engaging in other favourite activities at the garden centre.

Peter discovered that if he felt unwell it was *'more difficult to concentrate on making artwork'*. Ann, whose physical health had deteriorated since she was accepted into the study, felt her concentration and motivation slipping away, leaving her mystified and unsure of how she could become involved again in her favourite creative activities, knitting and crochet. Previously, Ann *'loved it, making something beautiful or nice was very pleasant and my feelings all along, I mean, I've been doing this for 40 years and my feelings were just happiness.'*

George always felt very engaged *'and in a way it blocks out all other thoughts, because I have to concentrate quite intensively to try to produce something, you want to produce something that is the best you can do'*. He had always believed that he had no creative ability and was surprised to discover his creative desire *'to produce something that is the best you can do'* and his creative potential. He did not recall having any negative feeling during engagement but acknowledged that *'perhaps, I've started doing something and failed, that I couldn't produce something that I felt was worthwhile, you know, I think then I might be very critical with myself.'*

4.7 Second theme: Engagement with people and places

Participants in this study came into contact with other people when they found places that offered opportunities for creative pursuits in their local community. Attending classes or courses brought them into contact with other like-minded people. Seeing or looking at other people's creative work, listening to other people's music, created further interest and curiosity in the participants, and fuelled their ambition to progress

with their knowledge and skills in her and his favourite creative ability. The desire to look for ideas in their natural environment sharpened their visual abilities and they would sometimes register with wonder details in other people's physical appearance, in plants, and in other people's artwork.

4.7.1 Subtheme: Being with people

Being with people held a special meaning for the participants because participation in creative activities created the opportunity to meet like-minded people, to talk to them, to work with them, to learn from them and about them, and to get to know them in a supportive environment. Attending a class, or meeting people who shared a participant's interest in her or his creative activity, was a valued and meaningful experience.

'People I have never met before from different backgrounds, different ages, get on very well, and you hear something about what their life is and the activities that they are doing during the week. So this helps to get to know them and I think also the fact that some of the things we do are group projects, not just doing things on your own.'

(George, attending a community-based art group, line 28-36)

When George was in hospital, staff suggested he should attend a community-based art group. He felt anxious at first, assuming it would be a life-drawing class but *'with the encouragement from the people in the group not just the artists but staff, too,'* he received compliments for his work and this gave him *'a good feeling'*. George found the group itself was very friendly and the contact with the other group members made it easier for him to realise that *'engaging with other people, chatting to them, and also seeing the problems they have,'* put his own problems into perspective to a certain extent.

Lisa pointed out how important the *'connection to other like-minded people'* had been for her in remission, and how working with other people had changed her: *'I was really suicidal, very introverted, didn't communicate well and now I feel, even if it's with the group of people I work with, at least, I'm much more outgoing, I don't have suicidal thoughts anymore, and I attribute that to the ceramic work that I've done and the connection that I've made with other like-minded people. It's just been brilliant.'*

Their engagement in ceramic work at the studio fostered her relationship with other attendees, because they shared an interest in ceramics. Their individual work had created topics for Lisa that she was able to contribute to. Charlotte, who described herself as shy, found that working with other people *'on a group project, which was making a mosaic for the garden path'* at the day centre, facilitated her engagement with them.

During the earlier years of his illness, Finn had spent long periods of time at home. When his need to join a band became stronger than his need to stay at home, staff and his parents encouraged him to join a local music group where he met a friend who also had an interest in music and *'we attempted to put a band together'*. This was an opportunity, but according to Finn it was *'lucky as well, because if I hadn't of got the opportunity to play at the daycentre with my band, I probably would have stayed at home, but I needed to get into a band'*.

Participants also expressed a need to learn more about their chosen area of interest and often attended classes or courses to achieve this goal. Two participants, Martyn and Finn, experienced illness-related symptoms that impacted on their ability to read and keep information. Martyn who *'attended a night class once'* was not able to retain the information. Long episodes during the day where he felt tired made it impossible for him to attend any formal classes at the moment.' Finn went *'to see a private tutor in the other town, and I went there for a number of years and he taught me, you know, learned a few songs'*, because Finn was *'unable to read the notes or a text'*.

George always looked forward to the next session of the art class where *'we are set an exercise and we have to try and finish it within a certain time'*, whereas Peter commented critically on art classes, because *'they are often not at the pace I would want them at'*, and he continued to say that *'they want you to do a set process'*, which he was not interested in. However, the need to learn more about their chosen creative activity, the need to share their work and to talk about it with other people was a powerful tool to engage the participants with other like-minded people. George discovered that there was *'less concentration on self'* when he focused his attention on the artwork or engaged with other people. He also started to look at other people's artwork: *'looking at paintings, because sometimes the artist will say this is in the style*

of Van Gogh, or this is in the style of something, and when you go and look at portraits and, sort of, pictures, these things stick in your mind and so you begin to look at the brush work and different techniques, and lots of little dots making up a bigger picture and so on.'

Peter viewed himself as *'lucky, in that I sometimes meet people who are artistic. I met a few people who are artistic, obviously a lot of artists have these sort of bi-polar things as well, which, I have met a lot of artists who have helped me as well. I mean, I still know a couple of people that I keep in touch with who are artistic and they quite often look at my pictures or they show me something they have done.'* One participant, Gareth, lived in a retirement home with thirty-two other residents, and he was not allowed to store any recycled material in the communal area or his living space: *'I have a kitchen and a living room in where I'm living and they gave me a brand new kitchen. And I was told not do it anymore.'* He noticed that *'people seem to be very impressed'* when they see his creations but there were also some residents *'who find me a bit bizarre, you know, a bit eccentric. And it makes them "what on earth are you doing that for' sort of thing and "why are you doing that?"'*

Both Ann and Gareth made objects for family and friends, and, at the time of the interviews, had made plans to donate their materials and products to charities. Ann *'used to make Christmas presents for people and birthday presents, perhaps a cushion cover or a blouse or something, you know, I always had the motivation of what I could do.'* Gareth, on the other hand, talked about another resident *'another old man about my age, well a bit older than me, you know, you get friends there and he wanted, he had a space in his kitchen, and he wanted a cabinet there. They did the same for him as they did for me, but there was space there and he wanted a cabinet put in, and so I said I would do it for him, and I just did it again, I didn't draw anything out.'*

Like-minded people also provided different kinds of support to facilitate access to creative pursuits. Lisa was given financial support by her consultant to pay for the private lessons: *'My consultant, his department have been paying for me to do, go to the private sessions because he can see the benefit as well and they have been doing this for years now, and I can't thank them enough really for that.'* A social worker trainee who worked with Finn *'managed to get me some money for an acoustic guitar, so I got 400*

pounds given to me from three different organisations so 'cos my psychiatrist and my social worker thought the music was good for me, so they got me 400 pounds, which brought me a beautiful acoustic guitar from Yamaha, acoustic with a pearl around the sound hole with a hard case which was 100 pounds' Both Lisa and Finn were very grateful having received meaningful financial support from staff.

Ann, who was unable to find out why she had lost interest and motivation to pursue her favourite pastime, was also grateful of her neighbour, who had *'insisted on making me start something, you know, because she thought it was right that I should be doing something, but there it sits, half done and I can't get it out to continue. She even bought me the wool I hadn't got for this project, you know, she went and bought it, it's for an event, it's for the doctor's baby.'* But even the special effort of another person did not motivate Ann to get started. She had a suspicion that maybe her memory was starting to fail making her unable to concentrate and follow instructions, but tests had been inconclusive.

When Charlotte started with a 3D object at the day centre, she required buttons and, even though she *'bought some, people gave me load'* her delight of having enough material to last for further projects motivated her to experiment with the material and to look forward to any future work. Emma and her late husband shared an interest in embroidery and *'when I started going to evening class, my husband – I don't drive – my husband had to take me, so he decided, he said "I might as well stay"'*. They joined the embroidery guild and Emma *'learnt a lot from that because without it, I would have missed a lot of the best brains in the country that came to talk to our club'*.

4.7.2 Subtheme: Being at places

The place where participants engaged in their chosen creative activity held a special individual meaning for them and it was either identified as their own home or a place in the local community. A dedicated area, encouraging atmosphere, and easy access to material and tools facilitated participants' engagement in creative endeavours. Eight participants in this study lived at their own home and they regularly set time aside to engage in their favourite creative activity or in aspects of it such as preparing for the next session by sketching or drawing ideas. Two participants did not live at home and

they had to move their creative pursuits to a day centre (Gareth) and an art centre (Nick), both of which were run by charities.

'I just did art in the art room there, they had materials, there weren't many people using it. I could go there every day and I loved that, but they closed it down unfortunately, yeah, that's the way it is. The other day centre is ok for art, but they haven't got a proper art room and there's too much noise in there, there's music going on all the time, and you can't concentrate, and there is not enough space.'

(Nick, making art at a day centre, line 397-405)

Emma preferred to stay at home because of her physical health problems and used a place in her sitting room with a view the garden for her embroidery work. She referred to the material as her *'treasure trove upstairs in the sewing room, every type of texture that you could want and every colour'*. For Ann, who also experienced several physical health issues, the material she referred to as *'boxes and boxes of wool, lots of patterns, books and books of patterns'* became the centre of her worries, because she was unable *'to transport it in anything.'* Her house became *'absolutely littered up with it and I know it's got to go.'*

The storage of material at his flat and communal areas was an ongoing area of concern for Gareth who has been *'making models for over a number of years'* but he thought *'that the circumstances have come about that I am no longer to do this.'* Charlotte, on the other hand, remained relaxed about the state of her home where artwork and material *'were just everywhere'*. When Lisa became unwell, she knew from her previous, personal experiences that it was important to *'get myself to the studio'* because the supportive atmosphere and her engagement in ceramic work always made her *'feel better.'*

Nick was very appreciative of a day centre's facilities and his past use during a difficult time when he lost his mother: *'I've been learning drawing as hard as I can since Mum died three years ago, that was the way how I dealt with my grief, my mother dying from cancer. So I just drew for a year every day, pretty much full-time at the day centre. I sat there, meditated, drew, meditated, got lunch, ate lunch, then take a group. It was great to have the opportunity to do that.'* Lisa, on the other hand had developed a critical

stance of the use of hospitals and day centres: *'I felt I had become so institutionalised by being at the hospital and the day centre, and being part of the hospital scene that there was nothing else in my life, really, except the hospital'*.

Places were also used for local exhibitions and the participants either went there as visitors or to share their work with the public. When Emma was younger she and her late husband went to the *'local museum and to craft exhibitions'*. George had discovered his interest in art and he started to *'look what's on the museum call into the museum to see if there is anything new and so on.'* Anna held fond memories of her time when she was the co-owner of a small knitting business and *'went to the big shows, you know, the arts and crafts shows and I used to go up and help her set up a stall and sell the things and package them'*. Finn and his band used to perform small gigs in their local community and he wasn't restricted *'to just stay at the day centre'*. The search for creative opportunities in her local community led Lisa to weekend courses and she tried to *'go to as many as I can or can afford really because I just find it so therapeutic and beneficial, and I love the atmosphere there'*.

The natural environment was a source for ideas, as Emma found out. She recalled sitting in her garden and *'just get a flash isn't that beautiful and you think well perhaps other people couldn't see'*. For her a flash was an inspirational thought about her next embroidery project. Since George attended the art class, he became more aware of his local environment which gave him ideas for his creative projects: *'It's in my mind, not all the time, but you know, particularly from where I work at my desk in the flat, I can see the garden and I can see the trees and shrubs, so again, my mind is thinking that's an interesting colour combination and that might be useful and sometimes when I am walking and see wall murals and the children at the local school have done a lot of wall murals and as I walk by you can see all these and again they give you ideas about what we might do.'*

4.8 Third theme: The need to express oneself and be known

All participants had a need or desire to express themselves through their chosen creative activity and to make their thoughts, feelings and ideas known to themselves and others. Negative feelings were described if an individual piece of work did not turn out the way it was anticipated. During the acute stages of mental illness, participants very often lost

confidence and stopped interacting with other people. Participating in a creative activity offered the opportunity to ‘get the inside out’ by the action of just doing it or with intensive concentration on what was about to be created. The person’s hands came into contact with the material (clay, cloth, paper, strings) or tool (hands, needle, brush/pencil, charcoal, guitar) and transformed it into a piece of ceramic work, embroidery, drawing, a sketch, painting or song.

‘I can’t put things into words sometimes, so art is the way, you know, I can express myself.’

(Charlotte, making drawings, line 5-7)

Participants developed the ability to create a drawing or an object from an idea in their head, and feelings of pride or frustration emerged depending on how close the finished product resembled their imagination. Being able to ‘*convey an image from your brain into your hand*’ was, for Martyn, sometimes difficult to achieve, particularly when he felt unwell. He struggled to overcome negative thoughts about himself and his inadequacy to draw accurately. Martyn knew that only practice could change this.

For two other participants, Emma and Gareth, the idea of their new creation was so strong that both saw the finished piece of work as an image in their brain. Emma had experienced what she called a flash, a moment of imagination, and remembered that she woke up one morning ‘*with a whole idea complete in my brain. I’ve never had that experience before, but I knew exactly what technique I was going to use, and what thread*’. This very vivid image of her new creation brought her into action because she then had ‘*to go and find the colours and background and it just came*’.

Gareth always worked from an idea in his head and he was particularly proud that he never used ‘*any plans, never, none, all comes from my head*’. The finished article appeared as a photograph in Gareth’s head so he ‘*can see it*’ and ‘*work with that*’. He also expressed his determination ‘*to keep going until I get it right*’ if an idea did not exactly work out, but also his agitation because he got ‘*very involved*’ with his project. Like Emma, he would leave the work for some time and return to it later.

Lisa found out that she had the creative ability to ‘*recreate a very – face-like face in clay and it comes to life as I am working on it, as I make*’. After seven years of regular

engagement in ceramic work, Lisa had developed skills in sculpting at a very high standard and was able to *'express myself through the act of making a piece of work. So sometimes I will do really wacky things, because I've dreamt them or I just had this vision in my head or something that I want to create, and I can do it now, I have the skills to do it, to recreate it as I saw it in my head, and that is thrilling'*. Similarly, Finn expressed feelings of pride about his skills in guitar playing and his ability to play *'something and to get it right'*. Getting it right meant for him *'getting in time with something else like a drum machine or other instruments'*. Playing the guitar became such an important part of Finn's life. It became his life, his sense of being.

Two other participants had only just started to learn how to draw and to discover different techniques. George who was always told that he did not have *'any creative ability whatsoever'* was particularly drawn towards a free style of self-expression. He found this style liberating and particularly liked the use chalk and charcoal. He *'was conscious that I was drawing leaves, but I was not copying the leaf, I was doing things in the style of'* realising for the first time that he had found his own style of drawing. Nick was convinced that his hand injury and lack of talent had forced the development of his self-expression through drawing in a certain way because his artwork was *'messy and scrappy'*. However, he valued the opportunity drawing gave him to get feelings out *'in whatever way they come out'* without interpreting too much into his drawings. The inability to talk about traumatic events in his life was compensated by his ability to draw out feelings, to bring them to the outside on a piece of paper, where they could be seen and looked at without the necessity of being explained to himself or an audience.

Peter liked drawing sketches because he could express his thoughts about something that had happened to him and he viewed this creative activity as *'a good way of reflecting, and you realise, yeah, that must have meant something and when you draw something to do with it, and it makes you understand it a bit more and makes you realise, why it was horrible (pause). For me anyway, and that's a good positive thing even if I do something that upsets me, it's still a way of getting that out, which is positive in the long run.'* Finn who had been playing the guitar for nearly two decades, was proud of his ongoing development as a guitar player as well as a songwriter. His ability to *'create a quality of music with it [the guitar]'* made him realise that he had found his own style of playing the guitar. Gareth's creative longing brought him into

conflict because he thought he got *'to scale down my operation which I don't really like to do, because my visions are big'*. But living in a retirement home with other people restricted his options to pursue a much treasured hobby.

Several participants noticed differences when they engaged in the creative process. Lisa was aware that she used two different styles in her creative work: one appeared more product-orientated, whereas the other seemed to be process-orientated: *'We are expected to reproduce as accurately as we can what we see in front of use in clay, but on a Tuesday when I go I do my own thing, so I go with an idea in my head and I just try and make it to best of my ability and I find even that is totally engaging for me.'* Martyn enjoyed drawing but at the same time he was battling with his intrusive and negative thoughts *'the thing that I think, while I am doing it, which is the same I think when I am doing most things, is I am rubbish at this, I shouldn't be doing this.'* Martyn's sense of self-worth had become very low when he was diagnosed with a mental illness but he still tried to keep his interest going, even though we would always criticise his efforts with drawing.

Three participants expressed feelings of frustration but they showed the willingness not to succumb to this negative feeling. Emma mentioned that *'sometimes'*, what she felt *'is frustration, because you can't get the idea yet out of your head that you want'*. But she would leave the work alone *'don't look at it for a week or two and then when the light is very good, have another look and see if you can see something else.'* If a drawing did not turn out the way Peter intended to draw it, he compared himself with other people who *'get very frustrated when it's like that'*. He pointed out that he used a different approach, because he tended *'to try and enjoy it just for doing something and if I have to finish a picture and just crumble it up and throw it out in the bin, it's a little bit frustrating for a minute but I'll try and start another one, or try not let it bother me too much.'* He thought that because he was not *'too much of a perfectionist'* it was easier for him to deal with work that did not turn out the way he thought it would.

If something did not work the way he wanted it to, then Gareth *'would stick to it. I will keep going until I get it right, yeah. I am like a dog with a bone.'* Gareth would not give up working on this detail until it was fixed, because he didn't *'like failure. I get very involved and I get sometimes very agitated.'* However, when he *'had a real sticking*

point, I've left it for a while, but I've always gone back to it.' He thought that despite some mishaps he would have always successfully completed any of his projects.

4.9. Fourth theme: The significance of continued engagement

Continued engagement in her/his favourite creative activity was of personal significance and meaning for each participant. The meaningfulness of engagement gave them the courage to extend their experiences into other aspects of her and his life. For each participant engagement in their chosen, favourite creative activity generated new experiences and increased their interest in trying out new things.

'I had given up embroidery, because I couldn't thread needles, and the movements were too precise. I was too shaky and with this project I broke new ground, really. This is almost a new type of embroidery.'

(Emma, making embroidery, line 255-259)

Emma experienced several physical health problems and she nearly had to give up embroidery as her pastime. However, her strong interest in embroidery, and her desire to get *'the inside out'* made her try out a new kind of embroidery. Even though she was unable to continue with her preferred personal style, her creative ability helped her overcome this challenge and gave her the opportunity for a new experience, which she thoroughly enjoyed.

George, who was always told when he was young, *'that I had no creative ability whatsoever'* was astonished when he found out that *'I could do some of the exercises. I was surprised that some of things I produced were not so bad'*. He discovered that *'art is a very interesting area and it would be nice to know more about it'*. Because his life had become very busy again after his hospital stay and although he didn't *'have time to read art books and that sort of thing, you know'* he felt inspired to *'go along to exhibitions and see other people's work and often at the art museum they will tell you the materials that people have used in the art work, not just ink but sometimes different colours, different sort of materials for the art work'*. George enjoyed the different aspects of art because they *'engaged my interest in art in a more general way'* and he felt his newly acquired knowledge had enriched his experiences in art. Art became a

new interest in George's life and he felt *'sad that, you know, I wasn't encouraged when I was young, as this is something that I might have built on over many years'*.

Martyn still struggled every day to overcome the symptoms of his illness, but he appreciated that whenever he was able to draw a sketch he felt that *'I learn something new from it.'* His desire to improve his drawing skills, because he was mostly self-taught, and to attend a course at an art centre during the day meant that he had to work hard *'to get into a proper sleeping pattern'*. He was persistent in his efforts to reach this goal because he wanted to enjoy new experiences with his artwork in the future. For Lisa, new experiences meant to *'move out of the network of people that I have made friends with and so that's something. I want to work on and to sell my work more to [pause] to feel that it's good enough to sell, because I struggle with that, I don't think my work is good (laughs).'* Despite small successes at local galleries, Lisa still expressed some self-doubt and insecurity in managing her future. However, she was confident enough to try out new things and overcome these internal struggles because it was meaningful for her and worth the effort.

Gareth decided that he would try to sell his handmade cranes and that *'if they sell, then the money is going to be donated. And I'm very grateful for what they've (staff at the workshop and garden centre) done for me, it's my way of saying thanks.'* Gareth was aware that his way of living was not welcome by other residents *'I don't think I will be able to carry on the way I'm doing it, which is sad'*, but his creative drive would not stop him *'taking things to pieces and putting them together (laughs), it's still there, I don't think it will ever leave me'*. Finn knew that he had *'outgrown'* going to the day centre with its music room three times a week, even though it *'it was such a good exercise to get up in the morning, because with Clozapine you wake up in the morning 'cos Clozapine sends you to sleep beautifully. If I wasn't to take my medication, I wouldn't get to sleep, it's sedating, it's designed to get you to sleep. So if I do wake up at nine in the morning, get going, get out of bed, you can shake off the Clozapine, you can, you head's tired but you can get going. Anyway, so I found the vigorous get out of bed, get dressed, get to town and play at the day centre, I found that exercise woke me up a lot.'* Even though this regularity had now come to an end, and meant that he had to re-organise his days, he was not fearful of taking on new projects and making new experiences with other people.

Due to financial cuts in mental health services the local day centre closed down and Lisa recalled how devastated she was when it happened. However, this event was an important turning point in her life and created a new experience for her, because she decided to step out from her role as a fulltime patient and *'being part of the hospital scene'* and become a citizen again, with the desire of attending a local ceramic studio *'I had been going to a day centre in this town, as I said, and then the funding was cut completely, and I didn't have anything to do and for a week I sat here at home and did nothing, absolutely nothing, and I just thought "If I do this, I'm going to be dead within a month. I'm just going to completely shut down and go backward".'* She feared that she would have a relapse and end up in hospital. Her desire to engage in a creative activity motivated her to go to the local art shop and to respond to an advert that announced *'that a new studio was opening in this village for ceramic work'*.

Lisa wrote a mail to the studio owner *'and I told her everything about, you know, me suffering from mental illness problems and that I was on lots of medication and stuff, and I didn't think I'll be able to do a full day, but that I really wanted to come to the sessions'*. The owner encouraged her to attend the next session and made Lisa believe *'that I could go and be part of this group even though I knew none of the rest of the people there had anything to do with mental illness or problems or (pause) and I had become, I felt I had become so institutionalised by being at the hospital and being part of the hospital scene that there was nothing else in my life, really, except the hospital.'* She believed that the experience transformed her and attributed the positive changes in her personality to *'the ceramic work I've done and the connection that I've made with other like-minded people'*.

In contrast, Ann was the only one who did not like her new experiences which entailed doctor visits and less involvement with her favourite pastime, knitting. Her physical health concerns had taken over her life and she felt that there was *'nothing to look forward to in that way.'* During the interview she became aware that her effort to donate her knitting material to other people was a way to create new and more positive experiences. *'I do take it along (to the crafts classes) and there is a lady there who's daughter wanted the material, 'cause I had lots of material, bags and bags of it and I've given all that away'*. Ann was also keen for *'other people to have it'* and she hoped that *it will help other people, you know, that other people will use it.'*

When Peter realised that *'I enjoyed it (drawing and working with clay) and found it helpful, I would search it out and find different places to do it and asking people whether I could do this or use the art work room and things like that, so I would search it out as such'*. Through his artwork, Peter had come into contact with other people and had *'met a few people who are artistic'* and *'a lot of artists who have helped me as well'*. His effort to share his artwork with other like-minded people was rewarded with the exchange of creative ideas and *'sometimes doing creative things together'*, creating new and positive experiences for Peter.

Charlotte was thinking about going to a local gallery and trying to sell her art work *'and maybe see if they are interested (pause)'*. At the moment, she is happy, to produce her artwork and build up a portfolio, but knowing that she had this opportunity was important for her. Nick who had a spell of acute illness, could not wait to get back to his artwork once he *'was corpus mente again'*. He had already made plans to *'properly do creative writing'*, anticipating new and meaningful experiences will happen soon. When Emma was a child she had to spend a long time in hospital and she learned to do a simple version of embroidery. Over the years she became more skilled and she was able to create new and positive experiences about herself: *'I lacked confidence (pause) after missing so much because of illness, when I was a child; I never thought, I could do anything and that became something I could do.'*

4.10 Summary

This chapter presented the findings of our study. Four themes and four subthemes emerged from the participants' descriptive account of their experiences with creative activities. The first two themes 'Engagement in a creative activity' and 'Engagement with people and places' related to the creative and social needs of our participants. Through engagement in a favourite creative activity, participants felt active and connected to the present moment, to people and places. It was a personally significant and meaningful experience that had the potential to engage them with reality, the real here and now, as opposed to unreal things happening in her/his mind. Deep concentration during engagement gave our participants temporary mental relief from worrying thoughts.

Activities revealed a multiplicity of uses with creative occupation depending on the individual's needs. They were used as a distraction technique to turn the mind away from disturbing or worrying thoughts; they helped to evoke positive feelings such as feeling relaxed and joyful; it was also a favourite pastime and perhaps a future work opportunity for three participants.

Most important, creative activities provided opportunities for self-expression and connectedness with people and places, thereby contributing to an active lifestyle. The active lifestyle was threatened during episodes of unwellness and illness which was reflected in the two themes 'The need to express oneself and be known' and 'The significance of continued engagement'. The next chapter focuses on the discussion of the findings of our study and places them within the context of findings from the relevant literature on creative activities and occupational science.

CHAPTER 5 DISCUSSION

5.1 Introduction

Here, I have further analysed and interpreted the findings and compared them within the context of already known published research in the field of occupational therapy, occupational science and other relevant disciplines. Additionally, contemporary literature on topics such as ‘making’ and ‘creativity’ from various fields helped us explain the findings from our study. The aim was to explore the experience of participation in creative activities for people in remission of mental illness, their feelings and reactions towards creative experiences, and thus to advance occupational therapists’ understanding of the therapeutic potential of certain creative activities.

In my clinical work, I am used to trying out new ideas for intervention programs with patients and I am encouraged by my clinical supervisor to take ideas based on research evidence from a variety of clinical areas. Working closely with a medical team allows me to ask them about new developments in neuroscience and neurology. The doctoral course has me allowed to explore ideas from occupational science to support my decision making as an occupational therapist and develop my understanding of the use of occupation as a health promoting intervention.

The research question *‘What is the experience of participation in creative activities for people in remission of mental illness’* directed me towards a qualitative methodology and I chose a hermeneutic phenomenological approach to answer it. I discovered from the findings of our study that the participants had chosen to engage in creative activities as a leisure occupation without the involvement of a therapist. They had identified a creative need which needed to be responded to as well as a social need to engage with like-minded people. I realised that over time my understanding of the themes had further developed into ideas which were conceptualised and they form the structure of the discussion which follows next.

This discussion is structured in the following way: the findings which consisted of themes and subthemes, and generated ideas. I conceptualised the ideas, and discussed

them with my supervisory team, colleagues and members of the Service User Forum. Appendix 12 shows the development of early conceptualised ideas, which were refined (Appendix 13) and led to an early concept map (Appendix 14). Further refinement produced the concept map that contains a form of higher order conceptualisation of the themes (Appendix 15).

The participants of our study expressed creative and social needs that appeared to be fulfilled through their engagement in creative occupation. I wanted to develop a deeper understanding of this and find out the possible reasons why our participants had an innate need to become involved in opportunities of creative self-expression without the help of a therapist. Continued creative occupation was linked to the theory of health promotion because our participants experienced a positive effect on their subjective wellbeing. I discussed the concept of creativity and the creative process and how perspectives on positive psychological states such as mindfulness, reversal theory and the flow process might help us to appreciate the effects of creative engagement. The participants' own knowledge and understanding of the effects of creative occupation was linked to the concept of experiential learning and was a powerful motivating tool to facilitate continued engagement in their individually chosen creative activity.

I will start this section with a discussion of the creative needs our participants expressed and reasons why interest might contribute to make the engagement in creative activities a meaningful experience. I will continue the discussion with the concept of health promotion and creativity, and how it applied to the participants. Following on this, possible links of our findings with mindfulness, flow process, reversal theory perspective, the Default Mode Network, stigma and learning will be explored. The chapter finishes with a summary of the strengths and limitations of the study, contributions to knowledge, implications for clinical practice and Public Health, recommendations for clinical practice, identification of further research, personal reflections and a summary.

My conceptualisation of the phenomenon of engagement in creative activities was previously shaped by my clinical and personal encounters, and has been reshaped by the research findings. When I started the research, I anticipated gaining a deeper insight into participants' experiences of creative activities within the context of structured class or

group programmes. I needed to better appreciate the possible therapeutic potential of such engagement. In my role as a researcher, I had to mentally remove myself from the context of service provision as an occupational therapist which Mattingly and Fleming (1994) referred to as *'a kind of short story within the longer life story a client is living. The therapist enters and exits a client's life, playing a part for only a small period'* (p. 19). By doing so, I opened myself up to discover a variety of other ways participants utilised creative activities in their lives. I did not expect to find out however, that creative occupation had always been or had become an important part of the participants' whole life, as a leisure pursuit, a life away from mental health services. I learned that the participants' choice of engaging in particular creative activities as a leisure occupation, had made them into active agents who purposefully contributed to their own subjective wellbeing and the wider health promotion agenda despite facing adversity from mental illness.

Their engagement was largely driven by a need to be creative because they enjoyed it so much. Conscious engagement in creative occupation supports Wilcock's theory of the use of occupation for self-restoration and keeping healthy (Wilcock and Hocking, 2015) Participants showed an innate need for action or, as Wilcock views it, a biological need because they did not want to succumb to the symptoms of their mental illness. The need for occupational engagement was addressed on a group and solitary level, and evoked positive emotions, amongst them happiness and pleasure.

Our participants used language in various ways such as storytelling, and distinct words and metaphors to talk about a creative activity that held personal significance for them. Some participants mentioned famous artists, musicians or other public figures, and quoted scenes from the literature that had influenced and inspired them. These were all hints that the participants viewed themselves as individuals who aspired to live normal lives despite health concerns. By listening to their verbal accounts, I began to realise that they had attributed meanings to their experiences which equipped them with personal knowledge and generated understanding about why continued engagement was helpful, enjoyable and made them feel better.

The findings emphasised that engagement in creative activities generated 'meaningful' experiences in the lives of participants. The four themes and their subthemes relate to

this meaningfulness, which was constructed through the interplay of the subjective experience of doing and making, personal knowledge, and understanding about the engagement in creative activities as it had presented itself to the participants during times of wellness, unwellness and illness. Unwellness describes the state of feeling unwell during remission when symptoms of mental illness, such as anxiety, low mood and self-referential intrusive thoughts become more evident.

The four themes are summarised below:

‘Engagement in a creative activity’ and ‘Engagement with people and places’ was related to a range of needs in participants, amongst them most prominently, creative and social needs. Creative needs were addressed through the ‘Action of doing’, and ‘Being in the moment of making’, while social needs seemed to be addressed through ‘Being with people’ and ‘Being at places’. Creative activities revealed a multiplicity of uses depending on the individual’s need – as a distraction, ‘therapy’, outlet for inner turmoil, joy, leisure and anticipated work – and provided opportunities for self-expression and connectedness with people and places, thereby contributing to a more active lifestyle. This active lifestyle was threatened during episodes of illness and during remission when a person’s mental health sometimes fluctuated which was reflected in the two themes ‘The need to express oneself and be known’ and ‘The significance of continued engagement’.

Through creative engagement, participants said that they were able to direct and focus their attention to a specific activity in the present moment. This seems to compare with the recently growing literature on the positive effects of mindfulness. The awareness of the present moment can be deliberately maintained through mindfulness techniques and might be helpful for people who have difficulties concentrating during occupational engagement (Martin, Sadlo and Stew, 2012; Martin and Doswell, 2012; Martin, 2009). Engagement was perceived at various levels of conscious thought, and a less conscious self-absorption happened in some instances during the creative process. These findings concur with the idea that deep engagement can be alternatively conscious and unconscious. ‘Unconscious’ engagement seems to equate with flow theory (Csikszentmihalyi, 1996). A rationale for different psychological states has been previously explored by Wright, Wright, Sadlo and Stew (2014a).

Previous research into creative activities that included people living with mental illness focused on structured programmes that were provided in community-based arts projects (Lawson, Reynolds, Bryant and Wilson, 2014; Swindells, Lawthom, Rowley, Siddiquee, Kilroy, and Kagan, 2013; Lloyd, Wong and Petchkovsky, 2007) or at day services (Horghagen, Fostvedt and Alsaker, 2014; Griffiths, 2008; Mee, Sumsion and Craik, 2004; Mee and Sumsion, 2001). The findings of the phenomenological study by Lawson, Reynolds, Bryant and Wilson (2014) indicated that the participants valued the personal process of art-making and the social context. The study by Swindells, Lawthom, Rowley, Siddiquee, Kilroy, and Kagan (2013) used a mixed-method design, and underlined the importance of skilled facilitation, the flexibility of creative activity to match the participant's skills, and providing a meaningful experience for them. In the Australian study by Lloyd, Wong and Petchkovsky (2007), art-making was regarded as a medium for self-expression and discovery, and changes in self-perception were linked to a conceptual model of recovery. The Norwegian study by Horghagen, Fostvedt and Alsaker (2014) used ethnography and the findings indicated that making craft activities in a group facilitated stability, routines, skills, abilities and peer support.

Griffiths (2008) conducted a grounded theory study with clients and occupational therapists and she discovered that the experience of engagement was linked to different levels of consciousness that seemed to influence the thought process. Deeper levels of engagement were experienced by participants as flow-like states. The ethnographic study by Mee and her colleagues (Mee, Sumsion and Craik, 2004; Mee and Sumsion, 2001) focused on the engagement of meaningful occupation, which generated motivation, improved competence and a self-identity. Only one study focused on needlecrafts as a leisure activity in the lives of thirty nine women living with depression (Reynolds, 2000). Our study emphasised creative leisure occupation as a meaningful experience in the lives of participants and I used an occupational perspective to interpret the findings. Within this perspective, occupation is thought to be linked to health and subjective wellbeing and the human need for occupation essential for survival and adaptation. The innate drive to respond to occupational needs seems to provide individuals with opportunities to explore their creative, social and educational potential, as a way of keeping themselves well (Wilcock and Hocking, 2015).

5.2 Creative needs

I will now start to discuss one of the important findings which was identified as 'creative needs'. The participants deliberately sought out opportunities to engage in creative activities without a therapist. The finding was related to Ann Wilcock's theorising about occupation as a health promoting activity. (Wilcock & Hocking, 2015; Wilcock, 2014; 2007; 2005; 2006; 2001a; 2001b; 1998) regarding humans as a creative species, with a natural desire to act on these matters almost like an instinct. These participants seemed to display an innate need to express themselves creatively in their everyday lives through individually chosen activities such as drawing, painting, woodwork, playing the guitar, knitting and embroidery. Initially, I did not understand the intentions or the implications of this, and wondered about their motivation to initiate participation. What I learned from the interviews was that participants used arts and crafts in their own time, away from services, because they simply 'enjoyed doing' them. I began to understand that particular creative activities had become important parts of their lives, and the participants were drawn to them of their own free will. Individual differences existed because of the participants' background, lifestyle, socio-economic status, commitments, health status, and duration of remission, but the longing to respond to their creative needs was not restricted to times when participants felt well.

During times of unwellness, intrusive and negative thoughts made it more difficult to engage because these thoughts interfered with the participants' ability to concentrate. However, the use of self-encouragement and individually adapted techniques seemed to facilitate involvement. This seems to be a unique finding from our study, whereas encouragement by others, usually family members and friends, had already been reported in two earlier studies with older people (Reynolds, 2009; Bedding and Sadlo, 2008) as a means to facilitate participation. It also indicated that our participants showed willingness and open-mindedness to try out alternatives or techniques to make engagement easier, because it meant so much for them. There is scope for occupational therapists to offer alternative techniques that could improve participation. Mindfulness training may have potential to increase concentration and an agreeable attitude (Martin, Sadlo and Stew, 2014), and perhaps could be more deliberately used to focus attention within occupational therapy.

As it will later be pointed out, the ability to concentrate, to focus one's mind and attention to the activity is pivotal to entering a state of deep concentration and to (it seems) experience positive psychological states, perhaps contributable to a soothing effect for an overactive Default Mode Network (DMN). It seems that the Default Mode Network has relevance to the findings of this study. During illness, it was even more difficult for our participants to perform everyday activities including creative endeavours. All participants had previous experience with participation in hospital or community-based groups. Illness can disrupt the person's intentionality, which according to Fleming (1994,), *'is an inner force that directs us outward into participation in the life-world'* (p. 207). Fleming defined occupational therapy based on the findings of the Clinical Reasoning Study, as a way of supporting an individual's intentionality through the provision of meaningful activities that relate to past interests or might evoke new ones. Phenomenologists hold the belief that choice making is as an intentional and significant act for the individual. These findings were supported by our study with six participants expressing an interest in creative activities since childhood and four participants who were introduced to creative work in hospital. Each person's intentionality was nurtured by ward-based occupational therapy staff giving her/him the opportunity to choose from amongst a variety of creative activities that evoked their past or a new interest.

The phenomenological view of intentionality implies that a person's orientation to the world includes an interest in being in, and an awareness of, one's world (Merleau-Ponty, 1962). This corresponds with the experience of four participants, who became interested in creative activities during their hospital stay. Familiarity and normality with traditional arts and crafts activities, the opportunity to make choices in engagement, and being encouraged by others appeared to facilitate their initial participation. Similar experiences were described by people with mental health needs who attended services that offered traditional crafts activities within an affirmative environment (Horghagen, Fostvedt and Alsaker 2014). Craft-making in a group strengthened the participants' self-identity as an artisan and maker, and daily participation generated a sense of everyday occupation as well as a sense of achievement for making products that could be displayed and sold.

When I started this study, I was surprised to find out that ‘interest’ and ‘the need to do something creative’ was a recurring theme amongst the participants. They described having an interest or motivation that made them start in the action of doing a creative activity that they found enjoyable and helpful. Six participants enjoyed creative occupation prior to the onset of mental illness and developed it into a life-long interest. Creative engagement as a meaningful experience had been constructed over a prolonged period of time and was manifested as a favourite leisure-based activity in their life, even when they were facing unwellness or illness. Small achievements such as making a piece of work from clay (Peter), a sketch (Martyn), a painting (George) or playing a familiar song (Nick), kept participants’ interest alive. Reynolds, Vivat and Prior (2008) reported similar findings from their study with ten women living with chronic fatigue syndrome/myalgic encephalopathy. It appears that interest and the knowledge that small achievements are possible through creative occupation facilitated participation despite the presence of severe disabling symptoms.

5.3 Interest and meaningful experiences

Fox (2008) views ‘*interest as a phenomenologically pleasant emotion*’ (p. 332) perhaps similar to wonder, curiosity and inner motivation. Interest was also found to be an essential factor in creating the desire to explore the environment (Panksepp, 2004). Furthermore, in the field of humanistic psychology, inner motivation was emphasised as an important belief by Abraham Maslow (1954) and Carl Rogers (1954, 1961), in their search for human happiness. These ideas may offer a theoretical explanation why some participants in our study were actively seeking out opportunities for creative occupation in hospital settings or their local community including Gareth’s search for recycled material to make objects, and Emma’s and George’s inspiration in nature for future endeavours. In contrast, the study by Reynolds, Vivat and Prior (2008) included participants who were confined to their home, but they responded to their creative needs through imagination and art-making which offered some contact with the outside world. Our participants voiced a desire for creative self-expression and enjoyed the active engagement in the creative process. It gave them valued experiences of control, choice and autonomy which they did not feel able to exert elsewhere. Participants in two other studies reported similar experiences (Timmons and Mac Donald, 2008; Reynolds, 2004). Regular engagement happened voluntarily and a useful theoretical position is the Self-determination Theory which was developed by Edward Deci and Richard Ryan

(1985). Both authors suggested that different types of motivation exist based on the different reasons and goals that generate the rise of an action. Deci and Ryan distinguish between intrinsic and extrinsic motivation, the latter referring to doing something because it leads to a discreet outcome, whereas the former relates to doing something because it is inherently interesting and enjoyable. Our participants experienced pleasure and happiness just through doing a creative activity, for example just drawing something, working with clay, playing the guitar. There were also instances where the participants worked towards a specific goal, for example Gareth who created a mobile crane from discarded material and knew exactly what it would look like once completed.

Craike (2008) conducted a study to examine the relationship between intrinsic motivation, behaviour regulators, enjoyment and regular leisure time physical activity. Intrinsic motivation was found by the study to be a stronger predictor of regularity of participation than enjoyment. The study demonstrated strong links between intrinsic motivation and positive outcomes, and confirmed the findings of an earlier study by Fredrickson (2004). Additionally, participation happened more regularly because physical activity was integrated into the participants' sense of self (identified regulator) and internally motivated. These results offer a possible explanation about our participants' dedication and regular commitment to creative occupation. Participants demonstrated inner motivation, desire and interest to engage in their preferred activity, which could have been all together stronger driving forces for regular participation than feelings of enjoyment, according to the Self-Determination Theory.

Wilcock (Wilcock and Hocking, 2014) does not necessarily exclude unwellness or illness in her position on the innate creative needs of humans but she has not specifically addressed it either. Living with a mental illness or chronic medical condition meant that individuals had to deal with the changing nature of severity of symptoms which brought disruptions to their lifestyle. Our participants experienced severe disruptions in their lifestyle during episodes of illness, when engagement was restricted to small projects and simple process-orientated creative occupation as a way to feel consoled and comforted. Nick would play a familiar song he knew he could play to console himself and Emma would make a few simple stitches in her embroidery to spark herself off. George valued a small achievement such as completing a drawing

because he was able to feel good about himself. However, it is still not clear how acute stages of mental illness interfere with a person's creative needs, and this warrants further consideration.

The study by Reynolds, Vivat and Prior (2008), earlier research by Reynolds (2000) that included women living with depression and our study, all revealed the personal initiative of participants who took up creative activities, whereas in other studies (Horghagen, Fostvedt and Alsaker, 2014; Lawson, Reynolds, Bryant and Wilson, 2013; Swindells, Lawthom, Rowley, Siddiquee, Kilroy and Kagan, 2013; Griffiths, 2008; Lloyd, Wong and Petschkovsky, 2007; Mee Sumsion, and Craik, 2004; Mee and Sumsion, 2001; Rebeiro and Cook, 1999) voluntary involvement in familiar arts and crafts was an option of structured programmes and arts projects. Mental health service providers recognised the therapeutic potential of the arts and crafts, working hard to offer voluntary participation and a choice of creative activities to individuals in order to add meaning to their lives (Horghagen, Fostvedt and Alsaker, 2014; Griffiths, 2008; Lloyd, Wong and Petchkovsky).

Occupation itself seemed to act as a valuable means to generate motivation in people living with persistent mental illness as Mee, Sumsion and Craik (2004) and Mee and Sumsion (2001) suggested. Their participants' desire for engagement through woodwork contributed to their subjective wellbeing and development of self-identity. Our findings were similar, because the participants' action of doing and making appeared to foster the growth of a self-identity that had, at its core, strength, interest and the ability to encounter unwellness and illness. In a study by Bedding and Sadlo (2008), retired participants' engagement in painting only happened during class attendance, perhaps indicating a short-lived interest in painting and perhaps a greater interest in the social aspect of meeting like-minded people at an art-class.

Similarly, participants in other studies who attended day services or participated in community – based arts projects (Horghagen, Fostvedt and Alsaker, 2014; Lawson, Reynolds, Bryant and Wilson, 2013; Swindells, Lawthom, Rowley, Siddiquee, Kilroy and Kagan, 2013; Griffiths, 2008; Lloyd, Wong and Petschkovsky, 2007; Mee Sumsion, and Craik, 2004; Mee and Sumsion, 2001; Rebeiro and Cook, 1999) seemed to limit their engagement in creative activities at these venues. The question remains, what

happens to the participants after an arts project ends or a day service restricts the attendance to a specific number of sessions in order to provide creative opportunities for a wider audience? These are serious issues for people living with mental health problems because they already experience social disadvantages caused by unemployment, limited social contacts and a lack of meaningful experiences in their lives (Leckey, 2011; Rebeiro and Cook, 1999). The importance of creating meaningful experiences will be discussed in the following section.

The relationship between occupation and experience has long been recognised in the occupational therapy (Kielhofner, 2007) and occupational science literature (Kuo, 2011). Kielhofner placed emphasis on how volition influenced individual human performance when engaged in an occupation. Kuo explored occupation as a conduit that creates meaningful experiences '*that matter*' (p. 131). In her paper, she argues that people have the ability to create desirable, meaningful experiences by focusing their attention on the way they perform occupation. The participants in our study viewed their engagement in their chosen activities as '*meaningful experiences*'. The familiarity of the movements to play the guitar, to hold a brush, a pencil or a needle, to use simple techniques, and the knowledge of positive effects on their subjective wellbeing, appeared to have given our participants the right amount of hope to engage in their favourite creative activity during times of unwellness and illness.

In Wilcock's occupational perspective of health (Wilcock and Hocking, 2015) occupation is viewed as a basic human need, conceptualised through doing, being, belonging and becoming. Research on meaning had been neglected in occupational therapy theory a decade ago, and instead focusing on purposeful activities (Hamm, 2004). Furthermore, in an earlier paper, Reynolds (2009) suggested that research in occupational therapy should pay tribute to the '*meanings of occupation for people in the community who are coping with illness and life transitions*' (p. 552). Nick, who had injured his hand during an episode of illness, acknowledged that his drawing was always messy but this did not stop him from thoroughly enjoying the action of doing and making a drawing. His emphasis was not on using drawing as a way to improve his hand function (purpose), but rather on creating a meaningful and significant experience that improved his subjective wellbeing.

Recent studies that investigated occupational engagement and experience (Watters, Pearce, Backman and Suto, 2013; Eklund, Hermansson and Hakansson, 2012) have enhanced our understanding that both experience of doing and meaning of the experience are fundamental aspects of occupation in people's lives. The findings of the study by Eklund (2012) found that people living with schizophrenia experienced engagement in only a limited range of everyday occupation, and reported loneliness and little meaning in their lives. Our findings concur with this in that participants faced life episodes of little meaning after discharge from hospital, but a natural desire to become an active being was perhaps facilitated in our participants by a re-awakened interest of doing, of taking up their favourite creativity activity again and aiming for small achievements. From an occupational perspective it is plausible that the action of doing itself encouraged self-expression through a meaningful, personally significant activity, thereby restoring the 'self' in the process (Wilcock and Hocking, 2105).

5.4 Health promotion

Our participants engaged deliberately in creative activities in their own time and without a therapist. In the beginning of this chapter I mentioned Wilcock's theory of the use of occupation for self-restoration and keeping healthy. Through creative occupation, the participants became their own active agents for health promotion by using their arts and crafts skills to influence their subjective wellbeing. The concept of health promotion and how it was used by our participants will form the discussion of the next section. Engagement in creative activities as a leisure pursuit and what it means for people living with mental health problems remains under-researched. The lack of in-depth longitudinal qualitative studies into creative occupations was raised as an important matter by Reynolds (2009) in her editorial note, where she stressed the importance of valued craft skills '*as a cultural capital in people to be used in time of need*' (p. 1). Solutions to the lack of research in this field will have to be addressed from a public health perspective in order to secure adequate funding, and to inspire innovative programmes for the wider public that includes people, living with health problems. Our participants demonstrated that arts and craft skills were part of their skills repertoire and used during times of wellness, unwellness and illness as a way to feel better and to experience joy. The implication of this is that they had become active people who were keen to manage their own subjective wellbeing and their health problems through

creative occupation. The health-promoting attitude of our participants was not short-lived because creative occupation had been integrated into their lifestyle.

There were multiple ways in which our participants utilised creative activities depending on their need. This finding is supported by research on textile art-making (Reynolds and Prior, 2003), ceramics (Timmons and McDonald, 2008), woodwork (Mee, Sumsion and Craik, 2004; Mee and Sumsion, 2001) and painting (Bedding and Sadlo, 2008). The studies highlight the issue of autonomy because our participants decided themselves which modality they would use in their creative occupation. Its application of activity analysis and activity grading, usually in the domain of professionals, has moved on to individuals who themselves determine what to use in order to influence their own subjective wellbeing. Participants themselves knew what activities held restorative powers for them. Our participants worked autonomously without a therapist – they had become active agents of their own health, thereby contributing to public health and its health promotion agenda. Immediate and long-term use of creative occupation had supplied our participants with personal knowledge about its health promoting effects.

Our participants expressed themselves through different media and techniques, and each one had found a preferred and unique style. Reynolds' studies with groups of women living with chronic health problems, such as multiple sclerosis, and chronic fatigue syndrome/myalgic encephalopathy, also found that art-making offered a way for her participants to build a positive self-image within the constraints of their illness. Art-making became a way of living for her participants and did more than just filled occupational voids. I found the positive decision of her participants to live with and through the illness, instead of striving for recovery, inspiring and often missing in the field of mental health.

Amering and Schmolke (2009) also suggested connections between the concept of health promotion and recovery. They urged us to strive for a broader understanding of health and, like Wilcock (2014), view it as an essential part of everyday life, and people as active agents with inherent abilities to adapt to changing circumstances. People with mental health problems are usually regarded as a vulnerable group and not often included in research. In the past, bi-polar disorder and schizophrenia were understood as

chronic illnesses, and research that included them as participants focused mainly on service provision in institutional settings. In contemporary practice the word ‘remission’ is used instead and this has broadened the inclusion criteria for their participation in research. Our study is the first that includes people in remission of mental illness who engaged in creative leisure occupation.

As the service user movement gained more attention in the media, the concept of ‘recovery’ became widely known. It remains controversial (Cooke, 2014) because it emphasises recovery from mental illness as a highly individual process. Some people find a diagnosis helpful and prefer that their mental illness is given a name. Other people dislike being labelled as a mental health patient because they often feel and are socially excluded. Members of our local Service User Forum advocate the use of a collaborative formulation between the person who experiences a form of mental distress and the professional. This approach focuses on the exploration of the personal meaning of events, social circumstances and relationships in a person’s life and their current experiences. The importance of engaging in healthy life style behaviours, including occupational and creative engagement alongside physical activity and a healthy diet, has been neglected in these discussions and requires our team’s closer attention for future community-based intervention programmes.

Participants in our study wanted to be known as citizens and not as psychiatric patients, and known for their achievements in arts and crafts (Appendix 15). This is another issue our team will have to address in our clinical practice as an important implication from our research findings. Creative occupation had helped participants to construct an identity, first and foremost as a creative human being living with mental health problems. Individuals who have a diagnosis of mental illness might have frequent experiences of stigmatisation, either in direct contact with others, as stigmatising representations in the media or through internalised stigma, and are likely to expect negative reactions from their environment (Angermeyer, Buyantugs, Kenzine and Matschinger, 2004). The subjective experience of devaluation and marginalisation shows psychological consequences that include low self-esteem, shame, social withdrawal, self-stigmatisation and concealment (Ritsher, Otilingam and Grajales, 2003) The construction of a positive self-identity seemed to be facilitated by realising their creative potential through self-expression and development of treasured creative

skills. This is a powerful finding supported by other studies (Horghagen, Fostvedt and Alsaker, 2014; Lawson, Reynolds, Bryant and Wislon, 2014; Swindells, Lawthom, Rowley, Siddiquee, Kilroy, and Kagan, 2013; Reynolds, Vivat and Prior; Lloyd, Wong and Petchkovsky, 2007; Griffiths, 2008; Mee, Sumsion and Craik, 2004; Reynolds and Prior, 2003; Mee and Sumsion, 2001).

Participants in our study used self-expression through creative occupation as a means to make ideas, thoughts and feelings known to themselves and others. Self-expression as a healthy lifestyle behaviour helped the participants to relieve stress (Peter, Charlotte), to relax (Lisa, Emma, George, Peter), to wake up (Finn), to concentrate on doing (all participants) and to experience joy (all participants). Health was viewed by Nussbaum (2011) as the capability 'to do and to be' (p. 18). She distinguished between internal – people's talents and abilities developed through occupation – and external capabilities – freedom and environmental opportunities to use those abilities. Creative leisure occupations seem to have the potential to support people living with mental health problems to use their abilities, but more resources need to be allocated in the community to create environmental opportunities that are socially inclusive and offer a range of creative activities. In our study, the action of doing was connected to the process of making, in which the individual could use her/his capability to create pieces of work that could be seen or listened to. The process of making connected participants with the present moment, the reality, and seemed to bring the essence of their being into the creation of work. Blanche (2007) believed that creative occupations are a means to display self-initiative, the authentic self and autonomy. Her belief is supported by the experiences of our participants who showed self-initiative to become involved in creative occupations, who produced pieces of work that showed their unique creative ability, and who demonstrated autonomy by choosing a particular creative activity, techniques, materials and tools to produce their own creative work.

5.5 Creativity and creative process

Another relevant aspect to discuss here is the concept of creativity itself. The participants in our study did not use the term 'creative activity' which made me realise that it was part of my professional jargon. They naturally talked about drawing, painting, making embroidery, and making a piece of artwork and a few referred to their creative ability. Some participants used the phrase 'to bring the inside out'. A critical

voice regarding creativity as an individual trait is Sawyer (2012) who supports the view that creativity is a collaborative effort rather than an individual endeavour. Similarly, Pope (2005) proposed that a person's creative potential represents a healthy and natural state, and flourishes in collaboration with others and in stimulating environments. In contrast, Csikszentmihalyi (1996) views creativity as potentially a state of flow and, in Maslow's hierarchy of human needs, creativity is referred to as self-actualisation. Furthermore, Csikszentmihalyi advocated that life could be lived more meaningfully if opportunities are made to enhance a person's creativity. The concept of creativity remains controversial as it lacks a universally agreed definition, although it is a widely discussed concept within human life.

In his latest book on 'creativity' Runco (2014) strongly advocates avoiding the word creativity and using the adjective 'creative' instead, so that future research could specify what aspects are being investigated or explored, for example 'creative personality', 'creative ability' or 'creative process'. In the study by Blanche (2007) two aspects of the creative process were noticed which Wallas (1926/2014) in his model referred to as conscious – preparation and incubation – and unconscious activity – illumination, verification. Wallas, who was influenced by Jung's (1922/1976) notion of creativity distinguished between conscious design and unconscious force. This notion reflected ideas from Classicism on careful craft and rules, and Romanticism, which accentuates spontaneous expression and impulse.

Two participants in our study, Emma and Gareth, both with more than fifty years of experience in their favourite creative occupation, recounted having a flash or an inspiration (illumination, verification). Their creative ability, combined with highly developed skills, enabled them to transform an interesting idea into 'a mobile crane' and 'an embroidery that broke new ground' (preparation, incubation). During the creative process, both Emma and Gareth became lost in what they were doing, with no time left to focus on negative thoughts because all their attention was directed towards doing and making the object, thinking what it could be and how it could be achieved with the material. This finding could mean that the creative process offered opportunities for deep engagement to encourage positive psychological states similar to flow.

The notion of creativity has generated modest interest in the occupational science literature. I located a study by Blanche (2007) that emphasises creativity in everyday life. Interest, and the anticipation of experiencing enjoyment to express one's creative potential and try out new things appeared to stimulate the participants in our study to become more active in other parts of their everyday life. Wilcock's occupational perspective emphasises the expression of creative needs through everyday activities and its positive effects on wellbeing (Wilcock and Hocking, 2015). Her position received support from research that was carried out by Blanche (2007) who explored the experience of creativity in the everyday lives of 10 women and 12 men using a mixed design – participant observation, individual interviews and survey. The findings revealed two types of creative occupation, one as process-orientated, motivated by an interest to express and explore, and the other as product-orientated, motivated by the interest to produce. Blanche then linked the process-orientated element to two concepts: one to the expression of one's authentic self and the other to play, though she did not mention the level of involvement of her participants or relate it to positive psychological states. However, her study is important because she explored people's creative ability as part of everybody's life, not just owned by exceptional people.

The creative process in our study was related to the engagement in a creative activity and its two subthemes, 'the action of doing' and 'being in the moment of making'. As a creative occupation, positive feelings of enjoyment, pleasure and happiness were experienced, providing evidence for the observation of early occupational therapists within the Arts and Craft Movement about the therapeutic potential of occupation (Reilly, 1962). Engagement in creative activities by our participants showed the therapeutic potential of temporary mental relief from negative, intrusive thoughts. It seemed that some participants (Lisa, Emma, Gareth, Finn, Anne) had the ability to focus their attention on the creative task in front them. Deep concentration and complete self-absorption during the process of making, was related to the creative process, and grounded participants in the present moment.

The participants of our study valued the action of doing, the physical act of playing the guitar, doing a painting, doing a few stitches on a piece of embroidery, doing a sketch. The action of doing was used for the exploration of simple ideas. During times of illness and wellness our participants felt drawn to their favourite creative activity and they

would use it as a means of consolation and solace, as previously mentioned. The action of just doing a creative activity seemed to show minimal effort and skill, but was satisfactory. This relates perhaps to positive distraction, a state in which awareness of the environment remains (Wright, Sadlo and Stew, 2007; 2006).

The Arts and Crafts Movement focused on occupations that produced hand-crafted objects as a means of repairing the detrimental effects of industrialisation. Early occupational therapists during this era acknowledged the therapeutic value of creative, pleasurable experiences patients perceived with handcrafts (Levine, 1987). Our participants expressed a lot of pleasure from the action of doing and the majority of participants were not concerned about the quality of their produced work. One participant who had sustained a hand injury during one of the darker episodes of his illness, accepted that his work was not accurate but it never stopped him to enjoy drawing as a simple act of using crayons on paper. As previously mentioned, the action of doing was also used to initiate engagement during episodes of unwellness and illness. Our study provides evidence that creative occupation can have a positive effect on subjective wellbeing, but also suggests that it has been neglected in occupational therapy practice as an intervention for too long. I learned from the participants of our study that they took the initiative themselves to use creative occupation in their life without professional help. Occupation as therapy places an emphasis on doing instead of talking and it is hoped that the findings from our study will encourage colleagues to reconsider the use of creative occupation in occupational therapy practice.

I found Tim Ingold's (2013) ideas on handwork in art, building and making tools – which he views as a correspondence between the maker and the material – very interesting. The action of doing, engaging with the material or corresponding according to Ingold, is closely linked to a process-orientated occupation and means that the individual tries things out, explores different options and sees what happens in real time. Our study demonstrated that people learn about a creative activity in multiple ways. They might learn it by doing it on their own or by joining other like-minded people in a group and learning from what is taught to them. They might ask others for an opinion on their work, or attend classes to learn the theoretical aspect as well as the practical side of doing the activity.

The different approaches to learning seem to transform the individual who gains knowledge and skills in her or his subject area over time. One participant wished to have more direction but at the same time he valued his freedom to experiment with colours and themes to see where this journey of exploration would lead him. Our participants distinguished between the formal act of bringing something into being, such as following instructions methodically and the informal act of being more explorative, which was led by the person's curiosity to see what the material can do. They preferred to work with certain materials and tools because they reacted to the material's form, texture, colour and shape. Research into visual art-making (Hunt, Nikopoulo-Smyth and Reynolds, 2014; Reynolds and Prior 2006) and ceramics (Timmons & McDonald, 2008) supported our findings because it provided opportunities for the individual to explore, use and enjoy their creative talent.

One participant, Finn, who enjoyed playing the guitar, viewed himself as being a musician and he pledged to the seriousness of his guitar playing. Being in the moment of making the music was his way to orientate himself to reality. I found one grounded theory study that explored a conceptual definition of playfulness in adults (Guitard, Ferland and Dutil (2005). Through interviews with fifteen adults, the researchers identified themes that were related to playfulness in adults: creativity, curiosity, sense of humour and pleasure. It has been mentioned previously that the concept of creativity remains controversial, and the authors of this study were unclear about the differences between artistic and intellectual creativity. However, curiosity was associated with interest, willingness to try out new things and the ability to observe. These are qualities that were also found in our participants as were pleasure, a positive sensation that can be linked to needs (Guitard, Ferland and Dutil, 2005) and sense of humour. Perhaps being in a playful mode facilitates participation in creative activities and enhances the ability in individuals to see the positive side of things.

5.6 Positive psychological states

Involvement in the creative process was experienced at different levels of consciousness and simultaneously engaged mind, senses and body. The participants were able to focus their attention to the creative task which provided them with temporary mental relief from negative thoughts. The expression of creative ability through the process of making seemed to provide an opportunity to experience the present moment as real and

true, as a connection to reality. Focused attention on the creative task, combined with deep levels of concentration which evoked feelings of calmness and relaxation, were interpreted by the participants as the therapeutic value of creative occupation. Feelings of excitement were expressed by our participants when a creative idea was successfully transformed into a skilful hand-made object or a beautiful song.

For Lisa, the ability to transform an idea from her head into a piece of clay and to create a ceramic sculpture made her forget everything else around her, being completely lost in the moment of making. She experienced a positive psychological state that was characterised by deep engagement in a skilled creative activity (sculpting), which instilled pride, excitement and pleasure in her. Her experience equates to the concept of losing self-awareness or 'self-forgetting' (personal communication, Sadlo, 2014) which can be explained from a neuroscience viewpoint that involves the Default Mode Network.

Another participant, Martyn, was proud of being able to concentrate for a short-time, because it took much effort to initiate engagement. Concentration has been defined as 'an ability to concentrate'. To concentrate means *'to direct one's attention, effort, etc intensively on something, not thinking about other less important things'* (Crowther, 1995, p. 236). He also found himself concentrating fully on the creative task, which entailed the drawing of his favourite comic character in a certain position. For Emma, the process of turning her full concentration to the embroidery and trying to complete it, meant that she had completely forgotten everything around her, even her responsibility to prepare supper for the family. Individual differences in psychological states were noted in our participants and initially related to the flow process (Csikszentmihalyi, 1990), then revised and explained through the use of reversal theory (Wright, Wright, Sadlo and Stew, 2014a; Wright, Sadlo and Stew, 2007; Wright, Sadlo and Stew, 2006). I will refer to them in a later section of the discussion.

An important finding was that all participants in our study mentioned that they were fully concentrating on what they were doing and described different levels of awareness or consciousness such as completely involved, immersed, fully absorbed, or not fully absorbed in the creative task. These findings correspond with other studies (Swindells,

Lawthom, Rowley, Siddiquee, Kilroy, and Kagan, 2013; Griffiths, 2008; Timmons and MacDonald, 2008; Reynold and Prior, 2006; Reynolds and Prior, 2003) that reported on participants' flow experience. In a study that explored the experiences of twenty-one participants who were involved in a community-based arts project (Swindells, Lawthom, Rowley, Siddiquee, Kilroy, and Kagan, 2013), older participants viewed the arts project as cognitively and creatively challenging. Two participants were able to refocus their attention on the artwork and away from the physical pain, and described an altered sense of time. These experiences were linked by the authors to flow experiences which were described extensively by Csikszentmihalyi (1990, 1996). Mihaly Csikszentmihalyi (1990) became interested in the work on human happiness from Maslow (1954) and Rogers (1954, 1961). His research on the exploration of optimal human experiences he called 'flow', related to May's (1959) earlier description of peak experience, namely being oblivious to the environment and the passage of time, having heightened consciousness, intense awareness and being absorbed (Saywer, 2012).

Griffiths (2008) conducted a grounded theory study with eight clients and five occupational therapists. Deeper levels of engagement concurred, according to Griffiths, with descriptions of the flow state. This included the loss of self-awareness, feelings of enjoyment and harmony within oneself. The findings of this study have to be regarded as preliminary because data saturation did not happen. In the phenomenological study by Timmons and MacDonald (2008) the participants described different experiences related to flow, such a sense of altered time, full concentration, reduced self-awareness, decreased awareness of illness symptoms, feelings of achievement, challenge –skill but they found that flow seemed to be happening during the creative process of working with clay. A phenomenological study by Reynolds and Prior (2006) which involved women living with cancer, explored their experiences of the creative process in visual art-making. The findings indicated that visual art making represented a creative opportunity for a flow-like experience named 'creative adventure' that included many of the main features of flow, such as intense concentration on the artwork, mastering artistic challenges, experiencing an altered awareness of time and reduced awareness of surroundings, immediate feedback but the absence of clear goals. Instead, the participants enjoyed the unexpected and unknown element during the creative process.

An earlier study by the same authors (Reynolds and Prior, 2003) found that engagement in textile arts produced experiences similar to flow which they called adventures. These adventures included the following elements: reaching clear goals, coping with meaningful challenges through high level skills, experiencing pleasure and a sense of achievement. None of the above studies identified reasons how and when flow started or when and why it ended. I wondered how creative activities could be used therapeutically in our clinical practice as a means of generating flow experiences in patients but I was not able to identify any research that could help me answer this question. Peter noticed that when he became unwell concentrating on his sketches became more difficult. Another participant, Martyn, described in detail how he became distracted by his thoughts even before he started and that it took a lot of effort to initiate engagement. For Ann, creative occupation had become a worry instead of a joy because she was unable to concentrate. She described a lack of interest and motivation, and several health concerns that stopped her engagement.

The experiences of our participants indicated that a lack of concentration was an obstacle that needed to be addressed prior to making any suggestions about which creative activities had the potential to provide flow experiences. I recalled a discussion with my family who asked me if we offer creative activities such as drawing and painting to all patients regardless if they like them or if they view them as totally useless. It was a provocative question, but it made me think about the meaningful and meaningless experiences of patients in occupational therapy, and our sometimes limited knowledge and understanding as occupational therapists about patients' past and current interests, hobbies and preferences. The implications for my clinical practice following on from my reflections are to search for a method or intervention that helps patients to concentrate, and to invest more time in clinical interviews to gather sufficient background information from patients to enhance the quality of their engagement in creative activities, as well as the meaningfulness of their experience in occupational therapy. Mindfulness training might be a helpful strategy to focus attention (Martin, Sadlo and Stew, 2012). Our participants seemed to be keen to enrich their repertoire of skills to be better prepared for the times when unwellness and illness started to dominate their lives, or when their interest dipped to low levels and made it difficult to initiate engagement in their favourite creative activity.

5.6.1 Mindfulness

Mindfulness has been widely studied in diverse disciplines and is thought of as a means to experience everyday life in a mindful way and experienced more formally as meditation. My own experience with mindfulness stems from an eight-week training course I initiated for our team four years ago when operational and structural changes in our department caused exceedingly high levels of stress amongst us. I have integrated mindfulness techniques since then in my daily life. From an occupational science perspective, the application of mindfulness might enrich the experience of an occupation and the process of engagement (Yerxa, 1993). The practice of mindfulness is relevant in daily life choices and occupations because it influences the way we feel, and it influences our subjective wellbeing. The experience of the present moment is the focus of being mindful and includes being fully engaged, attentive and receptive (Black, 2010). Martyn, one of our participants who had difficulties initiating engagement, attributed his attentiveness to his regular use of drawing because it helped him to focus his attention once he was able to start on the creative task. Three participants, Emma, Gareth and George, discovered that they were more attentive to their natural surroundings because of creative occupation. It also helped them to get ideas and inspiration for their creative projects.

It would be interesting to find out in future research if creative occupation in combination with mindfulness is an effective intervention method to reduce an overactive Default Mode Network in people with certain mental health problems such as depression and schizophrenia. Martin, Sadlo and Stew (2012) viewed mindfulness as a ‘particular way of focusing attention, with openness and acceptance’ (p. 54). They found, during their investigation of the phenomenon of boredom, that it seemed to relate to a person’s poor attentional capacity and her/his negative attitude to becoming engaged in an occupation. Previously, it was thought that occupational deprivation might be the cause of boredom. However, the authors provided a strong case that in our contemporary lifestyle an abundance of activities was available to choose from, therefore other strategies should be employed to facilitate occupational engagement.

The concept of mindfulness and concept of flow share the characteristic of living in the present moment. The difference appears to be how living in the present moment is approached by the individual. Flow pays attention to a task or activity, whereas

mindfulness asks the person to be receptive and attentive to oneself, other people and the surroundings (Martin, 2012, 2009).

5.6.2 Flow process and reversal theory

Csikszentmihalyi (1975) viewed flow as an optimal human experience. The term flow evolved from interviews Csikszentmihalyi (1975) conducted to examine what he termed 'autotelic experiences'. He stated that the word 'autotelic' derived from Greek 'auto' meaning 'self' and 'telos' meaning 'goal' and was used to describe experiences that completely involved the person in an activity, made full use of his or her skills and from which a person received clear feedback from his or her actions. The term, flow was a native category, a word that was frequently used by the people Csikszentmihalyi interviewed to describe their experiences. He decided to change the name of the terms he was using because he considered flow to be a relatively less awkward word than autotelic. Additionally, he believed that the word autotelic could cause confusion as when it is stated that an experience is autotelic we might implicitly assume that there are no external rewards or goals, although this may not be the case. However, despite over 40 years of research it still appears unclear if the flow process and its characteristics share similarities or have differences with other psychological states such as mindfulness, and how an optimal experience starts and ends (Wright et al., 2007).

One theory that might help understand the complexities of the flow process is reversal theory. Apter (2007, p.3) has defined reversal theory as a 'structural-phenomenological theory of motivation, emotion and personality. Importantly, instead of suggesting there is one type of flow state, Apter suggests that there are eight metamotivational states, each of which has an emotion that can be optimised and that people seem to move regularly – or 'reverse' – between the eight different states. In reversal theory, four domains of being – means/end, rules, interaction and orientation – are paired with opposite metamotivational states. These states are named telic/paratelic, conformist/negativistic, mastery/sympathetic and autic/alloic states. Each state encompasses optimal emotions which can be either positive – for example relaxation, relief and a sense of achievement in the telic state; excitement and enjoyment in the paratelic state – or negative in nature – anxiety and feeling overwhelmed in the telic state; boredom in the paratelic state.

The concept of flow is still evolving and Wright, Wright, Sadlo and Stew (2014b) have started to examine the relationship between the flow process and mental wellbeing through the application of reversal theory. This is an important topic, because it might help us to gain a better understanding about the different types of positive psychological states that account for optimal experience in occupational engagement. It remains unclear how flow can be conceptualised, and how the self-reporting of participants about a subjective experience that might be more or less meaningful for them can be improved. I also wonder if a further complication is added to the scientific exploration of flow because this phenomenon has become part of popular understanding in the search for happiness.

Four participants – Gareth, Lisa, Emma and Ann – who experienced complete absorption in challenging occupational engagement that demanded great skills but also the appropriate environment (studio, workshop and home environment), confirmed findings from research conducted by Wright, Sadlo and Stew (2007, 2006). The completion of the task was regarded as a very important one and of personal significance. Apter (2007) developed the reversal theory as a way to understand the flow process, and he emphasised four domains of being that correspond to pairs of meta-motivational states. I related the four states of ‘being’ in Apter’s reversal theory to the theme of ‘Engagement in a creative activity’ and to the two subthemes ‘Action of doing’ and ‘Being in the moment of making’. I mentioned earlier that our participants appeared to have an open attitude to try out new things and to experience thorough enjoyment by just the action of doing a creative activity. By using reversal theory I was made aware that participants could be seen as being in a paratelic, playful state to experience feeling of enjoyment and excitement.

The telic, serious state is described as a state in which somebody feels relaxed and with a sense of accomplishment because even small achievements can be celebrated. Peter and Charlotte thought that drawing was relaxing, particularly when they had a stressful day and being able to do a drawing was viewed by both as an accomplishment. Two other participants, Emma and Gareth, recounted to have experienced a ‘flash’ and had to act upon the creative desire individually by transforming the idea from their head into the material in front of them. It appeared that both were in the mastery state as described by Apter, and able to use all their skills and knowledge to successfully create the

objects. One participant, Gareth, recounted that he felt pride, a positive emotion, about his accomplishment but at the same time was challenged as he experienced the pride fading away, being replaced by a sad feeling that his project was completed but with nothing else exciting to do.

The findings of our study indicate that the participants moved between different states of consciousness but it was not possible to establish how they entered an optimal state or when it exactly finished. One participant, George, felt relaxed during art class despite the time pressure when work had to be finished within a certain time. According to reversal theory he was in a serious or telic state, felt relaxed and experienced a sense of achievement. He could switch to a more playful or paratelic state, and enjoy just doing the painting during the same session. From Blanche's viewpoint he would move from product – orientated to process-orientated creative occupation.

The conforming state in which the optimal feeling was described as a sense of belonging and doing the right thing in Apter's reversal theory, was not observed within our study. Our participants longed to be acknowledged as normal people and not as patients of psychiatric services. Attending day services appeared to prolong their sense of belonging as a service user or patient, or as one participant eloquently put it to 'become part of the hospital scene' rather than community life. This issue will have to be addressed with our team in collaboration with members of the Service User Forum and people living with mental illness.

I mentioned earlier that the Default Mode Network appears to have relevance to the findings of our study. The Default Mode Network refers to a set of regions in the human brain with reduced neural activity of self-reference during goal-orientated tasks. At present, there is uncertainty in the field of neuroscience about the specific functions of this network (Posner, 2012), for example if deep absorption decreases self-awareness and the self-critical areas in the human brain. At the moment, one can only speculate about a possible connection of the Default Mode Network to the flow process and reversal theory and more research is required to evidence this. Losing one self in an activity was regarded by Csikszentmihalyi (1996) as flow, an optimal experience. Reversal theory was developed by Apter (2007) as a way to understand different types of psychological states that comprise optimal experience during occupational

engagement. Several of our participants described deep levels of engagement in the creative task. One participant, Lisa, indicated that she stopped worrying about other people's opinion of her and her work when she became deeply absorbed in her creative work. Martyn who had been recently diagnosed with schizophrenia, had constantly negative thoughts running through his mind despite being prescribed a heavy dosage of anti-psychotic medicine. However, he worked systematically on a particular sketch design, so that he could direct his whole attention to the act of making it, leaving no time for his mind to turn into a self-referential mode. Both, Lisa and Martyn, experienced feelings of enjoyment and excitement that describe a playful (paratelic) state, reversing to a serious (telic) state when they felt a sense of achievement. People with major depression and schizophrenia seem to have an overactive Default Mode Network and, currently, psychotropic medication is used to ameliorate erratic behaviour and negative thought processes (Posner, 2012). Medication dosages can reduce these symptoms but they also diminish the person's drive to be active. This might explain why some patients appear lethargic and seem to have reduced motivation to engage actively in interventions methods that are offered in occupational therapy. The importance of having a thorough understanding about the patients' background, their interests and hobbies is pivotal to stimulating curiosity and re-awaken interest for activities that might have been meaningful prior to the onset of the illness. It also gives hope to occupational therapists to focus on the potential of each person's creative ability and perhaps stimulate new interest for creative occupation, similar to the experiences of one of our participants, George, who discovered art as new interest during his hospital admission. More research is needed to widen our understanding of the Default Mode Network, for example if the engagement in meaningful goal-orientated tasks and the experience of positive psychological states in combination with mindfulness and psychotropic medication ameliorates an overactive Default Mode Network in people with severe thought disorders (depression, schizophrenia).

5.7 Social needs

At the beginning of my discussion I mentioned that one of the important findings was that participants deliberately searched for opportunities to fulfil their creative needs, which I regarded as a health promoting activity. Another important finding was that creative occupation offered our participants opportunities for social interaction in different environments, which was also described in other studies on meaningful

creative engagement of class attendance (Bedding and Sadlo, 2008), and participatory art projects (Horghagen, Fostvedt and Alsaker, 2014; Lawson, Reynolds, Bryant and Wislon, 2014; Hunt, Nikopoulou-Smyi and Reynolds, 2014; Swindells, Lawthom, Rowley, Siddiquee, Kilroy, and Kagan, 2013). Participants repeatedly valued working with other people and learning with and from them. This finding can be linked to a theory by Bateson (1973) an anthropologist, who coined the term '*deutero-learning*' (p 141). It refers to the world as a place of study in which one learns from those with whom which one studies and also the environment in which one studies. All participants had attended art or craft classes, groups, seminars or workshops as part of their treatment in hospital or in the community. Four participants continued to attend mainstream classes, and one participant hoped to attend an art centre in the future. The need and desire for connectedness, to go to other places in order to learn more about a particular creative activity as well and able to socially interact with like-minded people, showed to have a positive impact on people's subjective wellness. Myers (2000) argues that social interaction is an important determinant of happiness, particularly with friends and family. It was also found that positive emotions might have a broadening effect on a person's cognitive functioning, giving them openness to new ideas and more flexible, creative ways of thinking (Fredrickson and Branigan, 2005). Several participants in our study demonstrated a willingness to try out new ideas and explore different ways of occupational engagement. For others, it was difficult to leave their comfort zone particularly after hospital discharge, but at least they considered a change of action at some point in their life.

The concept of belonging, another theoretical element of one construct of occupation (Wilcock and Hocking, 2015) was viewed as confounding for the participants. Most did not want to be related to other service users but they valued their roles as a family member or friend. One participant, Lisa, did not like the idea of belonging to the group of day service users so she took the initiative to enrol herself into a local ceramic studio when the day service closed. In previous research people living with a mental illness did not seem question the sense of belonging in their population group possibly because it was accepted as the status quo. Future research needs to take a longitudinal view to question these assumptions, otherwise we will continue as a society to retain a narrow view of what people living with mental illness can achieve and how they want to be treated.

5.8 Experiential learning

The acquisition of personal knowledge through direct experience could relate to Kolb's four-stage Experiential Learning Model (Kolb, 1984). It contains the direct experience in the here and now which is followed by reflective observation to consider what has worked or not. During the next stage, abstract conceptualisation, ways to improve the experience are thought about. Every new attempt of doing is informed by the previous experience, thought and reflection, and forms the last and fourth stage of the model, active experimentation. The individual engages in a meaning-making process of the direct learning experience by learning through reflection on doing, but she/he requires certain abilities to this to generate personal knowledge. Thus, there are many ways to consider how doing brings positive experiences.

Personal knowledge may encompass both positive and negative effects of occupational engagement, strategies to overcome the struggle for engagement during times of unwellness and illness, different modalities, and multiple uses of the preferred activity and its effects. These unique findings of our research revealed participants expressing the acquisition of knowledge during the interview through phrases such as 'I know'. The other form of personal knowledge acquisition occurred through '*deutero-learning*' (Bateson, 1975, p, 141). Meaningful creative occupation seemed to build resilience and promote self-management of mental health. This was confirmed in another study by Lawson, Reynolds, Bryant and Wilson (2014) whereas Timmons and MacDonald (2008) and Reynolds, Vivat and Prior (2008) emphasised adaptation to ill-health through doing.

Our participants realised the importance that creative occupation played in their life. This freshly formed understanding encouraged them to search for new meaningful experiences to support their personal development, as a creative being. Other studies reported personal growth (Griffiths, 2008) and the organisation of several further purposeful roles and activities (Reynolds and Prior, 2003) as long-term consequences of engagement in creative occupation. An understanding of their strengths and weaknesses was gained through personal experience and knowledge. Participants in our study were involved in a learning process that enabled them to live *with* mental health conditions. It made them understand how to deal with these more effectively and to actively participate in their local community life.

Participants also reported experiencing a few negative emotions that were linked to the creative process, particularly when they reached sticking points in their work. Individual approaches were implemented to overcome these negative states. A mind prepared through the application of mindfulness training could help individuals to become more attention-focused during times of unwellness and illness, and support them in their natural longing to fulfil creative needs. Meaningful creative occupational engagement seems to hold the potential key for an individual to enter positive psychological states and generate meaningful experiences in her or his everyday life. Neuroscience will play a vital role in the future of services and research-based clinical practice,

At the end of my discussion I would like to outline the strengths and limitations of our study, its contributions to knowledge, implications for clinical practice and Public Health. I have identified the need for further research on creative occupation and its therapeutic potential as a health promotion intervention. I will conclude this chapter with my personal reflections and a summary.

5.9 Outline of main aspects of the study

5.9.1 Strengths

- It used a hermeneutic phenomenological approach in which the actual experience of creative occupation was not only described but also interpreted and reflected upon, and produced knowledge and understanding for the individual participant.
- The first study that was carried out with people in remission of mental health problems to understand how they use creative occupation.
- It was guided by a client group who acted as advisors and helped to form the research questions. The viewpoint of members of the Service User Forum was heard, listened to, reflected upon and included in our study throughout the research process.
- It used appropriate qualitative methodology to more deeply appreciate their experiences of participation in creative activities.
- The analysis method led to a deeper appreciation of aspects of participation in creative activities that included a multiplicity of uses for the participants, for example creative occupation was used as a distraction, as ‘therapy’, as an outlet

for inner turmoil, joy, leisure, anticipated work, and also an understanding about the effects of continued engagement on their subjective wellbeing.

- The participants fulfilled eligibility criteria that were approved by three ethics committees – the Faculty of Health and Social Science Research Ethics and Governance Committee (FREGC), University of Brighton; the National Research Ethics Service (NRES) Committee North West – Greater Manchester North; and the local Research and Development Committee (R&D), Department of Psychiatry, University of Oxford.
- The participants came from diverse backgrounds, with an age range from 19 to 87 years. The duration of remission varied too, from six months to seven years. The heterogeneity of the sample reflected diversity in their perceptions and experiences.
- The involvement of participants in the research process produced rich data and each of them contributed to the produced text, based on verbatim transcribed interviews.
- The participants' experiences contributed to my own understanding of the phenomenon of participation in creative activities. Their subjective experiences emphasised some possible therapeutic potential of creative occupation, in particular temporary mental relief from self-referential thoughts through deep immersion into the creative process. Through dissemination, for example presentation at conferences and publications, the findings of the study can be shared with interested occupational therapy colleagues and the wider public to regenerate interest in creative occupation as a therapeutic intervention method and an important self-health promoting strategy.

5.9.2`Limitations

- Time for interpretation was limited due to clinical and managerial roles in full-time employment.
- Full reflexivity could have been used more effectively throughout the research period, to more deeply appreciate how my experiences impacted on the research findings.

- If each interview could have been analysed before the next data set and data were collected, I could have discovered even more aspects of the phenomenon and built on each interview.
- A team approach to analysis would have added to the discovery of more aspects of the phenomenon. The methodology used provided a rich description of our participants' experience with creative occupation but the data analysis proved to be too lengthy and time consuming. It helped me to immerse myself into the data but I would recommend a team of research and administrative support for future use of the hermeneutic phenomenological analysis method after Cohen, Kahn and Steeves (2000).
- The recruitment of participants was a challenge because of the nature of their mental health problems. Several interested individuals agreed to participate but they had to opt out due to episodes of acute illness. The sample of ten participants provided enough data for a rich description of the phenomenon but I had to be practical about the recruitment process and the time frame for completing the doctoral course.
- The use of a combination of more innovative data collection methods, for example using photography and video during participants' engagement in a creative activity could better enhance the documentation of an optimal experience, supplemented by participants' own written, audio or video-recorded description of what had happened before, during and after occupational engagement. Alternatively, it could have been more ethnographic with researchers in the role of participant-observer.
- Narrative approaches might have led to different levels of understanding of the effects of participation in creative activities over time.
- The data could continue to be interpreted in relation to many aspects – such as personal identity, stigma, intelligent hand use, personal causation, attention, learning and crafts.

5.9.3 Contributions to knowledge

This seems to be the first study that involved people in remission of mental health problems who used creative activities as a leisure occupation to keep themselves well without a therapist. The outcomes of the study may be seen as a contribution to knowledge.

The subjective experiences of our participants highlighted the possible therapeutic potential of creative occupation, in particular, temporary mental relief from self-referential thoughts through deep immersion into the creative process. Additionally, creative engagement seemed to empower the participants to become active contributors to their own subjective wellbeing by keeping well themselves. They enjoyed the engagement with their favourite activity just by doing it but continued interest stimulated them to develop their individual skills.

These findings indicate that creative occupation could bring meaning to the everyday lives of our participants. Creative self-expression supported the construction of a healthier identity for some participants who started to view themselves in conventional roles as being ‘a son’, ‘father’, ‘mother’ or ‘musician’, rather than ‘reducing their identity to the patient role’. This transformation appeared to happen through the action of doing and the involvement of the self in the creative process.

Achievements evidenced in a piece of work or music seemed to increase the participants’ self-worth as a human being and offered them the opportunity to adopt more conventional roles in daily life other than just being a psychiatric patient. Creative occupation was viewed as a leisure occupation and three participants anticipated turning it into a work occupation in the future. Deep immersion in the creative process was reached through focused attention and several participants experienced positive psychological states. Engagement in creative activities brought participants into contact with other like-minded people as well as with places and public life.

The study explored Wilcock’s hypothesis that people themselves use occupation to keep themselves well or to restore health. It supports the concept that an occupational perspective should be more prominent in Public Health. It seems to provide some evidence of personal resilience built through creative participation.

To some extent the study extends understanding to flow, mindfulness, reversal theory, experiential learning and the Default Mode Network. It supports NICE guidelines related to Lifestyle redesign through which occupational therapists could disseminate our theories and constructs to be implemented by other support workers, since there is still insufficient public understanding about the therapeutic potential of occupational engagement. It has links to the Arts and Health movement and the power of doing supports a return to creative activities in occupational therapy, which we have lost over recent years.

5.9.4 Implications for clinical practice and Public Health

Our study utilised a hermeneutic phenomenological approach which embraced temporality and historicity and was carried out within a specific context. The findings are subjective experiences of a particular population group. Whilst they are not generalisable, the rich description of the participants' experiences of participation in creative activities and what it meant for them created understanding for the reader.

The issue of a sense of belonging is of particular concern for people who are patients of mental health services. Our participants did not like being reduced to their diagnosis and called a 'paranoid schizophrenic'; they wanted to be known by what they do and be called a musician, an artist, or a person who is interested in art and crafts. I would recommend that we become more careful with the use of particular words in our clinical practice. We ask patients how they want to be referred to when we introduce ourselves to them at the beginning of an intervention. It would improve our work as occupational therapists if we expand on this and ask them what role they would like to aspire to, what life goals they have, and how we and other colleagues could offer the support, advice and information to achieve them.

The purpose of day services requires a review in adult mental health to avoid individuals living with mental illness 'becoming part of the hospital scene'. The integration of people living with mental illness into their local community remains an important goal for occupational therapists who are well suited to working collaboratively with the individual and community leaders to identify conventional opportunities for creative occupation. Stigma needs to be addressed on a societal level

to change attitudes within the general public towards people living with mental health problems.

Re-introducing arts as media in occupational therapy curricula would equip the new generation of occupational therapy practitioners with the necessary skills and knowledge about the therapeutic potential of creative occupation, and its effect on the subjective wellbeing of people. Combined with an understanding of reversal theory, effective occupational interventions could include telic (serious) and paratelic (playful) aspects to encourage participation. The application of mindfulness might enrich the individual experience of a creative activity and the process of engagement.

Prevention is currently a very small part in mental health strategies but it has been recognised that the promotion of mental wellbeing can support people to keep well (MIND, 2012). Our study supports the concept that an occupational perspective should be more prominent in Public Health. Figures show that about a quarter of the population will experience some kind of mental health problem in the course of a year. The most common mental health problems are depression and anxiety. 10% of children have a mental health problem at any one time. Among the older population depression affects 1 in 5 older people and self-harm statistics for the United Kingdom show the highest rates of all European Countries (MIND 2012). These figures are worrying and it is pivotal to facilitate health promoting strategies and healthier life style opportunities in the general public, and for people who are already in contact with services.

Regional and national Arts and Health networks promote engagement in the arts and wellbeing and include individuals and communities who are often not part of initiatives for the general public. Occupational therapists who work in mental health should be encouraged to make contact with these organisations and contribute to Arts project that will include people living with mental health problems.

5.9.5 Identification for further research

There is an urgent need to find out about occupational therapists' perceptions on the use of arts and crafts as media. Our participants provided evidence of the health promoting effect of their chosen creative activity because despite living with mental health problems they created opportunities in their daily lives to keep themselves well.

Further research into creative occupation with the use of functional Magnetic Resonance Imaging and measurement of physical parameters to find out if creative occupation has an effect on the Default Mode Network, heart rate, blood pressure, and biological markers would allow us to find alternative effective treatment interventions and preventative strategies for the two most common psychiatric mental disorder – depression and anxiety.

Further research into arts and crafts and its interplay with wellbeing and creative needs and how creative occupation might protect and preserve subjective wellbeing is recommended.

5.9.6 Personal reflections

Throughout the study I used a research diary to document my thoughts and my reflections about the research topic. The interpretations of the findings are based on a collaborative effort that includes my supervisory team, members of the Service User Forum and colleagues. My supervisory team met regularly with me and engaged me in inspiring and constructive discussions about the research topic. I realise, now, how often they had to hold back their specialist knowledge to give me intellectual space so I could develop my own ideas and reach a conclusion that will enhance our knowledge about participation in creative activities.

Conducting the research made me more appreciative about many things. I believe I have become more considerate and attentive when I listen to someone talking to me, and I make more effort to really try to understand what the other person is saying to me.

The findings of our hermeneutic phenomenological study are subjective experiences of people in remission from mental illness. My colleagues had already seen my preliminary findings which I presented at study days and staff meetings. The findings of our study will contribute to the design of new local community-based services aimed for people living with mental illness. I will invite this client group to our planning sessions alongside members of the Service User Forum to jointly work on service developments.

Creative occupation as an intervention needs to be re-introduced to our clinical practice and I aim to initiate partnership working with the artwork coordinator, colleagues from

the local Mindfulness Centre, and staff from the regional Arts and Health Forum to introduce evidence-based multifaceted approaches in our clinical practice.

The attendance of the doctoral course and the conduct of the study have inspired me to make research more relevant for my colleagues in occupational therapy and for other allied health professionals in our organisation. I want to support the aspirations of my colleagues for postgraduate education and hope to make a contribution to the education of our local occupational therapy workforce. Through presentations at conferences and study days, I would like to disseminate knowledge from occupational science about the use and power of occupation to my occupational therapy colleagues.

The findings of the study will be disseminated in our annual service review and they have motivated me to ask my organisation for funding to conduct further research about the use of creative occupation in contemporary occupational therapy practice

Furthermore, I want to negotiate with my line manager changes in my current job, and focus more on research and less on managerial responsibilities. I have already received an invitation to The Culture, Health and Wellbeing international Conference 2017, in Bristol and there will be other opportunities to share the findings of our study and to enhance my understanding about the topic at other conferences. I am motivated to disseminate the findings of our study through publications in occupational therapy and other relevant journals.

The attendance of the doctoral course and the conduct of the study has given me a great opportunity to develop my skills in research and academic writing; and to enhance my knowledge and understanding of occupational therapy theory and occupational science, whilst at the same time supporting my development as a human being and enhancing my skills in communication, resilience and determination.

5.10 Summary

This chapter offered my further analysis and interpretation of the findings which were linked to the research literature and contemporary contributions on ‘making’ and ‘creativity’. Our study has demonstrated some aspects of the importance of creative occupation as a meaningful experience in the everyday lives of people living with mental health problems. Previous observations from occupational therapists about some

of the therapeutic components of particular creative activities were confirmed by our participants, who perceived the effects as a positive impact on their subjective wellbeing. Our participants' longing to be creative seemed to transform them into active agents of health promotion who are enjoying a more active lifestyle. They valued creative occupations as a meaningful experience that continues to enrich their lives.

CHAPTER 6 Conclusion

The aim of this research was to enhance our understanding of participation in creative activities from the viewpoint of people who were in remission of mental illness.

Creative leisure occupation has previously shown the potential to enhance a person's subjective wellbeing and generate meaningful experience in her/his life, but no previous study had looked so deeply into the experiences of people in remission of mental illness. This qualitative study was able to discover a multitude of uses for creative occupation and opportunities for creative expression to fulfil the creative needs of our participants.

A hermeneutic phenomenological approach was utilised to explore the participants' experiences with their individually chosen creative activity. Interviews were conducted with ten participants and analysed with my interpretation of Cohen, Kahn and Steeves' (2000) hermeneutic phenomenological approach to data analysis. The findings of the study were themes and subthemes, and generated ideas which can be viewed as a form of higher order conceptualisation of the themes.

The therapeutic value of occupational engagement was linked to the positive psychological state of deep immersion which acted as a temporary relief for self-referential thoughts. We found that the participants derived pleasure from the simple act of doing their creative activity and they enjoyed the experience of being in the present moment as well as bringing their own being into the creation of their individual work. Through focused attention on the process of making, deep levels of consciousness were reached and the present moment was felt as real and enjoyable.

Participants in our study were involved in a learning process that enabled them to live with mental health conditions and to enter positive psychological states that generated meaningful experiences in her or his life and encouraged them to continued engagement with their chosen creative activity.

The contribution I feel I have made to occupational therapy is to add to the evidence base of creative activities as an intervention and their therapeutic value as a temporary mental relief by doing. In combination with other interventions it could become a

powerful and enjoyable health promoting strategy, not just for the individual but for the public too. The current financial climate does not see enough funding for non-medical approaches within health care, but this could be transformed into a more favourable position if more research is carried out about the use of arts and crafts in health care practice. One of the health promoting strategies to be implemented requires spaces as well as resources to be created in the community that invite the local population to participate, not just particular groups.

The research interest in creative activity as a valuable occupation-focused intervention remains modest despite its potentially powerful therapeutic effect on the subjective wellbeing of people with mental health problems. In combination with other techniques such as mindfulness, the quality of the experience of occupational engagement could be enhanced and this knowledge shared with patients as a health-promoting strategy for their everyday life.

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Appendix 1

International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10), (2010)

Chapter V: Mental and behavioural disorders, (F00-F99) and contains the following

F00-F09 Organic, including symptomatic, mental disorders

F10-F19 Mental and behavioural disorders due to psychoactive substance use

F20-F29 Schizophrenia, schizotypal and delusional disorders

F30-F39 Mood [affective] disorders

F40-F48 Neurotic, stress-related and somatoform disorders

F50-F59 Behavioural syndromes associated with physiological disturbances and physical factors

F60-F69 Disorders of adult personality and behaviour

F70-F79 Mental retardation

F80-F89 Disorders of psychological development

F90-F98 Behavioural and emotional disorders with onset usually occurring in childhood and adolescence

F99-F99 Unspecified mental disorder

Schizophrenia, schizotypal and delusional disorders (F20-F29)

This block brings together schizophrenia, as the most important member of the group, schizotypal disorder, persistent delusional disorders, and a larger group of acute and transient psychotic disorders.

F20 Schizophrenia

The schizophrenic disorders are characterized in general by fundamental and characteristic distortions of thinking and perception, and affects that are inappropriate or blunted. Clear consciousness and intellectual capacity are usually maintained although certain cognitive deficits may evolve in the course of time. The most important psychopathological phenomena include thought echo; thought insertion or withdrawal; thought broadcasting; delusional perception and delusions of control; influence or passivity; hallucinatory voices commenting or discussing the patient in the third person; thought disorders and negative symptoms.

The course of schizophrenic disorders can be either continuous, or episodic with progressive or stable deficit, or there can be one or more episodes with complete or incomplete remission.

F20.0 Paranoid schizophrenia

Paranoid schizophrenia is dominated by relatively stable, often paranoid delusions, usually accompanied by hallucinations, particularly of the auditory variety, and perceptual disturbances. Disturbances of affect, volition and speech, and catatonic symptoms, are either absent or relatively inconspicuous.

F20.1 Hebephrenic schizophrenia

A form of schizophrenia in which affective changes are prominent, delusions and hallucinations fleeting and fragmentary, behaviour irresponsible and unpredictable, and mannerisms common. The mood is shallow and inappropriate, thought is disorganized, and speech is incoherent. There is a tendency to social isolation. Usually the prognosis is poor because of the rapid development of "negative" symptoms, particularly flattening of affect and loss of volition. Hebephrenia should normally be diagnosed only in adolescents or young adults.

Mood [affective] disorders (F30-F39)

This block contains disorders in which the fundamental disturbance is a change in affect or mood to depression (with or without associated anxiety) or to elation. The mood change is usually accompanied by a change in the overall level of activity; most of the other symptoms are either secondary to, or easily understood in the context of, the change in mood and activity. Most of these disorders tend to be recurrent and the onset of individual episodes can often be related to stressful events or situations.

F30 Manic episode

All the subdivisions of this category should be used only for a single episode. Hypomanic or manic episodes in individuals who have had one or more previous affective episodes (depressive, hypomanic, manic, or mixed) should be coded as bipolar affective disorder (F31.-).

F30.0 Hypomania

A disorder characterized by a persistent mild elevation of mood, increased energy and activity, and usually marked feelings of well-being and both physical and mental efficiency. Increased sociability, talkativeness, over-familiarity, increased sexual energy, and a decreased need for sleep are often present but not to the extent that they lead to severe disruption of work or result in social rejection. Irritability, conceit, and boorish behaviour may take the place of the more usual euphoric sociability. The disturbances of mood and behaviour are not accompanied by hallucinations or delusions.

F30.1 Mania without psychotic symptoms

Mood is elevated out of keeping with the patient's circumstances and may vary from carefree joviality to almost uncontrollable excitement. Elation is accompanied by increased energy, resulting in overactivity, pressure of speech, and a decreased need for sleep. Attention cannot be sustained, and there is often marked distractibility. Self-esteem is often inflated with grandiose ideas and overconfidence. Loss of normal social inhibitions may result in behaviour that is reckless, foolhardy, or inappropriate to the circumstances, and out of character.

F30.2 Mania with psychotic symptoms

In addition to the clinical picture described in F30.1, delusions (usually grandiose) or hallucinations (usually of voices speaking directly to the patient) are present, or the excitement, excessive motor activity, and flight of ideas are so extreme that the subject is incomprehensible or inaccessible to ordinary communication.

F31 Bipolar affective disorder

A disorder characterized by two or more episodes in which the patient's mood and activity levels are significantly disturbed, this disturbance consisting on some occasions of an elevation of mood and increased energy and activity (hypomania or mania) and on others of a lowering of mood and decreased energy and activity (depression). Repeated episodes of hypomania or mania only are classified as bipolar.

F31.9 Bipolar affective disorder, unspecified

F32 Depressive episode

In typical mild, moderate, or severe depressive episodes, the patient suffers from lowering of mood, reduction of energy, and decrease in activity. Capacity for enjoyment, interest, and concentration is reduced, and marked tiredness after even minimum effort is common. Sleep is usually disturbed and appetite diminished. Self-esteem and self-confidence are almost always reduced and, even in the mild form, some ideas of guilt or worthlessness are often present. The lowered mood varies little from

day to day, is unresponsive to circumstances and may be accompanied by so-called "somatic" symptoms, such as loss of interest and pleasurable feelings, waking in the morning several hours before the usual time, depression worst in the morning, marked psychomotor retardation, agitation, loss of appetite, weight loss, and loss of libido. Depending upon the number and severity of the symptoms, a depressive episode may be specified as mild, moderate or severe.

F32.0 Mild depressive episode

Two or three of the above symptoms are usually present. The patient is usually distressed by these but will probably be able to continue with most activities.

F32.1 Moderate depressive episode

Four or more of the above symptoms are usually present and the patient is likely to have great difficulty in continuing with ordinary activities.

F32.2 Severe depressive episode without psychotic symptoms

An episode of depression in which several of the above symptoms are marked and distressing, typically loss of self-esteem and ideas of worthlessness or guilt. Suicidal thoughts and acts are common and a number of "somatic" symptoms are usually present.

F32.3 Severe depressive episode with psychotic symptoms

An episode of depression as described in F32.2, but with the presence of hallucinations, delusions, psychomotor retardation, or stupor so severe that ordinary social activities are impossible; there may be danger to life from suicide, dehydration, or starvation. The hallucinations and delusions may or may not be mood-congruent.

F33 Recurrent depressive disorder

A disorder characterized by repeated episodes of depression as described for depressive episode (F32.-), without any history of independent episodes of mood elevation and increased energy (mania). There may, however, be brief episodes of mild mood elevation and overactivity (hypomania) immediately after a depressive episode, sometimes precipitated by antidepressant treatment. The more severe forms of recurrent depressive disorder (F33.2 and F33.3) have much in common with earlier concepts such as manic-depressive depression, melancholia, vital depression and endogenous depression. The first episode may occur at any age from childhood to old age, the onset may be either acute or insidious, and the duration varies from a few weeks to many months. The risk that a patient with recurrent depressive disorder will have an episode of mania never disappears completely, however many depressive episodes have been experienced. If such an episode does occur, the diagnosis should be changed to bipolar affective disorder (F31.-).

Neurotic, stress-related and somatoform disorders (F40-F48)

F41 Other anxiety disorders

Disorders in which manifestation of anxiety is the major symptom and is not restricted to any particular environmental situation. Depressive and obsessional symptoms, and even some elements of phobic anxiety, may also be present, provided that they are clearly secondary or less severe.

F41.1 Generalized anxiety disorder

Anxiety that is generalized and persistent but not restricted to, or even strongly predominating in, any particular environmental circumstances (i.e. it is "free-floating"). The dominant symptoms are variable but include complaints of persistent nervousness, trembling, muscular tensions, sweating, lightheadedness, palpitations, dizziness, and

epigastric discomfort. Fears that the patient or a relative will shortly become ill or have an accident are often expressed.

F41.2 Mixed anxiety and depressive disorder

This category should be used when symptoms of anxiety and depression are both present, but neither is clearly predominant, and neither type of symptom is present to the extent that justifies a diagnosis if considered separately. When both anxiety and depressive symptoms are present and severe enough to justify individual diagnoses, both diagnoses should be recorded and this category should not be used.

F42 Obsessive-compulsive disorder

The essential feature is recurrent obsessional thoughts or compulsive acts. Obsessional thoughts are ideas, images, or impulses that enter the patient's mind again and again in a stereotyped form. They are almost invariably distressing and the patient often tries, unsuccessfully, to resist them. They are, however, recognized as his or her own thoughts, even though they are involuntary and often repugnant. Compulsive acts or rituals are stereotyped behaviours that are repeated again and again. They are not inherently enjoyable, nor do they result in the completion of inherently useful tasks. Their function is to prevent some objectively unlikely event, often involving harm to or caused by the patient, which he or she fears might otherwise occur. Usually, this behaviour is recognized by the patient as pointless or ineffectual and repeated attempts are made to resist. Anxiety is almost invariably present. If compulsive acts are resisted the anxiety gets worse.

F42.0 Predominantly obsessional thoughts or ruminations

These may take the form of ideas, mental images, or impulses to act, which are nearly always distressing to the subject. Sometimes the ideas are an indecisive, endless consideration of alternatives, associated with an inability to make trivial but necessary decisions in day-to-day living. The relationship between obsessional ruminations and depression is particularly close and a diagnosis of obsessive-compulsive disorder should be preferred only if ruminations arise or persist in the absence of a depressive episode.

F42.1 Predominantly compulsive acts [obsessional rituals]

The majority of compulsive acts are concerned with cleaning (particularly handwashing), repeated checking to ensure that a potentially dangerous situation has not been allowed to develop, or orderliness and tidiness. Underlying the overt behaviour is a fear, usually of danger either to or caused by the patient, and the ritual is an ineffectual or symbolic attempt to avert that danger.

Appendix 2

Search strategy and search results

Search strategy

1. Medline; ((Creative occupation)).ti,ab; 29 results.
2. Medline; OCCUPATIONAL THERAPY/; 10476 results.
3. Medline; MENTAL DISORDERS/; 123208 results.
4. Medline; CREATIVENESS/; 0 results.
5. Medline; 2 AND 3 AND 4; 0 results.
6. PsycInfo; ((Creative occupation)).ti,ab; 89 results.
7. PsycInfo; OCCUPATIONAL THERAPY/; 4746 results.
8. PsycInfo; MENTAL DISORDERS/; 68463 results.
9. PsycInfo; CREATIVENESS/; 13 results.
10. PsycInfo; 7 AND 8 AND 9; 0 results.

Search results

1. 'It's like having a day of freedom, a day off from being ill': Exploring the experiences of people living with mental health problems who attend a community-based arts project, using interpretative phenomenological analysis
2. The benefits of knitting for personal and social wellbeing in adulthood: Findings from an international survey
3. Eudaimonic well-being and community arts participation
4. 'Alchemy and Magic': the Experience of Using Clay for People with Chronic Illness and Disability
5. The experience of creative activity as a treatment medium
6. Creative adventures and flow in art-making: a qualitative study of women living with cancer.
7. Textile Art Promoting Well-being in Long-term Illness: Some General and Specific Influences.
8. Mental Health Clients Confirm the Value of Occupation in Building Competence and Self-Identity
9. Conversations About Creativity and Chronic Illness I: Textile Artists Coping With Long-Term Health Problems Reflect on the Origins of Their Interest in Art
10. 'A lifestyle coat-hanger': A phenomenological study of the meanings of artwork for women coping with chronic illness and disability
11. Mental health clients confirm the motivating power of occupation
12. Managing depression through needlecraft creative activities: A qualitative study.

1. 'It's like having a day of freedom, a day off from being ill': Exploring the experiences of people living with mental health problems who attend a community-based arts project, using interpretative phenomenological analysis.

Citation: Journal of health psychology, Jun 2014, vol. 19, no. 6, p. 765-777 (June 2014)

Author(s): Lawson, Jackie; Reynolds, Frances; Bryant, Wendy; Wilson, Lesley

Source: Medline

2. The benefits of knitting for personal and social wellbeing in adulthood: Findings from an international survey.

Citation: The British Journal of Occupational Therapy, Feb 2013, vol. 76, no. 2, p. 50-57, 0308-0226 (Feb 2013)

Author(s): Riley, Jill; Corkhill, Betsan; Morris, Clare

(PsycINFO Database Record (c) 2015 APA, all rights reserved)(journal abstract)
Source: PsycInfo

3. Eudaimonic well-being and community arts participation.

Citation: Perspectives in Public Health, 01 January 2013, vol/is. 133/1(60-65), 17579147

Author(s): Swindells R; Lawthom R; Rowley K; Siddiquee A; Kilroy A; Kagan C

Language: English

Publication Type: journal article

Source: CINAHL

Full Text: Available from *ProQuest* in *Perspectives in Public Health*

4. 'Alchemy and Magic': the Experience of Using Clay for People with Chronic Illness and Disability

Citation: British Journal of Occupational Therapy, March 2008, vol/is. 71/3(86-94), 0308-0226 (2008 Mar)

Author(s): Timmons A; MacDonald E

Language: English

Publication Type: Journal Article

Source: AMED

Full Text: Available from *British Journal of Occupational Therapy*

5. The experience of creative activity as a treatment medium.

Citation: Journal of Mental Health, Feb 2008, vol. 17, no. 1, p. 49-63, 0963-8237 (Feb 2008)

Author(s): Griffiths, Sue

(PsycINFO Database Record (c) 2012 APA, all rights reserved)(journal abstract)

Source: PsycInfo

Full Text: Available from *Journal of Mental Health*

6. Creative adventures and flow in art-making: a qualitative study of women living with cancer.

Citation: British Journal of Occupational Therapy, 01 June 2006, vol/is. 69/6(255-262), 03080226

Author(s): Reynolds F; Prior S

Language: English

Publication Type: journal article

Source: CINAHL

Full Text: Available from *British Journal of Occupational Therapy*

7. Textile Art Promoting Well-being in Long-term Illness: Some General and Specific Influences.

Citation: Journal of Occupational Science, Aug 2004, vol. 11, no. 2, p. 58-67, 1442-7591 (Aug 2004)

Author(s): Reynolds, Frances

(PsycINFO Database Record (c) 2013 APA, all rights reserved)(journal abstract)

Source: PsycInfo

8. Mental Health Clients Confirm the Value of Occupation in Building Competence and Self-Identity

Citation: British Journal of Occupational Therapy, May 2004, vol/is. 67/5(225-33), 0308-0228 (2004 May)

Author(s): Mee J; Sumsion T; Craik C

Language: English

Publication Type: Journal Article

Source: AMED

Full Text: Available from *British Journal of Occupational Therapy*

9. Conversations About Creativity and Chronic Illness I: Textile Artists Coping With Long-Term Health Problems

Reflect on the Origins of Their Interest in Art.

Citation: Creativity Research Journal, Oct 2003, vol. 15, no. 4, p. 393-407, 1040-0419 (Oct 2003)

Author(s): Reynolds, Frances

(PsycINFO Database Record (c) 2012 APA, all rights reserved)

Source: PsycInfo

10. 'A lifestyle coat-hanger': A phenomenological study of the meanings of artwork for women coping with chronic illness and disability

Citation: Disability and Rehabilitation, July 2003, vol/is. 25/14(785-794), 0963-8288 (22 Jul 2003)

Author(s): Reynolds F.; Prior S.

Language: English

Publication Type: Journal: Article

Source: EMBASE

11. Mental health clients confirm the motivating power of occupation

Citation: British Journal of Occupational Therapy, March 2001, vol/is. 64/3(121-8), 0308-0226 (2001 Mar)

Author(s): Mee j; Sumsion T

Language: English

Publication Type: Journal Article

Source: AMED

Full Text: Available from *British Journal of Occupational Therapy* in

12. Managing depression through needlecraft creative activities: A qualitative study.

Citation: The Arts in Psychotherapy, Jan 2000, vol. 27, no. 2, p. 107-114, 0197-4556 (2000)

Author(s): Reynolds, Frances

Source: PsycInfo

Appendix 3



University of Brighton

The experience of participation in creative activities



LETTER TO COLLEAGUES

Dear colleague,

As part of my doctoral degree in Occupational therapy at the University of Brighton, I am carrying out a study with individuals in remission from mental illness who are known to have some experience of engagement in creative activities. The purpose of the study is to explore how creative pursuits are perceived to affect the well-being of people with previous mental ill health and how they affect their mental health.

I will be recruiting patients who have contact with community mental health staff and may be seen in follow up appointments at clinics or community settings. Due to ethical guidelines the identification of potential study participants can only be carried out by those clinicians working with the patient. Therefore, I am writing to request your kind assistance with the identification of patients who fit the study inclusion criteria which are as follows:

Inclusion criteria

Individuals who

- are aged 18 years and older (full ICD-10 diagnosis criteria applied).
- The inclusion criteria apply to patients in remission in all cases including those who have had an admission to a mental health unit as long as they have been living in the community for a minimum of three months. Mental health workers should use their clinical judgement to evaluate whether the patient is psychologically well enough to count as 'in remission.'
- The term 'remission' for this study has been defined as the time that follows an episode of a formally diagnosed mental illness - the full criteria were previously met - in which currently only some of the signs and symptoms remain but less in number and intensity. They may result in a minor impairment of a person's occupational and social functioning.
- are living in the community
- are assigned to community mental health staff who monitor their mental health at regular follow up visits, and are judged by them to have the mental capacity to give informed consent to research participation.
- are actively participating in creative activities

Exclusion criteria

- Individuals who do not have the mental capacity to give informed consent for study participation as judged by mental health staff.
- Individuals who have been living in the community after being discharged from a mental health unit less than three months ago.
- Individuals with palliative care needs
- Individuals with complex co-morbidity
- Individuals with a care plan that identifies a risk to harm others
- Individuals for whom the researcher in her clinical specialist role has current /had clinical responsibility.
- Individuals who are professional artists/crafts practitioners, who earn a living by selling their arts and/or crafts products and are viewed as having highly developed skills and expert practice in comparison to individuals who engage in purposeful creative activities for recreation.

Please could *patients* meeting these criteria be provided with an

- INVITATION with an EXPRESSION OF INTEREST FORM and a stamped addressed envelope
- PARTICIPANT INFORMATION SHEET
- PARTICIPANT CONSENT FORM

when attending an appointment with yourself or a member of your team. Patients are able to opt-in to the study by returning the completed expression of interest form to me using the stamped addressed envelopes provided, within two weeks of them receiving the invitation to become a research participant. Potential participants will then be contacted to be interviewed about their experiences (flowchart enclosed).

To discuss any aspect of the study in further detail, please contact me on the

- telephone:
- e-mail:.

I would like to thank you in anticipation for your time and help with the study.

Yours sincerely

Beatrix Ruckli, MSc HPCOT
Clinical Specialist and Practice Development Lead, NHS Trust
Doctoral Student in Occupational Therapy, University of Brighton

Beatrix Ruckli, MSc HPCOT
Doctoral Student in Occupational Therapy
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Academic supervisors:
Dr. M Martin, Prof. G Sadlo, Dr. J Wright
Thesis Panel:
Dr. A Mandy, Prof. A Moore
Doctoral Course Leader:
Dr. N Petty

Appendix 4



University of Brighton

The experience of participation in creative activities



INVITATION

This study aims to explore how purposeful creative pursuits seem to affect the well-being of people with previous mental illness and perhaps sustain their mental health.

The study involves talking to the researcher about your current engagement in creative activities. You might also want to bring a photograph of an object you made during a specific time of your remission along to the interview and talk about the feelings you were experiencing whilst making the object.

Would you like to hear more about this study?

If the answer is yes, then please complete the expression of interest form below which can be sent back to the researcher.

The researcher from the study will contact you if you agree to hear more about the study.

.....
EXPRESSION OF INTEREST FORM

I agree for my contact details to be passed to the researcher.

Name:.....

Contact phone number:

Convenient time to be contacted:

Alternatively, you can leave your name and telephone number with the Occupational Therapy team’s secretaries, Tel:and the researcher will return your call.

Please return the EXPRESSION OF INTEREST FORM to:

Beatrix Ruckli, Researcher

Address:.....Tel:.....

Appendix 5



University of Brighton

The experience of participation in creative activities



PARTICIPANT INFORMATION SHEET

Invitation to take part in the study

You are being invited to take part in a research study. Before you say ‘yes’ or ‘no’, I would like you to know why the research is being done and what would happen if you took part. Please take time to read this information sheet carefully. If you want to, you may ask other people what they think. Please ask me any questions if there is anything that you do not understand, or if you would like to know more about the study. Take your time to think about taking part in the study. Thank you for reading this information sheet.

What is the purpose of the study?

Painting, drawing, photography, pottery or woodwork are activities which some people enjoy doing in their leisure time. For some these activities hold a personal meaning, and they engage in them because they know it makes them feel good. I am interested to find out why people who are in remission from an episode of mental illness have chosen to participate in creative activities, what feelings and thoughts they have during participation and why they continue to do them or alternatively stop doing them. The purpose of this study is to find out if engagement in creative activity affects the well-being of people with previous mental illness and perhaps sustains their mental health.

Why have I been chosen?

You have been chosen because you are receiving support from a Community Mental Health Team and have some experience of engagement in creative activity. You have received a brief outline of the study and returned a completed expression of interest form.

Do I have to take part?

It is up to you to decide whether or not to take part. A staff member of the community team will give you this information sheet to keep. If you choose to take part in the study you will be asked to sign a consent form (a copy is attached). You can stop taking part in the study at any time without giving a reason. If you decide not to take part, or agree, then wish to withdraw at a later date, this will not change the support you receive from your Community Mental Health Team or other services by the National Health Service (NHS).

What will happen to me if I take part?

If you decide to take part then you will need to return the expression of interest form to me, the researcher. I will phone you to arrange a convenient time and place for the interview. I, as the researcher, can visit you at your home if that would be convenient for you. I will go through the participant information sheet with you and if you are

happy to consent to taking part in this study I will ask you to sign the consent form which I will keep for our records. Then you will be interviewed by me, the researcher.

Interview

I will ask you questions about your experience of participation in creative activities. You might also want to bring a photograph of an object you made during a specific time of your remission along to the interview and talk about the feelings you were experiencing whilst making the object. There will only be one interview which will be expected to take a minimum of 1 hour, a maximum of 2 hours and it will be tape-recorded.

Interview questions

I will ask you the following questions regarding your experience of doing a particular creative activity: What are your feelings and thoughts while you were doing it, how has this creative activity affected you, has this creative activity helped or hindered you during the remission from your illness.

What do I have to do?

You do not need to do anything apart from returning the expression of interest from to me, the researcher, if you are willing to take part in this study. I will then contact you to talk with you about the study and to arrange a date for the interview.

What are the possible disadvantages and risks to taking part?

There are very few disadvantages to taking part apart from using up some of your time. With your consent the interview will be tape-recorded to help me with the analysis and the recording will be destroyed once the study is completed. If you are unhappy about this, then you should not take part in the study. There is a chance that you might become upset by some part of the interview. The interview can be stopped at any point and it will be up to you whether you would like to continue after a break or at a later point. In addition, I can talk through this with you. If you feel that you need to speak to someone else, I can arrange contact with one of my clinical supervisors. If you wish to be interviewed at a later point we can re-arrange the interview at a convenient time and place for you.

What if something goes wrong?

I do not expect anything to go wrong. However, if you become distressed, a distress management plan is in place and I am qualified and experienced to provide you with assurance and emotional support. If it happens you will be asked to have a break. I can stop the interview first, discuss feelings that have arisen from the interview and ask you if you want further assistance from a previously identified clinical supervisor. It is up to you to decide whether you would like to continue with the interview after a break or at a later time. If you are harmed by taking part in this research project, there are no special compensation arrangements. Regardless of this, if you wish to complain, or have any concerns about any aspect of the way you have been approached or treated during the course of this study, the address of where you can complain is written below. This is the usual National Health Service complaints procedure. The study does not involve any treatment so the risk of anything going wrong is very small. If you are unhappy with anything about the research process, please contact my supervisors whose details can be found at the end of this information sheet.

Will my taking part in this study be kept confidential?

All information that is collected about you during the course of the research will be kept strictly confidential. Any information about you will have your name and other personal details removed so that you cannot be recognised from it.

What will happen to the results of the research study?

The study will be written up for publication in a number of health service research and professional journals. With your permission direct, anonymised quotations will be used and it will not be possible to identify you from these written reports. If you are interested in receiving a copy of the study findings please contact me and I will arrange for you to be sent a copy. Your personal information will be stored in a secure place and destroyed once the study findings have been sent to participants.

Who is organising and funding the research?

NHS Trust is sponsoring and indemnifying the study. The research study is part of a professional doctoral course and an educational requisition to obtaining a doctorate. I am not being paid to conduct the study.

Can I claim travel expenses?

I am willing to interview you in your own home if this is more convenient for you. If you would like to be interviewed somewhere else – at Trust settings or in your local community – I will make arrangements so that you are paid for travel expenses to and from your preferred setting.

Who has reviewed the study?

The study has been reviewed by the Faculty of Health Research Ethics and Governance Committee of the University of Brighton, NHS National Research Ethics Service, Proportionate Review Sub-Committee of the NRES Committee North West – Greater Manchester North Research Ethics Committee and the local Research Ethics Committee of the Sponsor, NHS Trust.

Contact for further information

If you would like more information about this study and what is involved then please contact me. My name is Beatrix Ruckli, Researcher and Doctoral Student in Occupational Therapy, Tel:....., e-mail address:.....

Alternatively, you can leave your name and telephone number with the Occupational Therapy Office Tel:.....and I will return your call.

If you have any complaints about this study please contact The Complaints, Legal Services and PALS Manager, Address:.....Tel:.....

If you are unhappy about the research process, please contact my academic supervisors
Dr. Marion Martin Dr Jon Wright Professor Gaynor Sadlo
Senior Lecturer Principal Lecturer Professor of Occupational Science
Tel: 01273 643675 Tel: 01273 643877 Tel: 01273 643654
University of Brighton, School for Health Professions, Robert Dodd Building, 49
Darley Road, Eastbourne, BN20 7UR.

Thank you taking the time to read this information sheet and considering whether you would be willing to take part in this study.

Appendix 6



University of Brighton

The experience of participation in creative activities



PARTICIPANT CONSENT FORM

- | | Please
initial box |
|---|--------------------------|
| 1. I confirm that I have read and understand the information about the above study and have had the opportunity to ask questions. | <input type="checkbox"/> |
| 2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected. | <input type="checkbox"/> |
| 3. I understand that the Sponsor, NHS Trust and regulatory bodies are able to monitor and audit the study. | <input type="checkbox"/> |
| 4. I understand that all information given by me or about me will be treated as confidentially by the research team. | <input type="checkbox"/> |
| 5. I agree to tape-recording of my interview and that direct, anonymised quotations from my interview can be used in publications. | <input type="checkbox"/> |
| 6. I wish to receive a copy of the findings. | <input type="checkbox"/> |
| 7. I agree to take part in the above study. | <input type="checkbox"/> |

Name of participant

Date

Signature

Name of person taking consent
(if different from researcher)

Date

Signature

Name of researcher

Date

Signature

Appendix 7

Personal notes and field text, research diary, interview 1, PLEASE NOTE: PARTS REMOVED

Notepad

I wrote down words, simple phrases as reminders in a small notepad shortly after the interview

<i>transformation,</i>	<i>doing – making a piece of work,</i>	<i>being in the presence</i>
<i>'there' ,</i>		<i>connection with other</i>
<i>people</i>		
<i>hard to describe</i>	<i>fascination with human figure,</i>	<i>completely in the moment</i>
<i>of making</i>	<i>studio</i>	
<i>bad thoughts go away,</i>	<i>self-focused</i>	<i>whole attention focused</i>
<i>on doing the sculpture/portrait</i>	<i>exhibit my work</i>	<i>worries go</i>

Pocket memo recorder

I recorded my own observations and reflections immediately after the interview (car, clinic setting, my office), they were transcribed on the same day, (late evening); more and expanded further after reading/re-reading the transcript of interview 1

Documents, photographs

artwork: ceramic portraits, provided by Lisa

Experiential descriptions – dismissed at later stage

Lisa's own words from the transcript were used to create a poem about the meaning of doing ceramic sculpture and portraits

Lisa' 'Doing ceramic work'

I feel rapt by it.
All my attention is taken up
By the act of doing something physical, like sculpting.

But I also know,
I have to make creative decisions as well.
So that engages my mind on a different level
To what it would normally being used on.

I think about the aesthetic of the piece.
But..... it's really hard to describe.
I just feel completely at one with the clay,
Grounded by it almost.

I feel, I can express myself
Through the act of making a piece of work.
(Lisa, Transcript 1, L53- 62, p2)

Field notes

Observations of my own participation in the interview

My first interview with participant 1, called Lisa at her own home environment. I was a bit nervous as I had never met Lisa before, did not know anything about her current life style, previous mental illness problems. We had an informal talk before I started the interview. I think she was very patient with me as I check both recording devices, prepared the first question to be asked. As the interview progressed and because of Lisa's focused manner to really engage in the interview I became less nervous and was actually able to really listening to her answers. I observed that I leaned forward in the chair to shorten the distance between her and me in order to better understand her – her voice was very clear but sometimes her voice became softer in expression, particularly when she was closing her eyes in an attempt to re-play in her mind the particular situation she was describing-

Observations of the setting relevant to inquiry

Lives in small village, country side, she wanted to be interviewed at home, at a particular day (Mon), particular time (after 6pm) – 'quieter and less busy time of the day'.

Body language, tone of voice,

Lisa spoke in a very clear voice, articulate, very focused to answer my questions, would even close her eyes in an attempt to really think about it, to re-play the situation when she was doing the ceramic portrait.

Environmental distractions

None

Dress and demeanour of the informant

elegant appearance, keen to be interviewed, positive and patient attitude towards me, the interviewer

Important symbols (hanging on walls, standing on tables or bookshelves)

Display of her art work all around but very tastefully arranged, not cluttered

Recorded details after tape recorder was turned off (NOTEPAD)

I think transformation is an important word (essential characteristics) and the phrase 'to go to and to do' – it seems like that the action of 'doing' or 'making a piece of work' takes place at a particular venue and a particular time'

Self-focused – all attention focused on this one activity – physical component but also mental component (thinking about...), engagement of senses

Enriched life style

Personal notes, research diary, interview 1

lives in a small village,

gave her whole attention, concentration to answer the main questions, remained focused on them, had taken some time to prepare herself as main questions were mentioned in the Patient Information Sheet

financial implications of participating in lots of creative activities – consultant and his department are paying for the privately arranged sessions; 7 years without a ‘spell’ in hospital

Reflection

Overall very keen to point out how important the engagement in creative activities has become for her, future plans to ‘branch out’ and sell her work

Amazed and thrilled that she is able to get re-create things from her mind into clay, that she has got the skills to do it, Self-confidence has increased, being with other people – at least the ones from the weekly sessions Skill building

Remission – lengthy process; NHS culture – institutionalised – became part of the ‘hospital scene’

My own thoughts

Difficult to describe thoughts and feelings for one single event (still takes medication) – not as important rather long term engagement, was able to talk about early experiences when still aware of other people, nowadays not focused on their presence anymore

Aim of research: to get participants’ viewpoint about phenomenon, big part of it might be the illness experience of each individual and how they got involved into the engagement of creative activities.

Appendix 7
Personal notes and field text, research diary, interview 1,
PLEASE NOTE: PARTS REMOVED

Appendix 8
Transcript 1

Doing ceramic sculpture and portraits

PLEASE NOTE: REMOVED

Appendix 8
Transcript 1

Doing ceramic sculpture and portraits
PLEASE NOTE: REMOVED

Appendix 8
Transcript 1

Doing ceramic sculpture and portraits
PLEASE NOTE: REMOVED

Appendix 8
Transcript 1

Doing ceramic sculpture and portraits
PLEASE NOTE: REMOVED

Appendix 8
Transcript 1

Doing ceramic sculpture and portraits
PLEASE NOTE: REMOVED

Appendix 9
Transformation of transcript 1
PLEASE NOTE: REMOVED

1	<i>R: Tell me about your experience of doing ceramic sculpture and portraits. What is it like for you? I am particularly interested in your feelings and thoughts when you are doing it</i>
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Appendix 9
Transformation of transcript 1
PLEASE NOTE: REMOVED

Appendix 9
Transformation of transcript 1
PLEASE NOTE: REMOVED

Appendix 9
Transformation of transcript 1
PLEASE NOTE: REMOVED

Appendix10

Table 7-10

Digression

Table 7: Digression, transcript 2

‘...and I had never spoken to the people in that house, because they altered it. They altered that house and I was a great friend of the person who lived there for 40 years, and I thought there ‘Oh dear, how could they do it?’ All the beautiful trees they cut down and the whole line of the house against the church, everything. And my other neighbour felt the same. She, when they started doing it, she said to her husband ‘We will have to move’ (pause) but anyway, these things happen gradually, I gradually got to accept it , and (pause) she turned out to be such a nice person, but of course no understanding at all, the effect of what they were doing to others’

Early coding

Table 8: Early coding, transcript 3

Line no	verbatim text	code
164	I like charcoal and pencil, I like black and white sketching	likes particular drawing
165	and drawing. and	materials and techniques
166	I often draw things that mean something to me emotionally, I suppose, I	
167	mean it’s not abstract, like I draw a picture of my	
168	my dad passed, (pause) he passed away a	draws pictures with
169	few years ago so that reminds me of my dad and	emotional value
170	that’s quite emotional but in a positive way or I’ll	
172	draw a picture of my daughter, I have a little daughter	
171	so those are positive things, which I try	
173	out and be positive unless I’m feeling particularly	
174	bad and then I might draw something a bit negative	
175	but I’ll try and draw things with a bit of emotional	
176	value or I’ll draw a little scene which describes	little scenes
177	something about my day or something that has	
178	happened to me, my pictures aren’t really abstract.	fantastical things
179	Sometimes, I like to draw things that are a bit	
180	fantastical, like monsters or unicorns.	

Final coding

Table 9: Final coding, transcript 3

Line no	verbatim text	code
164	I like charcoal and pencil, I like black and white sketching	preferred style
165	and drawing. and	
166	I often draw things that mean something to me emotionally, I suppose, I	preferred personal style
167	mean it’s not abstract, like I draw a picture of my	
168	my dad passed, (pause) he passed away a	theme label
169	few years ago so that reminds me of my dad and	
170	that’s quite emotional but in a positive way or I’ll	
172	draw a picture of my daughter, I have a little daughter	
171	so those are positive things, which I try	
173	out and be positive unless I’m feeling particularly	
174	bad and then I might draw something a bit negative	
252	P: Yeah, <u>I think</u> you find a way that you do things	
253	that you like of what you want to draw or express	
254	and that sometimes takes a while to find out what	
255	how <u>your sort of style</u> is, really,	

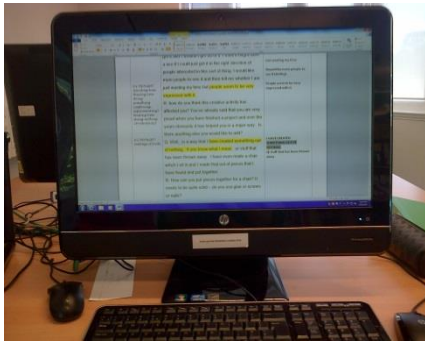
Moving individual texts between theme labels

Table 10: Moving individual texts between theme labels, transcript 6

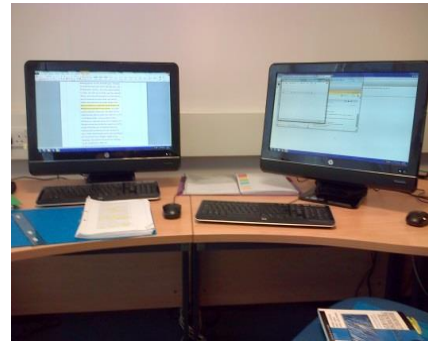
Line no...	verbatim text	theme label
279	Well, it's a really strange feeling, really,	
280	because, when I've finished something I feel really	
281	high, but I suppose it's like everything like the drug	moved from theme label
282	and the drink and all that it wears off and I think 'I'm	'Afterwards'
283	looking for the worse the same as that. What can I	to theme label
284	do with it now I've done it. You understand?	'Effect of engagement'

Appendix 11 Data analysis

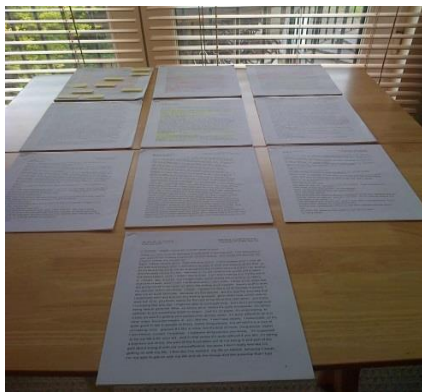
Essential characteristics



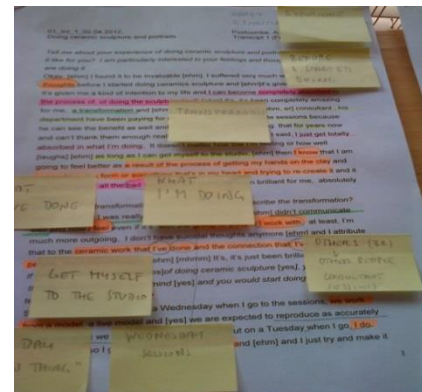
Part and whole of the text



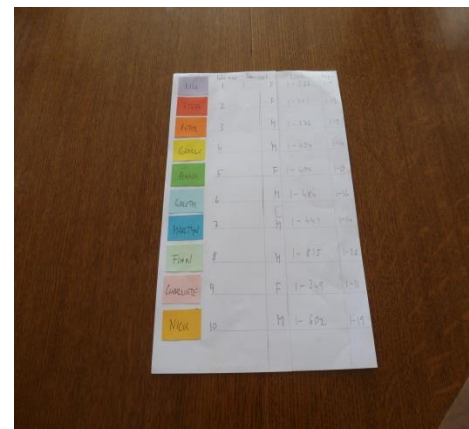
Individual transcripts



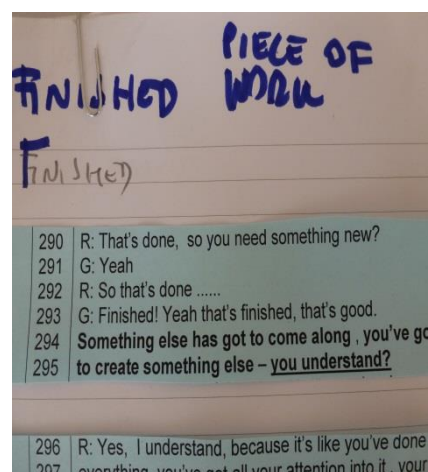
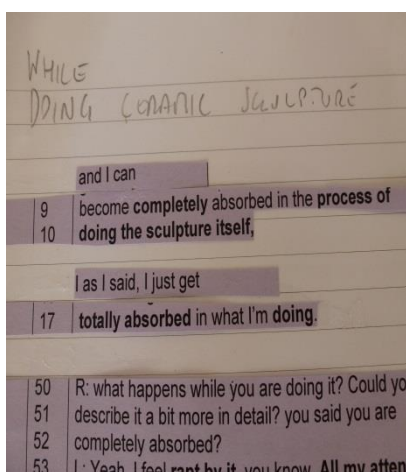
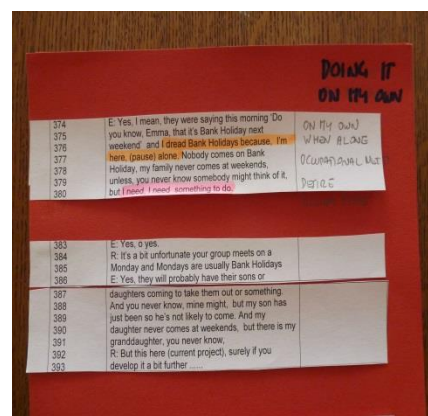
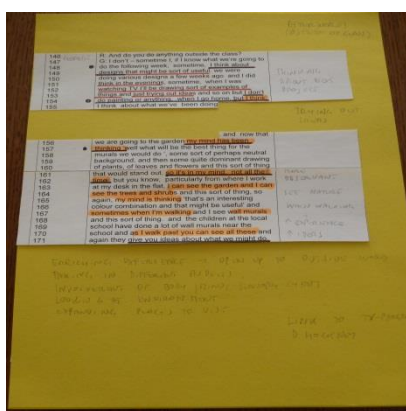
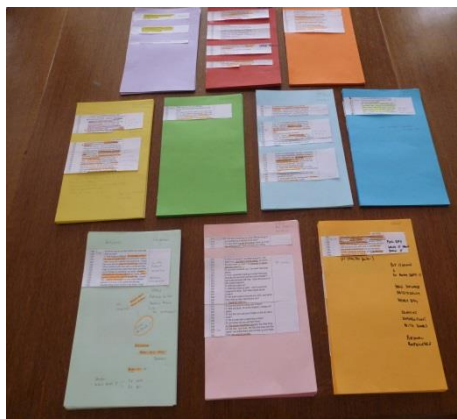
Early meanings



Individual texts on colored paper



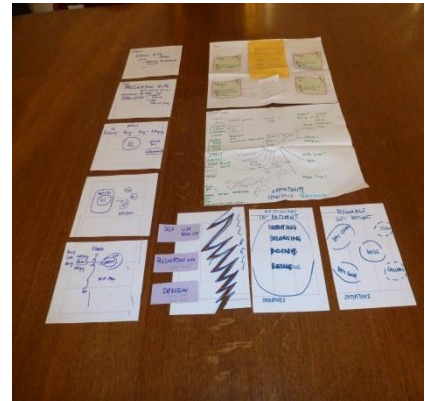
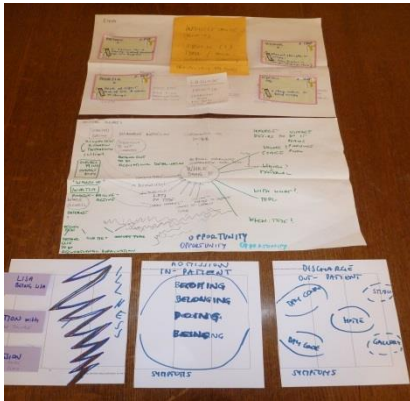
Themes emerging



Refinement of tentative theme labels



With members of the Service User Forum



With occupational therapy colleagues



Appendix 12
Early conceptualised ideas from themes
Example 1

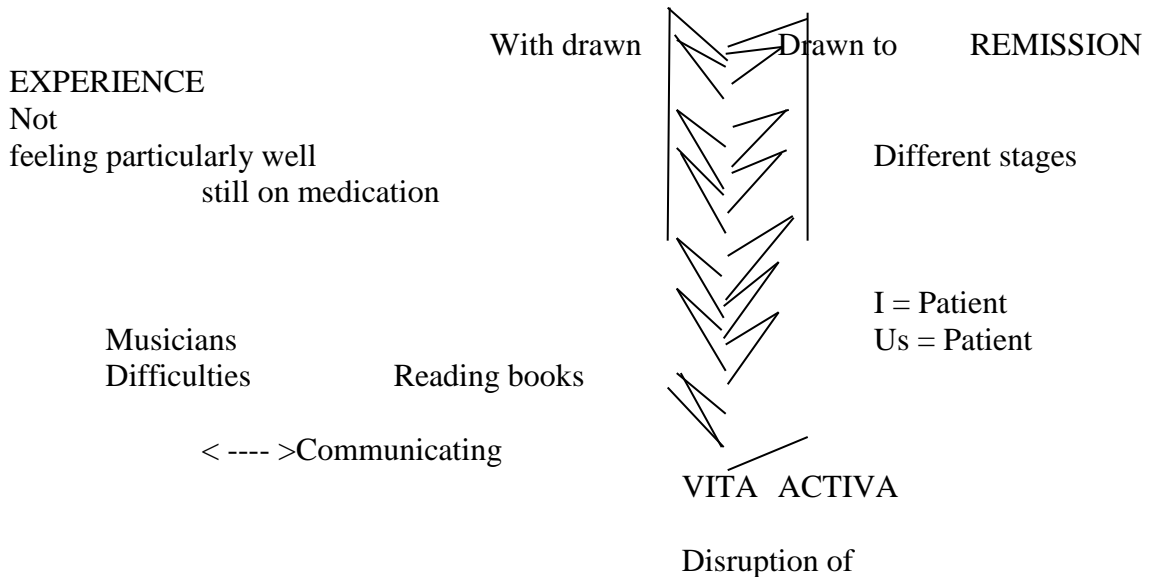
Location	Working	Doing	Other activities
Becoming ill	Doing (recent project)		Meaning
>OPPORTUNITIES	on my own	with others	
Material			
>OPPORTUNITIES			
Interests	Sharing/Doing		While doing it
Ambition	Support from		
Others			
>OPPORTUNITIES			
To look			
Fascination	Contact	Expression	forward to
	with services		Anticipatory
			Purpose
Get started (Hospital)		Preferred	Routine
		Style	
		Learning	to do 'it'
Difficult		Inventive	
to get started			
>STRUGGLE	Finished piece of work		
Transformation			
Enrichment	Stopped	Turns out differently	
	doing it		
		Fixed	Free
		idea	expression
>Afterwards			

Early conceptualised ideas from themes

Example 2

Home own Home parents Meaning Home
 Home Home parents Home own Home
 Homeless Assisted Centre living

Feeling well



no clear cut off point

Making sense of illness

Managing previous active life/life style

Doing Patient Inertia
 on my own Vigour/ lack of vigour
 Lassitude
 a person who is physical strength or energy
 receiving medical treatment
 lack of will to move forceful in thought,
 esp in a hospital

Doing with others

Going out to places

REMISSION EXPERIENCE OCCUPATIONAL EXPERIENCE
 CREATIVE EXPERIENCE OCCUPATIONAL ENGAGEMENT

CHOSEN ACTIVITY- CHOICE

CONTROL – when, where and how to participate

Early conceptualised ideas from themes

Example 3

SELF	MEANING	Personal	SKILL
EXPRESSION	`Reconstructing		INTEREST
			KNOWLEDGE
	their life		
	PARTICIPATION		
			CURIOSITY
To make known			
to speak, write or communicate	Voice		STATUS of WELL-BEING
Different Use of	ACHIEVING		FASCINATION
TECHNIQUES	Safety valve		
	MAKING		
in some other way			
what one thinks or feels	(thoughts, opinions, ideas)	Outlet	
MAKING FEEL BETTER		MATERIAL	DOING
	COLOURS		
RECREATE	Started	Series of actions	
NOT JUST AS A PAINFUL,	DISTURBING		
	ENJOY THINGS, FEELINGS		
	doing 'it'	as they happen	
Intellectualize			
EXPERIENCE	as you see them	ANTICIPATE	
	Started to draw	Control	
		to think with pleasure	
Impulse		the power to direct, manage	
thought	LOCKED INSIDE	& excitement about sth	
		(the ability to remain calm)	
	CREATIVE SELF	that is going to happen	
Idea	OCCUPATIONAL	over time, continued	
	EXPERIENCE		
SET FREE releasing			
make known to others		BECOME CALM	
Pre-occupied			
my mind	OCCUPATIONAL	present moment	
	EXPERIENCE	MIND - MENTAL	
		PERCEIVED THROUGH MIND	
	BEING A PATIENT		
	BECOMING AN ARTIST (ROLE)		
	PARTICIPATE		
	BEING LISA	BODY - PHYSICAL	
		EXPERIENCED THROUGH	
to take part in sth or			
	CONNECTION WITH OTHERS		
	BODY becomes involved in an activity		

Early conceptualised ideas from themes

Example 4

Self-initiative/self-encouragement	Enjoyment, happiness, fun
Interest/fascination	‘I enjoy it’
Motivation, Need/longing	‘It makes me happy’
Search for ‘something to do’	‘Helpful’ (relaxing, calming; invigorating, stress relief; safety valve)
	‘Able to concentrate on doing’
	Not thinking terrible thoughts’
Use of available time	‘It makes me feel better’

Question: concentration - different levels? for how long?

Quickly done (Peter, Charlotte)	>PREFERRED, PERSONAL STYLE
Effort to do, limited ability to concentrate (Martyn)	(SELF-EXPRESSION)
Bigger projects from own ideas (Emma, Lisa, Gareth)	‘Small achievement’ ‘Makes you feel well’

On my own / with others > ENGAGEMENT WITH OTHER PEOPLE
(SECOND MAJOR THEME)

	Groups	
Creative opportunity contact	Participation in	Engagement
Environment, materials, tools material	creative activities	in a creative activity
Encouragement by others significance) colours	(choice, exploring)	(personal tactile element
In-action	‘just doing’ Action of doing	Playing a familiar song, Copying, A few stitches,
‘nothing to do’ ‘something to do’ ‘Doing something else’ gardening (Ann, Emma, Gareth)		Strategies to get started
not specified (Finn)	Easy access to material/tools (Emma, Peter, Martyn, Charlotte)	
	Part of daily /weekly routine (Nick/ Lisa, George, Finn, Charlotte)	
	Important part of life: for all	
	Use of CBT techniques, positive diary: Lisa	
Unwell Episode of illness	Well Unwell distressing thoughts	Well
Unwell Hospital lethargic	drawing (Nick)	
	Remission	
Anne: currently no interest/motivation/ concentration previously ‘finding the time to do it’		

Early conceptualised ideas from themes

Example 5

IDEAS Own ideas desire to create it/recreate it
Careful concentrate on difficult pattern 'As I seen it in my head'/'in front of me'

See something (book, nature, real object)
Dreamt something

Creative ability, skills 'To make it to the best of my ability'
'I can do it, I have the skills to do it'

Creative process

Created product: inanimate object/song

Being in the moment of making

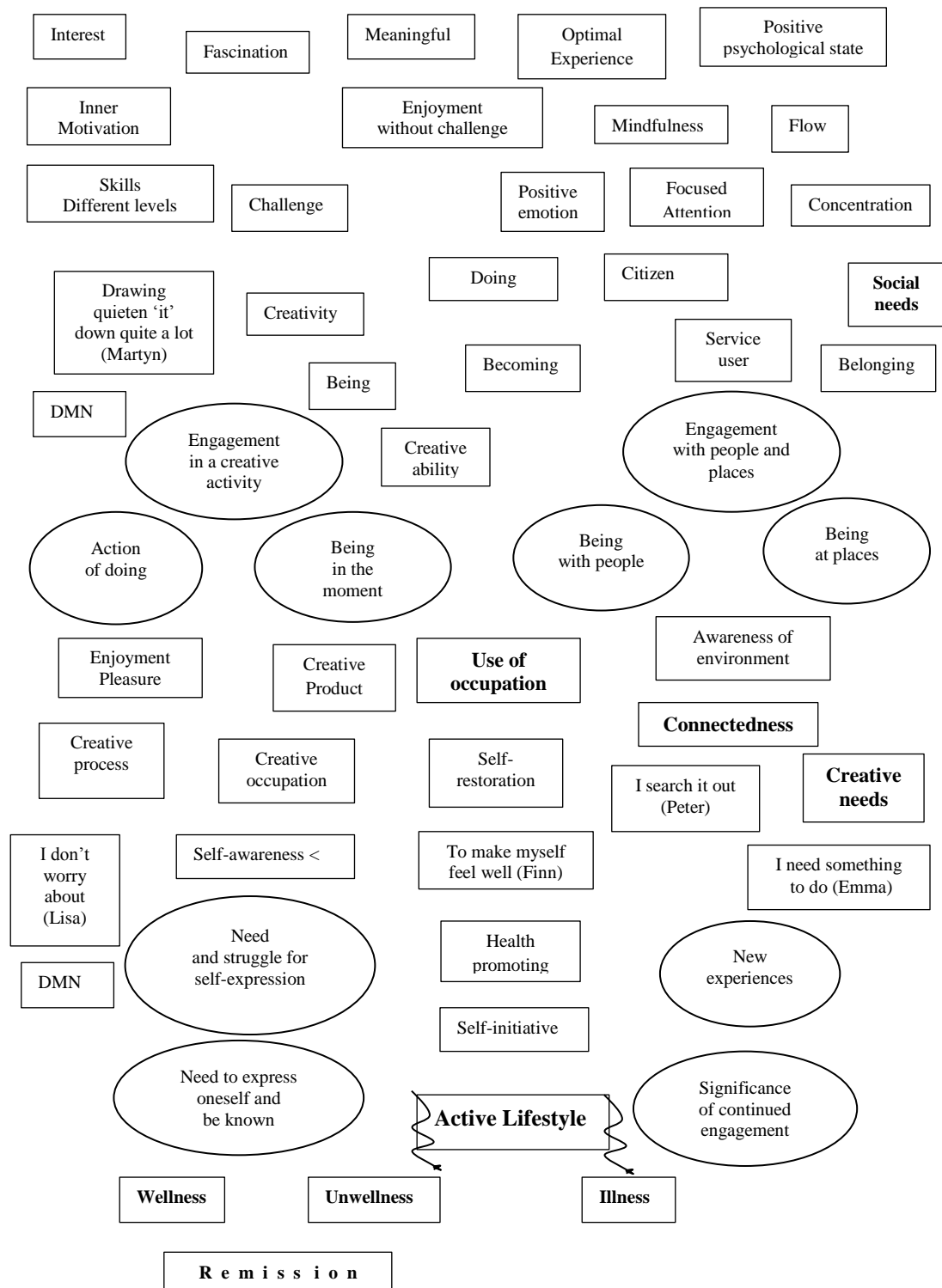
awareness of surroundings **deeper absorption/concentration** not aware of surroundings
self-awareness not self-aware

Question: 'medication and guitar work well to concentrate'(Finn)
'it (drawing) dampens it(negative thoughts)quite down a bit'(Martyn)
no/limited self-awareness=
self-forgetting?

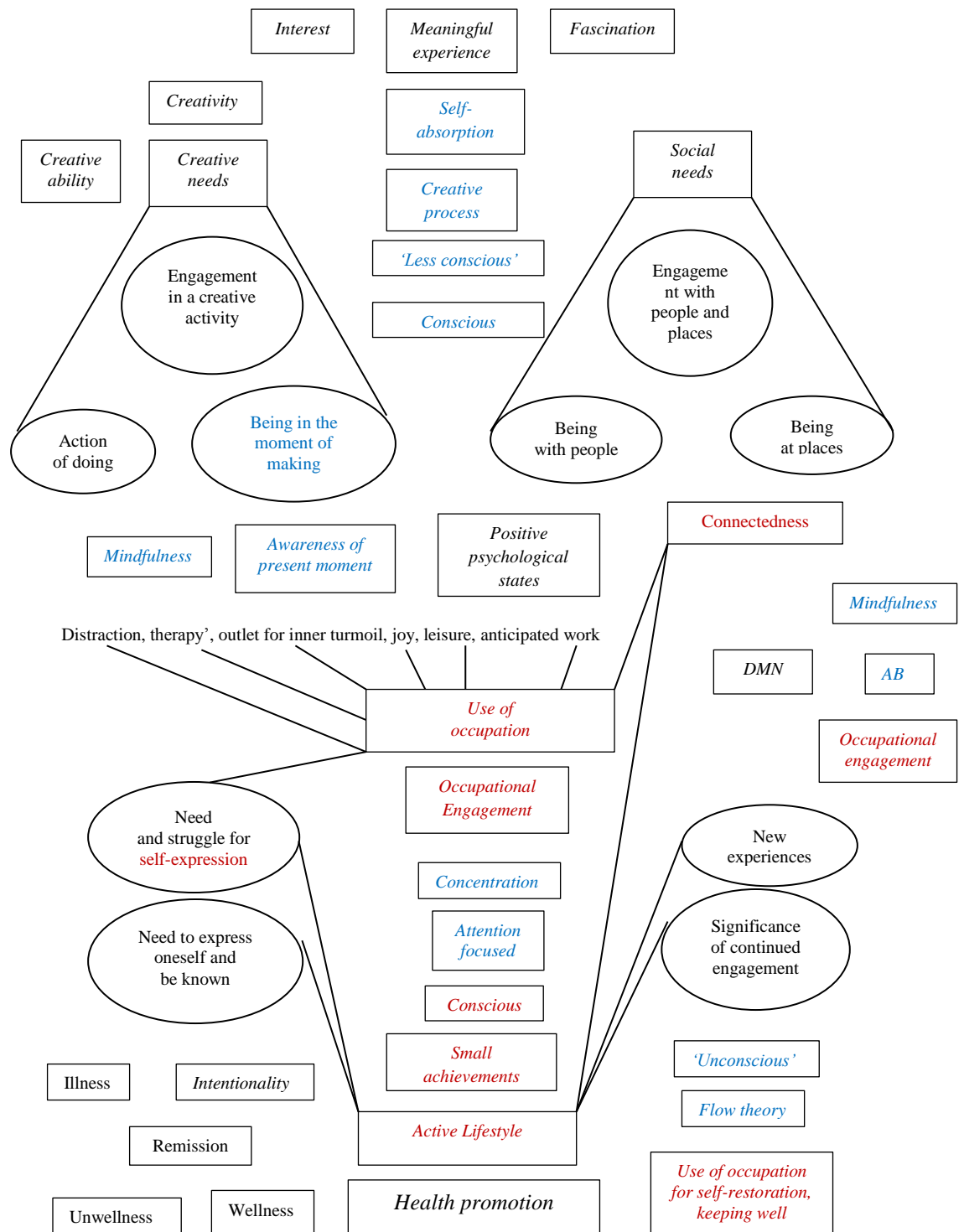
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Engagement in a creative activity

Appendix 14 Early concept map



Appendix 15
Concept map: Higher order conceptualisation of themes



Appendix 16
Individual artwork of participants

Working with charcoal



Making a drawing – feeling a bit down



Working with clay



Making a painting



Making group work



Trying out new things



Making a sketch



Making objects from thrown away material



Making careful geometrical designs



Making a ceramic portrait

