Exploring Complex Relationships Between Leisure and Persons with Mental Health Problems

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Abstract

Positive leisure opportunities for individuals with mental health problems (MHP) may contribute to better overall health (Caldwell, 2005) and play an important role in the recovery process (Iwasaki, Coyle, & Shank, 2010). However, leisure interventions to treat people with MHP are often understudied and underdeveloped (Rudnick, 2005). This dissertation explores relationships between leisure and persons with schizophrenia (SCZ) or schizoaffective disorder (SAD). The first manuscript was an autoethnography that uncovered the epistemological, ontological, and methodological beliefs of the doctoral candidate. A hybrid qualitative technique, that combined visual research methods and narrative storytelling, was used to recall my personal and professional experiences and reflect on knowledge development for people with MHP in the leisure context. These reflections led to an awareness of some deeply rooted societal issues that may impact the lives of persons with MHP and associated implications for leisure engagement. It also helped to develop several key research questions to frame the current research program. The second manuscript was a scoping review paper that spanned the years 1938-2016 to explore the effects of leisure interventions on persons with SCZ or SAD. The review identified 16 leisure interventions for people with these disorders. Five interventions focused on behavioural outcomes while the remaining 11 interventions focused on leisure outcomes. The findings suggested that leisure interventions may play a positive role in the recovery of persons with these disorders. However, relatively small sample sizes, variations in study design, different outcome measures, and the use of varying treatment approaches made it challenging to draw any definitive conclusions about the outcomes of the interventions. The third manuscript was a mixed methods study that explored the perceived leisure experiences of persons with SCZ to gain a preliminary understanding of complex relationships between MHP, leisure, health and recovery in the community. Study findings suggested the participants engaged in goal setting to achieve a greater sense of community belonging, were unmotivated to engage in social leisure, were cognizant of complex health issues surrounding SCZ, wanted to lead more healthy and active lives, and possessed fundamental understandings of leisure. These findings also revealed that study participants may have benefitted from leisure education (LE) interventions to address leisure and self-awareness, social- and leisure-related skills, improved health outcomes through active leisure and increased opportunities for social leisure engagement. The fourth manuscript describes a qualitative case study design that explored the community leisure experiences and factors that impacted participation in a LE program for persons with SCZ or SAD. Results suggested an understanding of leisure, relationship development, community engagement, and autonomy support were key to participation. In conclusion, this dissertation contributes to an in-depth understanding of the intersectional and complex issues that surround leisure, persons with SCZ or SAD, and community recovery. Results from this dissertation suggest that LE programs may be effective in helping to improve the leisure engagement and community recovery of persons with SCZ or SAD living in the community. Thus, leisure interventions may enable persons with these disorders to live more healthy, happy, active, and meaningful lives.

Résumé

Pour les personnes atteintes les problèmes de santé mentale PSM, avoir l'opportunité de participer aux loisirs positif peut contribuer à améliorer leur santé globale (Caldwell, 2005) et joue un rôle important dans le processus de rétablissement (Iwasaki, Coyle, & Shank, 2010). Cependant, les interventions qui utilisent les loisirs comme moyens d'apprentissage, pour traiter les individus atteintes de PSM sont souvent sous-étudiées et sous-développées (Rudnick, 2005). Cette thèse explore les relations entre les loisirs et les personnes atteintes de schizophrénie (SCZ) ou de troubles schizo-affectifs (SAD). Le premier manuscrit était une auto ethnographie qui a permis de découvrir les croyances épistémologiques, ontologiques et méthodologiques du candidat au doctorat. Une technique qualitative hybride, associant des méthodes de recherche visuelle et des récits narratifs, ont été utilisées pour rappeler mes expériences personnelles et professionnelles et pour réfléchir au développement des connaissances des individus atteints de PSM dans le contexte des loisirs. Ceci a également permis de développer plusieurs questions de recherche clés pour encadrer le programme de recherche actuel. Le deuxième manuscrit a été un examen de portée, qui exposais les années 1938 à 2016 et explore l'effets des activités de loisirs sur les individus atteints de SCZ ou SAD. L'étude a identifié 16 interventions de loisir pour les personnes atteintes de ces troubles. Cinq interventions portaient sur les résultats comportementaux tandis que les onze autres ont porté sur les résultats de loisir. Les résultats suggèrent que les interventions de loisirs peuvent jouer un rôle positif dans le rétablissement des individus atteintes de ces troubles. Toutefois, les tailles d'échantillon relativement petites, les variations dans la conception de l'étude, les différentes mesures des résultats et l'utilisation de différentes démarches de traitement on fait que les conclusions définitives sur les interventions ont été difficile à tirer. Le troisième manuscrit a été une étude de méthodes mixtes qui a exploré comment les individus avec la SCZ ont aperçu leurs expériences de loisirs pour acquérir une compréhension préliminaire des relations complexes entre PSM, les loisirs, la santé et le rétablissement dans la communauté. Les résultats de l'étude ont suggéré que les participants qui se sont donner le but d'atteindre un plus grand sens d'appartenance à la communauté, n'étaient pas motivés à s'engager dans le loisir social, étaient conscients des problèmes de santé complexes entourant SCZ, qu'ils voulaient mener une vie plus saine et active, et possédait une compréhension fondamentale du loisir. Ces résultats ont également illustré que les participants de l'étude ont pu bénéficier d'interventions en éducation de loisirs (EL) pour répondre aux besoins des loisirs et de la conscience de soi, aux habiletés sociaux et aux loisirs, l'amélioration des résultats de santé grâce aux loisirs actifs et une augmentation d'engagement en matière de loisirs sociaux. Le quatrième manuscrit décrit une étude de cas qualitative qui a exploré les expériences de loisirs dans la communauté et les facteurs qui ont pu affecter la participation des individus atteintes de SCZ ou SAD à un programme de EL. En conclusion, cette thèse contribue à une compréhension approfondie des enjeux intersectorielles et complexes qui entourent les loisirs, les personnes atteintes de SCZ ou SAD, et le relèvement communautaire. Les résultats de cette thèse suggèrent que pour les individus atteints de SCZ ou SAD vivant dans la communauté, le programme EL peut être efficace pour aider à améliorer leur participation aux loisirs et le relèvement communautaire. Ainsi, les interventions de loisir peuvent permettre aux personnes atteintes de ces troubles de vivre une vie plus saine, plus heureuse, plus active et plus significative.

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Contributions of Authors

Manuscript One: A narrative video – ethnographic exploration of leisure and mental health problems

Co-author: Shawn Wilkinson

- Contributions: I am first author of this manuscript. I conceptualized the study, conducted literature searches, performed the video narratives, reviewed the video narratives, analyzed the data, and wrote the manuscript.

Co-author: William J. Harvey, Ph.D.

- Contributions: Involved in the conceptualization of the study, played the role of critical friend during research meetings, reviewed the analysis, and edited the manuscript.

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Contributions of Authors

Manuscript Two: Leisure interventions and schizophrenia-schizoaffective disorder: A Scoping Review

Co-author: Shawn Wilkinson

- I am first author of this manuscript. I conceptualized the review, identified the review parameters, conducted all literature searches, analyzed the findings, and wrote the manuscript.

Co-author: William J. Harvey, Ph.D.

- Contributions: Involved in the conceptualization of the review, the analysis of findings, and writing and editing the manuscript.

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Manuscript Three: Schizophrenia & Leisure: Personal stories of struggles and triumphs.

Co-author: Shawn Wilkinson

- I am first author of this manuscript. I was involved in the conceptualization of the study, wrote the ethics, recruited participants, met with participants to explain the study, obtained consent, collected data, analyzed the data, and wrote the manuscript.

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- Contributions: Provided valuable insight about clinical practices. Assisted with writing and editing the manuscript.

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Manuscript Four: L.E.A.P.S.-Leisure Education and Active Participation for Persons with Schizophrenia & Schizoaffective Disorder.

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- I am first author of this manuscript. I was involved with the conceptualization of the study, wrote the ethics, recruited participants, met with participants to explain the study, obtained consent, designed the intervention, accompanied participants on all of the community outings, collected data, analyzed the data, conducted all debriefing sessions and wrote the manuscript.

Co-author: William J. Harvey, Ph.D.

- Contributions: Involved in the conceptualization of the study, design of the intervention and debriefing sessions, and the writing and editing of the manuscript. He also acted as a critical friend in qualitative analyses.

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Preface

This doctoral dissertation is comprised of six chapters. The first chapter presents an overview of the main research constructs that are relevant to the four research studies. It also discusses the construct of leisure and its use as a general framework for this dissertation. This chapter concludes by providing the purpose and objectives of the dissertation. Chapter two is an autoethnography that challenged the underlying assumptions, experiences, and knowledge of the doctoral candidate. This manuscript helped to frame the candidate's research position and developed research questions to explore. The manuscript is currently in preparation. The third chapter is a scoping review of the literature on leisure interventions between the years 1938-2016 for persons with schizophrenia (SCZ) or schizoaffective disorder (SAD). The manuscript is currently in preparation. Chapter four is a mixed-methods study that explored the leisure experiences of persons with SCZ living in the community. The manuscript is currently in preparation. Chapter five is a qualitative case study that investigated the implementation of a LE program for persons with SCZ or SAD living in the community. This manuscript is in preparation. Chapter six provides a summary of the dissertation and implications for future research.

Chapter One

Introduction

This chapter presents an overview of the main research constructs that are relevant to the dissertation. It also discusses the construct of leisure and its use as a general framework for this dissertation. This chapter concludes by providing the purpose and objectives of the dissertation.

Mental Health and Mental Health Problems

Mental Health (MH) is the capacity to feel, think, and act in ways that strengthen our ability to enjoy life and confront the challenges that individuals face (Mental Health Commission of Canada [MHCC], 2009). MH is a key component of well-being and it is fundamental to the health of all individuals living in the community (Harvey, Varriano, & Wilkinson, 2016). Mental health problems (MHP) are health conditions "characterized by alterations in thinking, mood or behaviour (or some combination thereof) associated with significant distress and/or impaired functioning over a period of time" (Health Canada, 2002, p. 16). MHP affect the lives of a significant number of people each year (Health Canada, 2002). Globally, more than 450 million people are affected by MHP (World Health Organization [WHO], 2008). North American estimates also suggested that approximately 20% of Canadians (Health Canada, 2002) and 26% of Americans (Kessler, Chiu, Demler, & Walters, 2005) will experience symptoms of a MHP during their lifetime. The signs, symptoms, and severity of specific MHP vary widely (Walker, 2010). The focus of this dissertation is on persons diagnosed with SCZ or SAD. My initial graduate work around children with emotional and behavioural problems led me to work with adolescents experiencing their first episode of psychosis. This experience led to an opportunity for me to work with and learn more about people with psychotic disorders specifically SCZ and SAD. I became extremely interested in this population and I identified a lack of recreation related research and clinical services for these individuals. Thus, I wanted to learn more about the complex relationships between leisure and persons with SCZ and SAD.

Schizophrenia and Schizoaffective Disorder

SCZ and SAD are serious psychotic illnesses that profoundly impact an individual's psychological, behavioural, and emotional functioning (American Psychiatric Association [APA], 2013). These disorders can affect an individual's ability to think, feel, perceive, and act; often resulting in a significant distortion or disconnection from reality (Castle & Buckley, 2015; Daniel, 2010). The following section presents diagnostic information related to SCZ and SAD.

Definition & Symptomatology

The Diagnostic and Statistical Manual of Mental Disorders (DSM-V) of the American Psychiatric Association (APA, 2013) defined SCZ in relation to the following diagnostic criteria: (a) two or more of the following symptoms [(1) delusions, (2) hallucinations, (3) disorganized speech, (4) grossly disorganized or catatonic behaviour, (5) negative symptoms] are present for a significant portion of time during a 1-month period and at least one symptom must be (1, 2, or 3 as listed above); (b) the person's functioning level in one or more major life areas is markedly below the level achieved prior to the onset of the disorder; (c) continuous signs of the disturbance persist for at least six months; and (d) the disturbance is not attributable to another psychiatric or organic disorder (APA, 2013).

People diagnosed with SCZ experience a range of cognitive, behavioural, and emotional dysfunctions, but no one symptom is pathognomonic of the disorder (APA, 2013). The DSM-V identified five types of symptoms characteristic of SCZ: delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behaviour, and negative symptoms. Delusions and hallucinations are classified as positive symptoms. These types of symptoms can be defined as "abnormal experiences added on to normal mental functions" (Compton & Broussard, 2009, p. 21). Specifically, delusions are firmly held false beliefs that can last for a long period of time (Reznek, 2010). A false experience of one of the five senses (e.g., seeing, hearing, feeling, tasting, and smelling) is known as a hallucination and auditory hallucinations are experienced the most (Blom, 2010). Disorganized symptoms are identified by a disruption in the normal flow of thought, speech, or behaviour (Compton & Broussard, 2009). These symptoms have a deleterious impact on goal-directed behaviour and may lead to difficulty with self-care (Compton & Broussard, 2009). Negative symptoms are symptoms that subtract or remove something from an individual's typical everyday experience (Reid, Barker, & Smith, 2010). A loss of interest or pleasure in life (e.g., anhedonia), a lack of motivation (e.g., avolition), and little to no sign of outward emotion (e.g., blunted/flat affect) are all considered to be negative symptoms associated with SCZ (Reid et al., 2010). These symptoms are considered to have a significantly adverse impact on the individual and tend to be associated with poorer long-term functional outcomes (Reid et al., 2010).

SAD is defined in the DSM-V (APA, 2013) by four specified diagnostic criteria: (a) the presence of a major mood episode (e.g., major depressive or manic) concurrent with Criterion A of SCZ for an uninterrupted period of time; (b) the experience of delusions or hallucinations for 2 or more weeks in the absence of a major mood episode occurs during the duration of the illness; (c) there is a presence of symptoms that meet criteria for a major mood episode for the majority of the total duration of the active and residual portions of the illness; and (d) the effects of a substance or another medical condition are not the cause of the disturbance (APA, 2013).

Persons with SAD experience a combination of psychotic symptoms (e.g., hallucinations or delusions) and affective symptoms (e.g., mania or depression) (Daniel, 2010). Schizoaffective bipolar type and schizoaffective depressive type are the two major forms of this disorder (Lawrence, First, & Lieberman, 2015). The presence of a major depressive and/or manic episode must occur concurrently with an active-phase of psychotic symptoms for a diagnosis of SAD to be made (APA, 2013). A major depressive or manic episode is understood to be part of the disorder and not classified as a disorder alone (Daniel, 2010). Individuals with SAD may also experience additional symptoms (APA, 2013). For example, deficits in social cognition, difficulty with self-care, and anosognosia (e.g., inability to recognize one's own impairment) may all have a negative impact on functioning. However, anosognosia and negative symptoms may be "less severe and pervasive" for persons with SAD (APA, 2013, p. 107). Persons with this disorder often experience more affective symptoms and a better course and outcome than people with SCZ (Lawrence et al., 2015).

Etiology

The etiology of SCZ and SAD remains unclear (Lawrence et al., 2015). Research suggests that a complex interplay between biological, genetic and environmental factors is believed to cause these disorders (Lawrence et al., 2015). Neuroimaging research has identified differences in brain regions of persons with SCZ and SAD when compared to persons without disabilities (Amann et al., 2016). Differences in cellular architecture, white matter connectivity, gray matter volume, and overall brain volume were identified (Amann et al., 2016; Bora et al., 2011; Steen, Mull, McClure, Hamer, & Lieberman, 2006). Environmental factors such as obstetrical complications, maternal stress, and exposure to traumatic life events can also play a role in the development of SCZ or SAD (Daniel, 2010; Walker, Kestler, Bollini, & Hochman, 2004).

Prevalence & Classification

Lifetime prevalence of SCZ appears to affect approximately 1% of the population (Compton & Broussard, 2009). North American estimates suggested that 300,000 Canadians (Schizophrenia Society of Canada [SSOC], 2015) and 3.5 million Americans (Schizophrenia and Related Disorders Alliance of America [SARDAA], 2015) are affected by SCZ. Lifetime prevalence of SAD appears to affect approximately 0.3% of the population (Perala et al., 2007). A review of the diagnostic literature suggested the concept of SAD has evolved over time and impacted classification (Lawrence et al., 2015). For example, SAD has been viewed as a type of SCZ, a type of mood disorder, a variant of SCZ in terms of symptomatology, a phenotypic variation of either SCZ or mood disorder, or a simultaneous expression of SCZ and a mood disorder (Abrams, Rojas, & Arciniegas, 2008; Lawrence et al., 2015).

Developmental Course

SCZ can affect both men and women across all cultures and socioeconomic groups. It can develop abruptly and without warning, but most people gradually develop a variety of clinically significant signs and symptoms over time (APA, 2013). The psychotic features associated with SCZ tend to emerge between the ages of 16 and 25 years (SARDAA, 2015). Moreover, men generally tend to experience a first psychotic episode 3-5 years earlier than women (Ochoa, Usall, Cobo, Labad, & Kulkarni, 2012). A diagnosis of SCZ, prior to the age of 12 years or after the age of 40 years, is considered to be extremely uncommon (SSOC, 2015). SCZ is considered a lifelong disorder, however, research suggested that 50% of individuals may improve over a 10-year period (SARDAA, 2015). Unfortunately, approximately 25% of individuals reported no improvement over the course of their lifespan (SARDAA, 2015). Negative symptoms tend to be more persistent than positive symptoms and an individual’s negative symptoms are often more closely associated with their prognosis. In general, most people with SCZ will require some form of treatment to help alleviate symptoms over the course of their lifetime.

SAD often develops in late adolescence or early adulthood, with an average age of onset between 16-30 years (Daniel, 2013). It can affect both men and women but women tend to present with the illness more (Malhi, Green, Fagiolini, Peselow, & Kumari, 2008). However, similar to SCZ, men tend to experience symptoms of the illness at an earlier age (Lawrence et al., 2015). SAD is considered to be a lifelong disorder but the expressions of psychotic and affective symptoms and the overall impact on social and occupational function vary greatly. Research suggested that 20-30% of persons with SAD present with a deteriorating course of impairment while approximately 10% of people with the disorder experience a shift in both affective and schizophrenic symptoms over time (Malhi et al., 2008). SAD can be challenging to diagnose because of the shared symptomatology with SCZ, depression and bipolar disorder (APA, 2013). The onset, timing, and duration of specific symptoms help a psychiatrist to distinguish between a diagnosis of SCZ, SAD, or bipolar disorder (Daniel, 2013). According to the DSM-V, a significant number of people, initially diagnosed with another psychotic illness, may eventually be diagnosed with SAD when a shift in affective symptoms occurs (APA, 2013). Moreover, individuals with an initial diagnosis of SAD may be provided another diagnosis once the affective symptoms become less prominent (APA, 2013). For example, individuals who first present with a co-occurrence of psychotic and mood symptoms, but later only present with residual psychotic symptoms, may have a change in diagnosis from SAD to SCZ (APA, 2013).

Community Recovery

Early detection and multimodal forms of treatment are keys to the short-term symptom reduction and long-term recovery of individuals with SCZ or SAD (Compton & Brossard, 2009;

Randall, Simpson, & Laidlaw, 2003). The concept of recovery can be understood in different ways (Whitley & Brake, 2010). For example Davidson and Roe (2007) defined recovery in two distinct ways. The first definition, ‘recovery from mental illness’, is when an individual is cured of their serious mental illness and s/he gains back their previous life. The second definition, ‘recovery in mental illness’, refers to approximately 35-75% of people with mental illness who are (a) not cured and (b) currently living with symptoms of their disorder while being treated in the community (Davidson & Roe, 2007). The latter definition emphasized the importance of social inclusion and self-determination where people with MHPs are expected to become increasingly more involved and empowered in the decision-making process related to individual treatment and inclusion in community living (Davidson & Roe 2007, Onken, Dumont, Ridgway, Dornan, & Ralph, 2002). Since engagement in an active and healthy lifestyle is essential for improved mental health and physical well-being of people with MHP (Harvey, Delamere, Prupas, & Wilkinson, 2010); leisure is a key construct to explore for all persons with MHP (Iwasaki et al., 2010), including individuals with SCZ or SAD (Iwasaki et al., 2014).

Leisure

Leisure is a fluid concept that is often defined in relation to its role in society and impact on the individual (McLean & Hurd, 2015). For the purposes of this dissertation, leisure is conceptualized as “a relatively freely chosen humanistic activity and its accompanying experiences and emotions that can potentially make one’s life more enriched and meaningful” (Iwasaki et al., 2010 p. 485). Leisure is being used as a general framework for this dissertation to better understand its relationship to life, health, and recovery for persons with SCZ or SAD. Leisure as a framework may be informed by a number of different theories.

Flow theory reflects the idea of leisure as a state of mind and suggests that when the challenge of an activity and the skill level of an individual match, the person enters into a state of flow (Csikszentmihalyi, 1997). Flow experiences may result in increased levels of intrinsic motivation, self-determination, self-efficacy, and self-actualization (Csikszentmihalyi, Rathunde, & Whalen, 1997). Leisure may provide opportunities for people with SCZ or SAD to identity activities, engage in decision-making, and become self-actualized (Shivers & deLisle, 1997). Outcomes related to self-actualization may be directly linked to decision making and choice in leisure (Harvey et al., 2010) For example, individuals who freely choose to engage in activities may be more likely to feel a sense of fulfillment and control over their lives and leisure pursuits (Harvey et al., 2010).

The theory of optimal arousal states that an individual is either motivated to seek arousal if the current situation lacks stimulation or escapes arousal if the experience presents too much stimulation (Iso-Ahola, 1980). Optimal leisure experiences may contribute to internal locus of control, enhanced pleasure, and overall well-being (Hawthorne, 1997). Individuals who experience optimal arousal are more likely to continue to engage in the activity or to seek out new activities that may provide similar feelings of arousal.

Neulinger's theory suggested perceived freedom and intrinsic motivation are key links to leisure (Neulinger, 1981). For example, leisure may provide opportunities to engage in decision-making and enable people to feel a sense of control over their lives. Research suggested that individuals experience greater levels of intrinsic motivation and freedom of choice when engaged in leisure compared to other daily activities (e.g. work, personal care) (Csikszentmihaltyi & Graef, 1980).

Perspectives about leisure may also be influenced by self-determination theory. Deci and Ryan (1987) found leisure experiences, including self-determined activities, led to greater levels of autonomy. Feelings of autonomy and perceived freedom, related to leisure, also helped to buffer against the effects of life stress on mental illness (Lloyd, King, McCarthy, & Scanlan, 2007). Furthermore, leisure may provide opportunities for people to develop a sense of competence and relatedness to others (Iso-Ahola, LaVerde, & Graefe, 1989). Thus, leisure may help to fulfill an individual's basic needs and improve overall well-being.

Purpose and Objectives of this Research

The purpose of this dissertation was to better understand complex relationships between leisure and persons with SCZ or SAD living in the community. More specifically, the research objectives were to: (a) explore the experiences of a doctoral candidate with MHP who was interested in learning more about these complex relationships, (b) explore the research design characteristics and outcomes of leisure interventions for people with SCZ or SAD, (c) explore the community leisure experiences of persons with SCZ, and (d) develop and implement a LE program for persons with SCZ or SAD living in the community. A cohesive series of four manuscripts is presented below to inform the reader of how these objectives were obtained.

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Bridging Text

Chapter one presented an overview of the relevant research constructs and theoretical grounding for leisure as a research framework. Leisure may play a positive role in the lives of persons with MHP including people with SCZ or SAD. However, relationships between leisure and persons with these disorders are complex. Chapter two explored the experiences of a doctoral candidate with MHP who was interested in learning more about these complex relationships. This autoethnography challenged the underlying assumptions, experiences, and knowledge of the doctoral candidate.

Chapter 2

A narrative video – ethnographic exploration of leisure and mental health problems

Abstract

Social, cultural, and health issues may significantly impact the leisure lifestyles of persons with mental health problems (MHP). Many people living with MHP seem to also be grappling with the intersectional effects of poverty, joblessness, marginalization, stigma, and other comorbid health problems. A novel visual research method, narrative video journal, was used to explore the experiences of a doctoral candidate with MHP who was interested in learning more about the complex relationships between leisure and persons with MHP living in the community. This method helped him to learn more about the use of creative methods to better understand experience, uncover some of his own feelings and assumptions about mental health research, and explore key relationships between leisure and MHP. Reflecting on these key relationships led to an awareness of some deeply rooted societal issues that may impact the lives of persons with MHP and associated implications for leisure engagement. Moreover, the creative method led to the development of a novel research program to help address these complex relationships.

Today was a day that will forever be etched in my memory. For the first time in my academic career I had experienced both fear and excitement at the same time. I was overcome with emotions as I reflected on how I came to arrive at this particular intersection of academia and life. What am I doing here, what have I done, and what am I going to do about it were the questions that I kept asking myself over and over again throughout the day today. I have taken on this enormous task they call a PhD and really have no idea what I have gotten myself into. Today might very well be the first day of the rest of my academic life...Today truly is the beginning of a new story...

My story begins on a cold and sunny January morning during the first year of my doctoral work. I was sitting across the table from my advisor enjoying our morning ritual of coffee and friendly banter when the conversation suddenly turned serious. My advisor looked at me and said, “now that you have completed your first semester as a doctoral student, have you given any more thought about what research projects you would like to pursue?” I told him that I was interested in learning more about the relationships between leisure and persons with mental health problems (MHP) and that I had spent the last few months casually reading through the appropriate literature. As we discussed several potential research projects, I realized for the first time the sheer enormity of the task I was volunteering to undertake. *“What the hell am I doing here?”* I thought to myself.

My advisor sensed the level of anxiety in my voice and calmly asked me “what do you think is preventing you from moving forward at this point?” I reflected on his question for a moment and then said, “I don’t even know where to begin!” My advisor looked back at me with a smile and said “not knowing where to begin is the perfect place to start.” He explained to me that my uncertainty presented the perfect opportunity for me to start documenting my thoughts and experiences as I learned more about the relationships between leisure and persons with MHP. This personal reflection piece could help to categorize my knowledge and my reflections about leisure experiences that, in turn, would lead to the identification of several research questions to guide my doctoral work. Certainly, the personal reflection process sparked my imagination and challenged me to think about the different ways I could undertake such a project. I spent the next few weeks reading and learning more about inductive research methods, qualitative storytelling, researcher positioning and arts-based inquiry. Moreover, I was involved with another unique research project that helped me to learn about visual research methods and the use of stimulated recall and reflection to better understand past experiences (Harvey, Wilkinson, Presse, Joober, & Grizenko, 2012). As I began to read more about creative research and the life experiences of others, I started to reflect on the personal and professional experiences that, in turn, had shaped my professional knowledge and guided me to this very moment in my research career. *"What have I done to get here?" I thought to myself.*

Personal Experience

MHP have played a significant role in my personal life. My mother was diagnosed with depression and generalized anxiety several years before giving birth to me. I witnessed, first hand, the hardships and stigma that often surround someone with MHP while growing up around my mother. Several of my closest relatives also struggled with serious MHP and substance abuse issues over the course of their lifetime (e.g., grandmother, grandfather). Discussions about hospitalization, medication, and symptomatology were quite common during my childhood. I have personally dealt with issues related to anxiety since about the age of 6 years. My initial battle with anxiety, during the first year of primary school, remains a vivid memory still to this day. I often experienced heightened tension, trouble breathing, racing thoughts, and a sense of feeling trapped. I knew that something was not quite right but could not fully understand what was wrong or why it was happening to me. Feelings of loneliness, helplessness and isolation were quite common during my childhood years. Since those days, more than 25 years ago, I have sought out professional treatment and I continue to use a number of different coping strategies to help balance my life and my anxiety. MHP have shaped my personal identity and I have worked hard to accept and embrace this reality.

Professional Experience

My personal experiences with MHP eventually led me to pursue a 3-year undergraduate degree in therapeutic recreation (TR) and leisure sciences. I worked closely with adults, who were living in a hospital setting, during my undergraduate training. People with depression, anxiety, and dementia were just some of the individuals that I worked with and cared for. I learned a great deal about life and, consequently myself, from some of the people who were willing to share their personal stories of recovery with me. My assumptions about age, illness, life, and death were constantly being challenged. I also worked with children with attention deficit hyperactivity disorder (ADHD) during the third and final year of my degree. This experience had a significant personal and professional impact on me. Children with ADHD can experience additional social and psychological challenges at a very young age (Banaschewski & Rohde, 2010) and these challenges resonated with me on a personal level. I continued to volunteer my time even after my coursework was finished and, eventually, I returned to the very same clinical supervisor to complete my graduate degrees in adapted physical activity.

I have chosen to share these intimate experiences with the reader so that she/he can better understand my personal and professional connections with the subject matter. For example, I am writing this paper from the position of a leisure researcher who has (a) personally battled MHP and (b) gained an enormous amount of experience with, and respect for, persons living with MHP. My role as a member of the mental health (MH) community has afforded me an opportunity to appreciate the challenging clinical work that is conducted each day in hospitals and community MH clinics. As a result, it has also enabled me to conduct MH research from an insider's perspective, develop an enhanced understanding of the complete social experience and guide my own recovery (Corbin Dwyer & Buckle, 2009). These personal and professional experiences have shaped my learning and have significantly contributed to the development of my professional knowledge.

Professional Knowledge

MHP may have a significant impact on the physical, social, and emotional health of an individual. Many of the people, I have worked with, often face challenges associated with daily functioning, independent living, and community engagement. For example, people with MHP are less likely to engage in active leisure lifestyles (Harvey, Delamere, Prupas, & Wilkinson, 2010) because they have, traditionally faced medical, financial, and community barriers limiting positive leisure opportunities (Nagle, Valiant Cook, & Polatajko, 2002). The clinical work, I have done in TR, has taught me that field professionals can promote self-efficacy, self-determination, competency, and the adoption of a healthy and active leisure lifestyle for persons with MHP (Stumbo & Peterson, 2004). Positive recreation and leisure opportunities for individuals with MHP may contribute to better overall health (Caldwell, 2005) and play an important role in the recovery process (Iwasaki, Coyle, & Shank, 2010). However, leisure as therapy to treat people with MHP is often understudied and underdeveloped (Lloyd, King, Lampe, & McDougall, 2001; Rudnick, 2005). Moreover, leisure may not be included as part of the treatment process in community MH clinics (Snethen, McCormick, & Van Puymbroeck, 2012). Thus, there seem to be disconnects between where people with MHP live (e.g., in the community) and where TR and leisure services usually operate for people with MHP (e.g., in institutions). Therefore, I wanted to know more about the types of research questions that I should be asking to assist people with MHP to take an active role in developing leisure pursuits in the community. *What am I going to do about this?* I thought to myself.

Method

I think I finally got it! I have spent the better part of the last month trying to develop a method to document and analyze my thoughts and experiences. Since our last research meeting I have been fixated on this idea of a narrative of the self. I've been reading a lot of qualitative pieces, especially autoethnographies, which have given me a lot of great ideas about how to write myself into my work. I think if I use this idea of an autoethnography it can provide me with the cool method that I have been looking for. My advisor was right! What a unique opportunity I have here! I will actually be able to document my knowledge progression and the questions that I want to potentially ask and answer for my dissertation.

Autoethnography

Autoethnography was used to capture my personal journey. I am a leisure researcher and person with MHP who is trying to better understand the relationships between leisure and persons with MHP in the community. Autoethnographies have been defined as narratives of the self that are "highly personalized accounts that draw upon the experiences of the author/researcher for the purposes of extending sociological understanding" (Sparkes, 2000, p. 21). This qualitative research method affords the researcher an opportunity to share how his/her personal experiences and emotionality have influenced and guided the research process (Ellis, Adams, & Bochner, 2011). I selected this methodological approach because I wanted to reflect on my past experiences and investigate the research process, itself, as a series of experiences (Trahar, 2009). This unique personal narrative allowed me to investigate my part of the phenomenon in question and uncover my position as both a researcher and member of the MH community. It also provided me with an opportunity to better understand how my narrative fit within the larger cultural context of leisure and MH in society. Moreover, I wanted to invite the reader into my world so they could learn from and reflect on my personal story and, as a result, potentially apply their learning to better understand their own narrative (Ellis, 2004).

Data Gathering

A series of video journals and a written journal were used to collect my thoughts and experiences about relationships between leisure and persons with MHP. They were also gathered to create a personal description of my perceptions and reflections throughout the research process. The rationale for selecting this approach stemmed from my recent involvement in the use of visual methodology to better understand the physical activity experiences of children with ADHD. Our recent research study suggested that visual methodology may help to substantially increase the richness of qualitative data (Harvey et al., 2012). Furthermore, to the best of our knowledge, this type of researcher-recorded reflection had never been done. Thus, I felt this procedure represented an opportunity to make a novel contribution to the narrative literature. Visual research methods may be used to capture thoughts, experience, and emotion in real time. These significant moments can be replayed for individuals to recall their experiences and reflect on their thoughts and emotions (Heath, Hindmarsh, & Luff, 2010; Lyle, 2003).

Video journals were recorded using the camera feature on an I-Pod touch and transcribed verbatim. Video entries were recorded twice per month over a 4-month period (e.g., 8 entries between March – June). Each entry ranged from 10-12 minutes in length. No set schedules were predetermined for the collection of video data. A written journal was also kept to organize my personal thoughts and feelings about the research process. The written journal was implemented as a reflective tool so that I could further document the research process as a series of experiences. A total of 23 passages were entered in my written journal, with no designated order.

I also recorded notes from meetings that took place with my advisor. My advisor acted as a critical friend who I could: (a) share ideas with, (b) count on to question me in a theoretical and practical manner, and (c) ask for feedback to guide me through the qualitative research process (Brewer & Sparkes, 2011). For example, I was trying to observe the relationship between leisure and persons with MHP from the perspective of an outsider or novice researcher. My advisor questioned this approach and encouraged me to use my knowledge as an insider to fully embrace my learning and the evolution of my experience. For example, when I started my research I took on the role of an expert TR specialist who was going to help fix a patient centered problem. I focused on incorporating knowledge and understanding about empowerment and self-determination that I had learned from my undergraduate and graduate training. Over time I began to re-frame my perspective and incorporate the lessons that I had leaned from my personal struggles with MHP. It became clear that a shared expertise would be necessary to effectively assist these individuals to manage their MHP.

Data Analysis

I transcribed all eight video journals verbatim after my final video journal was recorded. Transcribed journal entries and written journal entries underwent a thematic analysis (Braun & Clarke, 2006). No visual facial expressions were analyzed for the purposes of this study. First, I watched each video journal several times and read each journal entry several times to become more familiar with how my thoughts and ideas were progressing. Next, each individual transcript was reviewed and initial codes were developed, reviewed and collated to produce a set of candidate themes (Braun & Clarke, 2006). Individual themes were then defined, given a name to help identify and label the essence of each theme and the related, unique, contribution to the story. Finally, each theme was embedded within my analytic tale to help provide the reader with insight into my personal thoughts and experiences (Braun & Clarke, 2006). My personal meeting notes were used as guide posts to develop my data gathering method and discuss the process of analysis with my critical friend (Brewer & Sparkes, 2011). Meeting notes were originally handwritten, then typed and reviewed following the completion of each individual meeting.

Results

The ‘narrative video journal,’ ‘overwhelmed,’ and ‘relationships’ themes emerged to create a personal description of my journey as a person with MHP who is trying to better understand relationships between leisure and the experiences of persons with MHP. Each theme is described in detail below.

Narrative Video Journal

The first theme was called ‘narrative video journal’ as I reflected on the research process as a series of experiences. I spent a significant amount of time reflecting on and questioning the use of a personal video journal as a creative method to help capture my experiences.

> The purpose of this video journal is to capture my thoughts and personal experiences over the next few months using a unique method. I never thought that my doctoral work would start like this. I mean I am sitting here all alone in the house talking to myself. I am sure this will be a really cool method once it is fully developed but I am really out on a limb here so to speak.
>
> This unique method has allowed me to learn more about the relationship between personal experience, knowledge development, and knowledge transfer. I have come to appreciate even more how we as individuals understand and give meaning to our lives through the medium of story. This process has led me to undertake a broader epistemological view.

I also shared this unique idea of a video journal with other graduate level scholars to acquire their thoughts and feelings about the method. Initially, I felt a lot of self-doubt about the legitimacy of my video journal. Positive feedback from colleagues and professors helped me to recognize the value of my personal insights and experiences.

> This month I made a formal presentation to my doctoral seminar class about my research interests in leisure and MH. What was really interesting was that this idea of a video narrative was really well received. It seemed to spark the interest of both students and professors. Frankly, I was surprised. I thought this would get labelled as navel-gazing research but in the end it was well received. It eventually even led to a larger group discussion about the relationships between knowledge and experience.

Furthermore, I reflected on the written methods that I used to categorize my knowledge and keep track of my experiences.

> I thought it would be a good idea to keep a written journal as well. As funny as it sounds … when I record myself, I seem to get nervous and don't always express things the way I want to. So I will keep a written journal to help me to reflect on this video journal and to keep track more of my progress.
>
> I have also taken the time to record notes from all of the meetings that I have had with Dr. Nick. These notes have been used as guide posts to help me to better understand more about the narrative data that I have been collecting and how I can potentially analyze or organize all of my ideas. Dr. Nick and I do not always see eye to eye but he really has been a great...what is the word I want to use here...lighthouse? Sure, lighthouse which has helped me to guide my thinking as I drift out here in this sea of new knowledge.

Overwhelmed

My initial feelings and assumptions towards conducting MH research as a leisure scholar highlighted the ‘overwhelmed’ theme. I experienced feelings of sadness and exhaustion as I began to identify personal links between the subject matter and my own MH experiences.

> As I continue to read more and more about MH and mental illness, it certainly has a more personal feel. I continue to see my reflection in the readings. I start to think to myself … how does this apply to me? Have I felt this way lately? Do I act like that or can this happen to me?
>
> This is my final video entry for a while. This has really been an emotional process. I am not sure if this really was the best way for me to record my thoughts. As I became more comfortable with the process, I started to talk more about some personal issues surrounding my MH and that really struck a nerve. After signing off from the last 2 videos, I actually felt depressed...not depressed but sad. I mean the personal reflection talk has really taken me to a different place … a dark place.

As time went by I also realized that it became increasingly difficult to separate my personal experiences from the experiences of other persons with MHP that I was reading about.

> This journey really has become more personal than I could have ever imagined. I really need to work on separating my work from my personal experiences. For the first time, I am really starting to feel that I am on a slippery slope. I can't help but wonder is this healthy for me?
>
> I have spent a lot of time trying to accept my personal MH issues and this has brought a lot of questions back to the surface for me. I mean in one way it has been therapeutic ... I mean I have never said some of these personal things to anyone...I guess I still haven't really but to hear them said out loud … has stirred some emotions....

I also experienced positive emotions when I reflected on my motivation and personal research goals.

> I know why I am doing this! I am doing it because I know leisure can help. Leisure has helped me to improve my own MH and it has worked wonders for my mother and for my clientele. I am motivated by the possibility of giving back to the people in my community who have MHP. So many factors are out of our control but leisure is something we can take control over if the right opportunity presents itself. It will be a personal goal of mine to continue to learn as much as I can over the next few months so that I can relate to my committee the importance and necessity of leisure research in the area of MH.

Journaling further afforded me the opportunity to question my foundational beliefs and uncover some of the pre-existing assumptions that I held about leisure, TR, and MH. It was important to uncover these assumptions at such an early stage in the research process because it helped me to be more aware of my own biases and preconceptions. I can use this reflective exercise to understand more about the leisure experiences of persons with MHP in the community.

> I really thought that more would be written from the perspective of the client(s). I am reading a lot of papers that really marginalize the voice of the participants. I thought that leisure research would be less exclusionary and that the voices of the participants would help to guide more of the research in the field.
>
> We always think we can cure people. It's the model that drives the business that we are in. Curing people is not the goal... empowering them is. Reading more about recovery has helped me to better understand how people with MHP go through the recovery process. Each of us is unique and different in our own way and our ability to self-actualize and to function is more important than fitting the mould of what others consider to be normal.

> I am the specialist and I know what is best for my clientele. Wow! I can't believe I thought that way for so long. Who really is the expert here … me or the client? No wonder so much of the literature discusses TR from a top-down clinical perspective...that's the way many of us have been trained. It really is a shared expertise when you think about it. We should be discussing with the client what they want, what motivates them, their interests, and their expectations. This is their leisure for Christ sakes! The one thing we should be able to have some level of control over is our own leisure.

Relationships

The third and final theme was called 'relationships' because it identified main relationships surrounding leisure for persons with MHP. I reflected on my readings and highlighted six key issues that I felt were important to leisure engagement for persons with MHP. First, choice was a key issue linked to leisure engagement.

> I have been thinking lately more about the idea of choice and how it has an impact on how we perceive our experiences. I mean if we think about flow experiences or peak experiences, we need to think about how choice has an impact on our ability to engage in flow or peak experiences. If we are unable to have some degree of choice over what we are engaging in, that surely must have an impact on how comfortable we feel when engaging in that activity. That level of comfort surely has an impact on the level of anxiety or boredom we experience during an activity. Thinking even bigger … this relationship between choice and experience must have an impact on our self-actualization or fulfilling our leisure potential.

Next, work and free time may have a significant impact on an individual's leisure engagement.

> It is generally assumed that individuals with MHP don't work for extended periods of time and, therefore, have a significant amount of free time on their hands. I am not sure if that is entirely true. Free time means that you are free from obligations. If you are experiencing MHP, you may have more obligations than ever before. It should not be assumed that people with MHP have more time for leisure or other pursuits. I think it might be the opposite. If you have to deal with a new set of health-related circumstances in your life, it may leave little time for you to be concerned about your leisure. So time may be a barrier to participation and not an affordance. If time is constrained, then people must be able to utilize their free time effectively and efficiently.

Third, income may impact the leisure engagement of persons with MHP. Significant amounts of time away from work and the cost of treatment may have a negative financial effect on leisure. For example, persons with MHP may need to pay for a portion of their prescriptions, private counselling or gain access to community programs.

> Finances are also an issue we need to be aware of. If we want people to engage in certain activities, especially physical activity, we may need to provide them with the proper equipment and facilities at a significantly reduced cost. We also need to consider the costs associated with healthy living (e.g., good food, affordable housing, safe communities). I think, sometimes, we assume people choose to be unhealthy. Although this may be true some of the time, other times we are forced to choose between the lesser of two evils. It just goes to show you that there are so many issues surrounding the health of our communities that when we present a potential solution (e.g., exercise), we often uncover another set of challenges (e.g., cost).

Fourth, I felt it was important to identify health-related challenges that people with MHP may encounter. I discussed these challenges in relation to potential impacts on a person's leisure lifestyle. For example, people may choose not to engage in leisure pursuits with others because of the signs, symptoms and behaviours associated with MHP.

> I think that it is important for me to learn more about the different signs and symptoms associated with each specific MHP. These signs and symptoms may have a significant impact on where people with a certain MHP choose to leisure. For example, someone with severe anxiety may want to avoid crowded or busy places. Come to think of it, what if these signs or symptoms make other people uncomfortable? How would someone be received if he or she had a psychotic breakdown or a major depressive episode at their local gym in front of other members? Do you really think that they would be welcomed back with open arms? I doubt it! So, really, someone may want to go out to their local community center or local gym but avoid doing so because of the fear of not being accepted.

A person with MHP may also experience physical health challenges linked to inactivity, weight gain, and/or the side effects of medication.

> When we really think about it, MHP can lead to such a vicious cycle of poor behaviour...and this poor behaviour can have such a negative affect on a person's health. If someone is diagnosed with MHP, they may lack the motivation to be socially engaged or they may fear the social stigma of having a MHP. This may cause people to actually lock themselves in their homes. This level of inactivity and reclusion can lead to significant weight gain as well as a number of other health related issues. As these health issues begin to escalate, it may lead people to have a negative image of themselves, causing them to become even more socially isolated. We really need to focus on engaging and educating these clients as soon as possible to help break this vicious cycle.

> Medication is another issue that we need to be aware of. Medications can have a number of different side effects which can cause health-related problems. Medications can cause significant weight gain, increased appetite, and lethargy all of which can have a negative impact on your health. Damn not to mention that certain medications can cause tremors, ticks, and long term movement issues. All of these potential physical side effects can cause someone to avoid public places or social interaction significantly impacting their leisure lifestyles.

Fifth, I developed a better understanding of how different social cultural issues affected community recovery. Social and cultural values may play a fundamental role in how recovery with MHP is understood and how people with MHP may be valued in their respected communities.

> Social and cultural values really do play a significant role in shaping our views about leisure and MH. The way a particular culture understands MH, or the way that leisure is valued among certain cultures, will play an enormous role in the recovery process. We need to respect and understand these distinct differences so that we can work with people of different cultures to optimize their recovery. People may feel shame. They may feel different or they may not see the importance or value of seeking treatment. So this is something I never really thought about before but now I can see that the different social and cultural values will impact the leisure lifestyle of a person with MHP.

Stigma may also pose challenges for people with MHP in the recovery process. People may lack knowledge about a specific MHP, feel uncomfortable around people who have MHP, or be under the impression that people with MHP are dangerous.

> Stigma is a major issue that I have seen discussed by authors in both the leisure and MH literature. Stigma towards people with MHP may limit where and when they can engage in leisure pursuits. If someone with MHP does access a community service, how will they be received? People may avoid making contact with them. They may refuse to share space with them or, in the event of a group activity, people may not want to work with someone with MHP. Imagine if you took the initiative to go out into your community and try something new, only to be rejected by the people around you? I am sure that rejection by my peer group would make me think twice about trying new things. So thinking back to leisure education and counselling, it is important to inform and educate the community as well as the person with MHP. I wonder how we can achieve this lofty goal?

Persons with MHP may additionally face several different challenges when trying to engage in community leisure. For example, leisure programs and facilities may not be accessible.

> When we think about access and disability, we always think about a person with some type of physical limitation. Inaccessibility is so much more...a person with MHP may not be able to access a particular program or facility because it is simply too far away, they do not have the financial means to afford it, or they do not have the support network in place to help them to access it. I mean the person may not live in the specific neighbourhood where a service is provided or may feel uncomfortable in a particular place where he or she feels that they just don't fit it. Identifying a community service is paramount but helping someone to access it may even be more important.

Finally, the strength and stability of an individual’s social network may potentially help or hinder the recovery process.

> I can only imagine how a certain diagnosis can impact your social network. Especially if you are young, like in your late teens or early twenties. A diagnosis can cause your closest friends to stay away from you and it must be very hard at that stage of your life. If you are starting to define yourself as an adult and starting to establish more lifelong relationships and habits; it must be a huge blow to have your social network or your social fabric ripped away from you. Even if those around you, do not know what the diagnosis is … they may not understand why you are going through changes or what is exactly going on with you, so that can cause them to pull away and cause you to feel virtually alone...and that has a direct impact on how you feel or how you think that others perceive you...such a dangerous cycle.

Discussion

Autoethnographies are a unique medium for storytelling and this novel approach has enriched the exploration of my lived experiences, as a leisure researcher and person with MHP who is trying to better understand the relationships between leisure and the experiences of persons with MHP. It also provided an opportunity to better understand the unique position that I hold as a researcher and insider of the MH community. This position continues to have a direct effect on how I interpret the larger cultural context of leisure and MH as well as the major implications of this research. Thus, my autoethnography allowed me to invite the reader into my world and to share my intimate secrets and knowledge of that world (Ellis, 2004).

Three themes emanated from this experience and the major implications are discussed along with potential research questions and future research recommendations. First, in the narrative video journal theme, I documented and openly reflected on the novel methods employed to capture my story because conscious reflection of the research journey helped to construct a richer and more vivid narrative (Trahar, 2009). It helped me to understand what I learned about the creative method. It allowed me to learn how to fuse together elements of visual methodology and evocative storytelling. It also afforded me the opportunity to learn about the underlying theoretical approaches that may guide visual methods. For instance, my video passages served as the subject of investigation and they acted as a resource to help uncover other topics of research interest (Harrison, 2002). Videos replays helped me to recall my learning and reflect on personal and professional issues that have shaped who I am as a researcher and person with MHP. Initially, I was concerned with selecting a method that challenged more traditional ways of conducting research and representing the self (Ellis et al., 2011). However, I was pleasantly surprised about the positive feedback and encouragement I received when presenting my narrative to colleagues and supervisor. Professors and practitioners applauded this innovative method and they also helped to guide my research journey through questions and feedback. This creative method has strengthened my position as a qualitative researcher and helped to situate my research within the larger socio-cultural discourse on MH.

The detailed accounts, obtained through the video and written journals, facilitated my learning and helped to capture the meaning of my experiences in real time. They led to a critical questioning of my learning and provided links between my personal and professional experiences. Thus, the video journals proved valuable to reconstruct my reality and question my learning (Harvey et al., 2012). Moreover, a written journal was kept so that I could further explore my learning. It was used as a reflective tool to keep track of my thoughts and emotions during my journey. I think it is important to share these methodological details with the reader so he/she gains a better understanding of how my narrative was constructed.

Next, the overwhelmed and relationships themes emerged to focus on what I learned about leisure and MHP from the creative method. First, I shared my personal feelings towards conducting MH research as a leisure scholar and person with MHP in the overwhelmed theme. I experienced a range of emotions as I began to identify links between my narrative and the narrative of other people with MHP (Ellis & Bochner, 2000). The qualitative process helped me to revisit and give meaning to my own MH experiences. My research journey became a very personal and emotional process. Memories and emotions, that lay dormant for years, began to resurface as I made links between my professional knowledge and personal life. Initially, I felt uncomfortable with the thought of openly sharing my personal MH history with others. I had never shared these feelings or experiences with anyone other than a MH professional. However, I felt that it was paramount to openly share my own story about these experiences and emotions.

I also learned the importance of separating my experiences from the experiences of others as time went on. I read many articles that resonated with me on a personal level but they were not my story. My story is unique and individual and it belongs to me. The ability to separate my experiences from those of others helped me to be more aware of how I may influence research processes and products. Fortunately, my reflections led me to realize that I felt strongly that TR could help people with MHP in the community recovery process! Furthermore, it helped me to critically question some of the models (e.g. medical model), approaches (e.g. disability or problem based), and assumptions (e.g. people with MHP need treatment) that I have adhered to. This exercise helped me to better understand how the medical model has influenced my learning and traditionally shaped the practice of TR and leisure for persons with MHP. It also provided me an opportunity to be more critical of my own assumptions about the role of persons with MHP in their recovery, the relationships between persons with MHP and MH treatment, and how I have framed my research predominantly from a disability or deficit-based approach. The reflections on my personal experiences, professional learning, assumptions, and research practice helped to strongly position myself as an insider to conduct research in the area of leisure and MHP.

Next, I identified some of my key issues surrounding leisure for persons with MHP in the relationships theme. Initially, the greatest leisure challenges for persons with MHP were deemed as leisure engagement, health-related problems and recovery in the community. However, I became more conscious of the larger underlying social, cultural, and political issues that may impact persons with MHP when I began to replay my videos and reflect on my learning. Many people living with MHP seem to also be grappling with poverty, joblessness, stigma, and other comorbid health problems. The intersectionality, or overlapping, of these issues and immense combined impact they may have on a person's life, contributed to my feelings of being overwhelmed. For the first time, I felt that I was starting to grasp the enormity of some of these issues and how they may directly impact relationships between leisure, MHP, and recovery.

Leisure engagement may enable persons with MHP to develop personal, social, familial, and cultural meanings that produce emotional and psychological health benefits (Iwasaki, 2008). However, persons with MHP may face significant financial challenges when engaging in community leisure opportunities. For example, they may not have the financial means to pay for club membership or basic equipment required to participate in leisure activities. Joblessness and poverty may also impact the neighbourhoods where persons with MHP can afford to live in and accessible community venues. Additionally, the cost of transportation may limit the travel distance required to access leisure programs in surrounding communities. Thus, leisure engagement may be a more deeply rooted and complex issue that needs to be directly addressed by TR practitioners and community MH experts.

Health-related problems also have a significant impact on the leisure lifestyles of persons with MHP. Psychological symptoms like anxiety, depression, hallucinations, or delusions may cause individuals to isolate themselves, fear the outside world (Compton & Broussard, 2009), feel uncomfortable in public places or fear social contact with others (Videbeck, 2010). Persons with MHP may also exhibit challenging behaviours, related to their unique illness, which may make people around them uncomfortable. For example, someone who experiences a psychotic breakdown in public may be ostracized. Isolation can lead people to withdraw from community, significantly limiting individual leisure options (Lloyd, King, McCarthy, & Scanlan, 2007). A diagnosis of a MHP may also have a significant effect on physical health (Compton & Broussard, 2009). Lethargy, fluctuations in appetite, sleep cycles, and medication side effects may have negative effects on physical health (First & Tasman, 2010). These unexpected changes may cause physical pain and discomfort, which, in turn, can limit mobility and make leisure engagement challenging.

Health-related problems may also have a direct impact on a person’s ability to work and secure income. Persons with MHP, who are unable to work, may not have the financial stability to access support systems that contribute to positive health. For example, the ability to learn about and purchase healthy food, access to personal training and diet services, or other community health services (e.g. massage therapy) may not be affordable or accessible (Borras et al., 2007). Thus, a negative cycle of poor health and limited accessibility to health services may have a deleterious impact on the recovery of persons with MHP in the community. TR practitioners will need to work with community MH experts to address these gaps in order to make greater connections between community MH clinics and leisure services to improve the health and recovery of people with MHP.

People with MHP, who are recovering in the community, may also face social challenges when trying to engage in leisure (Harvey et al., 2010). Social and cultural values, stigma, and accessibility can all have a direct effect on a person's leisure repertoire. For example, social or cultural groups may lack the knowledge to effectively understand MHP (Compton & Broussard, 2009). This lack of knowledge may lead to fear and stigma, which may prevent people with MHP from engaging in specific leisure activities. Stigma may also prevent people with a MHP from gaining access to local community groups, sports teams, or public events. People may feel uncomfortable socializing with persons with MHP or they may perceive them to be dangerous. In fact, survey research suggested one-third of respondents believed people with major depression were likely to be violent towards them while 60% of the participants expected violence from people with schizophrenia (Pescosolido et al., 2010). In contrast, crime research suggested people with MHP were more likely to be victims of violence than to commit violent crimes (Wehring & Carpenter, 2011). Such myths may play a role in preventing community access for people with MHP. Therefore, leisure professionals also need to gain access to family, friends and community members to provide education about specific MHP and dispel associated myths. Communication with these circles of people may also provide insight to how different relationships may have an impact on the leisure development of persons with MHP. For example, an ecological perspective (e.g., Bronfenbrenner, 2000) may be adopted to gain greater understanding of the complex relationships that may impact leisure behaviours of people with MHP. To effectively address this issue, I believe that TR professionals need to learn more about how these individuals view MHP and the role that leisure may potentially play in the recovery process.

Future Research

My reflections led to an awareness of some deeply rooted societal issues that may impact the lives of persons with MHP and associated implications for leisure engagement. My "evolved" understanding of the issues has led to more critical reflections about marginalization and social justice issues that may surround persons with MHP. I realized that the popular discourse in this area revolves around the idea of recovery where an individual with MHP has greater choice and personal decision-making power in treatment plans within community contexts (Harvey et al., 2010). While many people with MHP may want to work as part of the recovery process, it may be difficult to acquire or maintain a job (Nagle et al., 2002). Hence, a challenge will be to ensure that people with MHP do not experience the effects of meritocracy. This term suggests that a person, who does not work hard, will be disadvantaged and unsuccessful as a result (Casey & Kentel, 2014). Since many people with MHP do not work, we must be aware of the potential effects of such thinking in order to protect the ways that persons with MHP are valued and treated. I intend to use qualitative research approaches to better understand these underlying social issues and how they may impact relationships between MHP, leisure, and community recovery.

I realized during this process that, although I was searching for research questions, the deeper and richer information about marginalization and social justice issues has led to the creation of a research program. The overarching research question for my current research program is: How does being diagnosed with MHP impact engagement in leisure? The following six research questions were also developed to initiate my research program. First, how do people with MHP experience and understand leisure in their daily lives? Second, how do people with MHP identify leisure opportunities in their community? Next, where do people with MHP leisure? Fourth, what attitudes and beliefs about leisure do health professionals, family members, friends, and communities hold about persons with MHP? Fifth, how does the concept of recovery link to leisure in the community? Finally, how would a leisure intervention impact the health and well-being of people with MHP? The first three questions identified above were addressed in subsequent research studies as part of this dissertation. The remaining three questions will be addressed in future studies as the researcher continues to develop his research program. In conclusion, this creative research method will enable the development of a cohesive research program where, in turn, research studies will be conducted to gain a cohesive and in-depth understanding of complex issues surrounding leisure and people with MHP.

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Bridging Text

Chapter two helped to uncover the underlying assumptions, experiences, and knowledge of the doctoral candidate. These research reflections led to an awareness of some deeply rooted societal issues that may impact the lives of persons with MHP and associated implications for leisure engagement. My "evolved" understanding of the issues has led to more critical reflections about marginalization and social justice issues that may surround persons with MHP. This reflective piece also led to the development of several research questions to explore complex relationship between leisure and SCZ or SAD. Chapter three presents a scoping review of leisure interventions for persons with SCZ or SAD to gain a better understanding of design characteristics and outcome effects for the identified studies.

Chapter 3

Leisure interventions and schizophrenia - schizoaffective disorder: A scoping review

Abstract

Leisure interventions may play an important role in the lives of people with schizophrenia (SCZ) or schizoaffective disorder (SAD) but these types of interventions have not been usually included as part of the treatment process in community mental health clinics. In fact, they are often understudied in psychiatric rehabilitation. The purpose of this scoping review was to explore the research design characteristics and effects of leisure interventions for people with SCZ or SAD. A five-stage review process was conducted to search for leisure interventions between 1938-2016. Sixteen interventions were identified and placed into either behaviour modification or leisure outcome categories. Results suggested that leisure interventions may help people with SCZ or SAD to increase appropriate behaviours, decrease inappropriate behaviours, increase self-esteem and self-confidence, develop coping and planning skills, improve daily functioning, increase socialization, ameliorate anhedonia, experience enjoyment, increase community participation, and decrease body weight. Limitations of this literature review and future research directions are also discussed.

Introduction

Leisure may contribute to the quality of life of all individuals including persons with mental health problems (MHP; Ponde, Pereira, Leal, & Oliveira, 2009). It may play an important role in promoting mental health recovery (Iwasaki et al., 2014) and have a positive impact on the health and well being of persons with MHP (Harvey, Delamere, Prupas, & Wilkinson, 2010). Leisure experiences may help to enhance community living (Lloyd, King, McCarthy, & Scanlan, 2007) and create meaningful lives for persons with schizophrenia (SCZ) and schizoaffective disorder (SAD; Iwasaki, Messina, Shank, & Coyle, 2015). Yet, leisure interventions may not be included as part of the treatment process in community mental health clinics (Snethen, McCormick, & Van Puymbroeck, 2012). In fact, they are often underdeveloped and understudied in psychiatric rehabilitation (Lloyd, King, Lampe, & McDougall, 2001; Rudnick, 2005).

Leisure is a fluid concept that is often defined in relation to its role in society and impact on the individual (McLean & Hurd, 2015). For the purposes of this review, leisure is conceptualized as “a relatively freely chosen humanistic activity and its accompanying experiences and emotions that can potentially make one’s life more enriched and meaningful” (Iwasaki, Coyle, & Shank, 2010, p. 485). Therapeutic recreation (TR) is a treatment service that focuses on the connection between leisure, health, and well-being (Mobily & Ostiguy, 2004). TR may be defined as a systematic process that engages individuals in planned leisure-related activities with the purpose of improving individual daily functioning, health, and quality of life (Theodore, 2015). It was developed to “assist people who had trouble in their leisure, caused by illness, disability, or some other condition” (Caldwell, 2005, p. 8). For example, people with serious MHP including people with SCZ or SAD have received TR services within hospital settings (Mobily & Ostiguy, 2004).

Relationships Between Leisure and Serious MHP

SCZ and SAD are serious MHP that primarily cause psychosis and impact an individual's ability to process information, regulate emotions, make decisions, and relate to others (Lawrence, First, & Lieberman, 2015). These disorders are the result of a complex interaction between internal (e.g. genes) and external (e.g. stress) risk factors that may bring about the illness (Compton & Brossard, 2009). SCZ and SAD tend to develop during late adolescence or early adulthood. Leisure and recreation experiences during adolescence may help young people with and without disabilities to develop skills, establish a sense of identity, make choices, and experience personal and social growth (Kleiber, Walker, & Mannell, 2011). Cross-sectional research suggested that people generally tend to participate in a higher number of leisure activities during early adulthood when compared to all other life stages (Gordan, Gaitz, & Scott, 1976). The experience of a non-normative life event during these formative years, such as a diagnosis of SCZ or SAD, can alter our understanding of and engagement in leisure activities (Kleiber et al., 2011). The long-term prognosis of SCZ or SAD may also influence personal decisions about leisure throughout the lifespan. People with serious MHP may benefit from engaging in leisure (Harvey et al., 2010). However, people with SCZ or SAD often face medical, financial, and community barriers that may limit leisure opportunities and hinder the pursuit of leisure goals (Nagle, Valiant Cook, & Polatajko, 2002). Medical and social barriers are discussed below.

Medical barriers include symptomatology, brain abnormalities, significant comorbid health conditions and psychiatric disorders. The onset, duration, and severity of symptoms may have a significant negative impact on health, daily functioning, and community engagement for persons with SCZ or SAD. For example, positive symptoms (e.g. hallucinations, delusions) may confuse the mind, distort perceptions, and negatively impact relationships (Martin, 2009). Individuals, experiencing positive symptoms and not adhering to antipsychotic medication, are less likely to interact socially and more likely to withdraw from their communities (Martin, 2009). Moreover, persons who adhere to medication to treat positive symptoms often experience side effects that negatively impact physical health and energy levels (Chugg & Craik, 2002). Negative symptoms may alter an individual's affect, motivation, empathy and ability to experience pleasure (Snethen et al., 2012). Negative symptom severity and poor physical health for persons with SCZ or SAD may also have a direct impact on self-efficacy, perceived disability and leisure participation (Chugg & Craik, 2002; Pieris & Craik, 2004).

Brain abnormalities and related issues of cognition may negatively effect executive functioning, planning, verbal and visual memory, information processing, and motor functioning for persons with SCZ or SAD (Holthausen et al., 2003; Minzenberg, Laird, Thelen, Carter, & Glahn, 2009; Walther & Strik, 2012). We suggest that cognitive issues may have an effect on how persons with these disorders learn about and successfully engage in leisure. Further, impaired executive functioning may negatively impact an individual's ability to plan activities or make decisions about how to engage in leisure. For example, persons with SCZ or SAD tend to perceive their cognitive functioning to be higher than actual scores on objective tests of cognition (Johnson, Tabbane, Dellagi, & Kebir, 2011). A gap between perceived and actual cognitive functioning might lead to continuous failure and the avoidance of future opportunities to engage in activities that can positively impact health and well-being.

Persons with SCZ or SAD often present with significant comorbid health conditions (American Psychiatric Association [APA], 2013). For example, they may be at greater risk for unhealthy weight gain (Brown, Goetz, Van Sciver, Sullivan, & Hamera, 2006), cardiovascular disease (Citrome, 2005; Hennekens, 2007) and diabetes (Alvarez-Jimenez, Hetrick, Gonzalez-Blanch, Gleeson, & McGorry, 2008). Poor dietary choices (Strassnig, Singh Brar, & Ganguli, 2003) and limited amounts of physical activity (Mason & Holt, 2012) may also have a significant negative effect on the health of persons with SCZ or SAD. The relationship between inactivity and poor health outcomes is often more prevalent for individuals with serious MHP (Mason & Holt, 2012). Physical inactivity may lead to increased risk for developing diabetes (Knowler et al., 2002), heart disease (Williams, 2001) and hypertension (Rossi, Dikareva, Bacon, & Daskalopoulou, 2012), often resulting in premature death (Richardson et al., 2005). Physical activity plays a critical role in reducing the risk of weight gain (Blair, 1993) and the development of cancers of the breast (Sesso, Paffenbarger, & Lee, 1998), colon (Howard, Freedman, Hollenbeck, Schatzkin, & Leitzmann, 2008), lung (Leitzmann et al., 2009), and pancreas (Michaud et al., 2001). Research suggests that physical activity may help decrease the risk of cardiovascular disease (Chomistek, Cook, Flint, & Rimm, 2012), decrease fatigue (Froelicher & Froelicher, 1991) and increase overall levels of cardiorespiratory fitness (Lakka et al., 1994). However, persons with SCZ or SAD often have difficulty adhering to physical activity and exercise programs (Archie, Hamilton Wilson, Osborne, Hobbs, & McNiven, 2003). Active leisure may provide persons with SCZ or SAD an opportunity to discover different types of activities which, in turn, may help to address comorbid health issues. (See Mason & Holt, 2012; Ellis, Crone, Davey, & Grogan, 2007; Faulkner & Biddle, 1999 for in-depth reviews of physical activity related to health for persons with psychotic disorders).

Persons with SCZ or SAD are also at increased risk for developing comorbid psychiatric disorders that include anxiety, obsessive compulsive, panic, and substance abuse disorders (Buckley, Miller, Lehrer, & Castle, 2009; Daniel, 2010). The constructive use of leisure time may help to effectively cope with stress (Iwasaki, Zuzanek, & Mannell, 2001) and produce feelings of positive affect (Cassidy, 1996). People who identified positive feelings during leisure also reported feeling healthier, less distressed, less depressed, less anxious, less hostile, and generally happier (Cassidy, 1996). Furthermore, epidemiological data suggested people, experiencing high levels of stress, reported that physically active leisure helped to maintain better functional health (Iwasaki et al., 2001). Leisure engagement may also help to effectively cope with negative life events (Kleiber, Hutchinson, & Williams, 2002) and provide opportunities to create a sense of positive meaning in life (Iwasaki, 2008). For example, Iwasaki (2008) suggested that positive leisure engagement may generate personal, social, familial, and cultural meanings that have emotional and psychological health benefits. Psychological health is a key component of optimal health and many individuals participate in leisure for its psychological benefits (Stumbo & Peterson, 2004).

Social barriers include stigmatization and limited social support. Persons with SCZ or SAD are still often misunderstood and highly stigmatized in the community (Gonzalez-Torres, Oraa, Aristegui, Fernandez-Rivas, & Guimon, 2007). The experience of stigma, and self-stigmatization that may result, may prevent persons with SCZ or SAD from engaging in their home communities (Snethen et al., 2012). Thus, it is important to understand that persons with these disorders may not have the same opportunities as others to participate in leisure. For example, people with SCZ or SAD often experience limited social support and greater levels of social isolation (Harvey et al., 2010). Fortunately, leisure consists of a strong social component that can play an important role in the development of social skills and the interplay of social exchanges (Stumbo & Peterson, 2004). Individuals may develop, strengthen, and test their social relationships during leisure participation. Coleman and Iso-Ahola (1993) suggested that leisure-related social support and strong beliefs about self-determination helped to buffer against stress and contributed to the development of social well-being. Similarly, Iso-Ahola and Park (1996) found that people who experienced high levels of leisure friendship, leisure companionship, intrinsic motivation, and perceived freedom also reported higher levels of perceived health. Individuals, who believed their leisure friendships provided them with social support and tangible aid, also believed they were able to better cope with stress (Iwasaki & Mannell, 2000). Leisure relationships may play a key role in helping people with disabilities to successfully integrate into the community, adjust to living with a disability, and develop a sense of coherence (Hutchinson, Loy, Kleiber, & Dattilo, 2003). Thus, leisure may provide an ideal context for persons with MHP to practice social skills and develop social relationships (Caldwell, 2005).

The purpose of this scoping literature review was to identify and understand leisure interventions for persons with SCZ or SAD. Levac and colleagues suggested scoping reviews can be important to disciplines with emerging evidence where there is a lack of randomized control trials that make it challenging for researchers to conduct a systematic review or meta analysis. Moreover, a scoping review can be used to better determine “the value of undertaking a full systematic review” (p., 1). Small sample sizes, participant variability, differing methodological approaches, and limited randomized controlled trials in the area of leisure and SCZ or SAD provided strong rationale for the use of a scoping review in this dissertation. Levac and colleagues (2010) also suggest “scoping studies are ideal because researchers can incorporate a range of study designs in both published and grey literature” (p., 1). The review methodology, search protocols and criteria for study inclusion and exclusion are outlined below.

Review Methodology

A five-stage review process was implemented to provide a thorough review of eligible studies (Levac, Colquhoun, & O'Brien, 2010). First, the following research questions were identified for the study. What were the main research design characteristics in leisure interventions for persons with SCZ or SAD? What effects have leisure interventions had on persons with SCZ or SAD? Thus, the scope of this review included interventions designed for persons with SCZ or SAD that were identified as leisure or TR interventions. Next, key search terms were identified and agreed upon by the authors (e.g., leisure, recreation, therapeutic recreation, schizophrenia, & psychosis). Second, various combinations of the key terms were searched within the following electronic databases: Academic Search Complete (1939-2016), Expanded Academic ASAP (1981-2016), Omnifile Mega (1985-2016), AMED (1950-2016), Medline (1950-2016), PsychInfo (1966-2016), Cochrane Library and Cinahl (1938-2016). Next, a more concise search strategy was implemented, by exploring the key search terms in the electronic table of contents within the following eight leisure and TR journals: American Journal of Recreation Therapy (2002-2016), Global Therapeutic Recreation (1990-2002), Therapeutic Recreation Journal (1983-2016), Journal of Leisureability (1995-2000), Journal of Leisure Research (1995-2016), Leisure Science (1977-2016), Leisure Studies (1982-2016), and World Leisure (1985-2016). A footnote chasing approach was also used to review the reference lists of all eligible articles to identify any additional interventions that may have been missed. Footnote chasing can be implemented as an additional step to help identify research articles that may not be available via electronic sources (White, 1994).

Third, the following study selection criteria were determined a priori and followed for eligibility in this review. Inclusion criteria included articles published in the English language which utilized a leisure or TR intervention with adults who were: (a) 18 years and older, (b) provided with a clinical diagnosis of SCZ or SAD and (c) receiving inpatient or community mental health services. Articles were excluded if the intervention: (a) did not include a research component, (b) did not primarily focus on leisure or TR, or (c) included heterogeneous participant samples with different mental health diagnoses (Dorstyn, Roberts, Kneebone, Kennedy, & Lieu, 2014).

Next, the first author reviewed 3,939 article titles and abstracts overall in the study identification process (See Figure 1, Appendix A p. 173). This first screening led to the identification of 107 articles that specifically discussed the use of leisure or recreation for persons with MHP. Next, a total of 32 of the 107 articles were selected because relationships between leisure and persons with schizophrenia spectrum and other psychotic disorders were discussed. Ten of these studies were then identified as eligible for review according to the a priori selection criteria. Six additional studies, identified manually in the footnote chasing approach, were included for a total of 16 eligible studies for review. The fifth and final stage of the process was to provide the study results that may be found below.

Results

Similar to other reviews in the area of SCZ (Ellis et al., 2007; Holley, Crone, Tyson, & Lovell, 2011), a decision was made to present an overview of the research designs, participants, intervention characteristics and outcome measures used in the 16 studies before presenting the main intervention outcomes. We attempted to gain an understanding of research design before collectively interpreting the findings because, to the best of our knowledge, this study represents one of the first scoping reviews in this area.

Research Design Characteristics

Table 1 (Appendix B, p. 174) provides research design characteristics for interventions included in the review. Research designs were categorized into the following three groups: experimental (n = 3; Barak, Savorai, Mavashev, & Beni, 2001; Voruganti et al., 2006; Wong et al., 1987), quasi-experimental (n = 9; Card, 1989; Finnell, Card, & Menditto, 1997; Morris, Card, & Menditto, 1999; Nathans-Barel, Feldman, Berger, Modai, & Silver, 2005; Pestle, Card, & Menditto, 1998; Roder, Jenull, & Brenner, 1998; Snethen et al., 2012; Wolfe & Riddick, 1984; Wong et al., 1988;), and qualitative (n = 4; Bizub, Joy, & Davidson, 2003; Corring, Johnston, & Rudnick, 2010; Corring, Lundberg, & Rudnick, 2013; Gimmestad, 1995). A total of 193 participants overall took part in the 16 intervention studies. The age of participants ranged from 24–82 years. The number of participants in each intervention ranged from 1-54, with more participants being males (58%). Thirteen interventions included both male and female participants (Barak et al., 2001; Bizub et al., 2003; Card, 1989; Corring et al., 2010; 2013; Finnell et al., 1997; Morris et al., 1999; Nathans-Barel et al., 2005; Pestle et al., 1998; Roder et al.,1998; Snethen et al., 2012; Voruganti et al., 2006; Wolfe & Riddick, 1984). Few intervention studies used gender-specific samples (males only: Wong et al., 1987; 1988; females only: Gimmestad, 1995). A majority of studies included persons diagnosed with SCZ (Barak et al., 2001; Bizub et al., 2003; Card, 1989; Gimmestad, 1995; Morris et al., 1999; Nathans-Barel et al., 2005; Roder et al., 1998; Wolfe & Riddick, 1984; Wong et al., 1987; 1988) while a few studies included participants who were diagnosed with either SCZ or SAD (Corring et al., 2010; 2013; Finnell et al., 1997; Pestle et al., 1998; Voruganti et al., 2006), with only one study that included persons diagnosed with schizophrenia spectrum disorders (Snethen et al., 2012). Limited or no information was available in relation to comorbid conditions or previous diagnostic history.

The participants' treatment history indicated that previous or recurring hospitalization was reported in 10 studies (Corring et al., 2013; Finnell et al., 1997; Gimmestad, 1995; Morris et al., 1999; Nathans-Barel et al., 2005; Pestle et al., 1998; Roder et al., 1998; Wolfe & Riddick, 1984;Wong et al., 1987; 1988). Ten interventions were focused exclusively on persons who received inpatient treatment (Barak et al., 2001; Card, 1989; Finnell et al., 1997; Corring et al., 2010; Gimmestad, 1995; Morris et al., 1999; Nathans-Barel et al., 2005; Pestle et al., 1998; Wong et al., 1987; 1988). Outpatient treatment was reported for five interventions (Bizub et al., 2003; Corring et al., 2013; Snethen et al., 2012; Voruganti et al., 2006; Wolfe & Riddick, 1984) while another study combined inpatient and outpatient treatment (Roder et al., 1998). Six interventions mentioned the use of neuroleptic or psychotropic medication (Card, 1989; Finnell et al., 1997; Nathans-Barel et al., 2005; Pestle et al., 1998; Roder et al., 1998; Wong et al., 1988) while eight interventions did not report the use of medication at all (Barak et al., 2001; Bizub et al., 2003; Corring et al., 2010; 2013; Morris et al., 1999; Snethen et al., 2012; Voruganti et al., 2006; Wolfe & Riddick, 1984) Only two interventions reported the specific type and dose of medication prescribed (Gimmestad, 1995; Wong et al., 1987).

Intervention Characteristics

Table 2 (Appendix C, p. 179) provides detailed characteristics for the 16 interventions included in the review. The duration, frequency, and selected delivery format for each intervention study are discussed below. The interventions ranged in length from 8-weeks (Finnell et al., 1997) to 15-months (Gimmestad, 1995; Pestle et al., 1998). Intervention sessions were delivered once per day (Gimmestad, 1995; Wong et al., 1987); weekly (Barak et al., 2001; Bizub et al., 2003; Corring et al., 2010; 2013; Nathans-Barel et al., 2005; Voruganti et al., 2006; Wolfe & Riddick, 1984); bi-weekly (Card, 1989); three times per week (Finnell et al., 1997; Morris et al., 1999; Pestle et al., 1998; Snethen et al., 2012); or five times per week (Wong et al., 1988). One study did not report the frequency of intervention sessions (Roder et al., 1998).

The people, who delivered the interventions varied with regards to professional discipline and experience. Recreation therapists led four interventions (Corring et al., 2010; Gimmestad, 1995; Snethen et al., 2012; Wolfe & Riddick, 1984) while certified TR specialists conducted three interventions (Finnell et al., 1998; Morris et al., 1999; Pestle et al., 1998). Other interventions incorporated a recreation therapist in conjunction with an occupational therapist, social worker, and nurse (Voruganti et al., 2006); a psychologist, physician, and psychiatric nurse (Roder et al., 1998); a psychologist and three mental health professionals (Wong et al., 1988); a licensed practical nurse and three graduate students (Card, 1989); clinical staff and a therapeutic riding instructor (Bizub et al., 2003; Corring et al., 2013); certified animal therapists (Barak et al., 2001; Nathans-Barel et al., 2005); and an intervention agent as a therapist (Wong et al., 1987).

The format selected for intervention delivery varied slightly. The predominant type of format chosen was group (n = 13). Other interventions used individual activities within a closed group format (Voruganti et al., 2006), an individual format (Wong et al., 1987); and a combination of individual therapy sessions and co-participation in community activities (Snethen et al., 2012). The type of activities selected for interventions included both physically active and passive forms of recreation. Thus, the predominant type of approach included a combination of active and passive recreation. See table 3 (Appendix D, p. 183) for a list of activities used in each intervention.

Tables 4 (Appendix E, p. 184) and 5 (Appendix F, p. 185) provide information about the quantitative and qualitative research instruments administered for each intervention as well as each study's findings. There were a variety of quantitative research instruments utilized in 11 studies. The Time Sample Behaviour Checklist (TSBC) was the research instrument used in four different interventions to record appropriate and inappropriate behaviour during recreation time (Finnell et al., 1997; Morris et al., 1999; Pestle et al., 1998; Wong et al., 1988). Microcassette audio recordings and case study notes were used in another intervention to record self-talk and mumbling during recreation time (Wong et al., 1987). Stereotypical vocalizations were taped and later rated by observers who recorded the duration of self-talk. Mumbling was monitored through portable FM microphones using a 15-s time sampling procedure. The Leisure Time Interview (LI) and the Leisure Time Questionnaires (LQ) were used to compare leisure time use before and after the intervention was completed (Roder et al., 1998). The Leisure Attitude Scale and the Rosenberg's Self-Esteem Scale measured leisure attitude and self-esteem in pre- and post - leisure counselling sessions (Wolfe & Riddick, 1984). Card (1989) used the Comprehensive Leisure Rating Scale (CLEIRS) to assess leisure behaviour. Specifically, the Revised Leisure Diagnostic Battery to measure perceived leisure freedom, the Brief Leisure Rating Scale to assess leisure helplessness and the State Technical Institute's Leisure Assessment Process to measure activity competency prior to and twice during participation in a recreation program. The Scale for Social and Adapted Functioning (SAFE) was used in one intervention to determine the effect of animal assisted therapy (AAT) on social-adaptive functioning (Barak et al., 2001).

Nathans-Barel et al. (2005) administered three psychological tests and two mental health tests to better understand the impact of AAT over time. The Snaith-Hamilton Pleasure Scale (SHAPS) measured anhedonia, the Quality of Life Enjoyment and Satisfaction Questionnaire (QLESQ) measured enjoyment and satisfaction, the Subjective Quality of Life Scale (SQLS) measured quality of life (schizophrenia specific), the Positive and Negative Syndrome Scale

(PANSS) measured symptom severity, and the Schedule for the Assessment of Negative Symptoms (SANS) measured negative symptoms.

Voruganti and colleagues (2006) administered several different mental health instruments to understand the impact of adventure recreation over time. The Positive and Negative Syndrome Scale (PANSS) measured symptom severity, the Global Assessment of Functioning (GAF) measured social, occupational, and psychological functioning, the Adult Self-Image Scale (ASIS) rated self-esteem, the Subjective Scale to Investigate Cognition in Schizophrenia (SSTICS) measured self-appraised cognitive dysfunction, and the Sickness Impact Profile (SIP) measured health-related psychosocial adjustment. The weight of each participant was also recorded in pounds (e.g., lbs).

A qualitative research approach also guided five interventions identified for review. Semi-structured interviews were used in three interventions to gain a deeper understanding of participant experiences in therapeutic horseback riding (THBR; Bizub et al., 2003; Corring et al., 2010; 2013) while another study combined semi-structured interviews and modified day-reconstruction methods (DRMs) interviews to explore daily community leisure participation, activity type, and motivation for participation (Snethen et al., 2012). Case study notes and activity observations were used in another study to record active participation and socialization during recreation time (Gimmestad, 1995).

Main Intervention Outcomes

The 16 studies were placed into either a behaviour modification or leisure outcome category. The studies are presented in chronological order to provide a historical progression of the types of interventions that were conducted over time. Studies in the behaviour modification category reflected the intention of the specific intervention studies to reduce inappropriate behaviours. The leisure outcome category was comprised of interventions that sought to produce a leisure-related outcome for study participants. Tables 4 (See Appendix E, p. 184) and 5 (See Appendix F, p. 185) provide detailed information about the main findings from each behaviour modification and leisure outcome intervention respectively. Research design characteristics are provided in the description of the results for each study in order for the reader to place the results into the context of the respective intervention.

Behaviour Modification

Wong et al. (1987) attempted to minimize stereotypical vocalizations and self-talk with two adult males with SCZ over a nine week period in a non-randomized alternating treatment design. Audio recordings indicated that medium-rate self-talk in one person and high-rate mumbling in the second person were reduced by 60-70% as a result of participation in the structured recreation activities. Thus, participation in structured TR activities provided more opportunities to display appropriate behaviours when compared to unstructured free time.

Wong and colleagues (1988) attempted to reduce the bizarre behaviours and increase the appropriate behaviours of 10 persons with SCZ over nine weeks in a non-randomized alternating treatment design. Behavioural observations were made during unstructured free time and structured recreation time. Results from the observations suggested that engagement in structured recreation led to a 70% reduction in bizarre behaviours (e.g. screaming, self-talk) as well as a fivefold increase in productive and appropriate behaviour. Thus, participation in structured TR activities led to significantly more appropriate behaviours for persons with SCZ when compared to unstructured free time.

Finnel and colleagues (1997) compared the appropriate behaviour scores of 6 persons with SCZ or SAD who participated in a TR and vocational rehabilitation (VR) intervention over two months using a non-randomized posttest design. VR is a form of treatment that focuses on increasing productivity and successful employment in the community (Finnel et al., 1997). Findings from the paired t-test, conducted on the TSBC scores, suggested that participants displayed significantly more appropriate behaviours when engaged in TR compared to VR. Thus, TR was deemed more successful than VR in helping persons with SCZ or SAD to appropriately engage with others and display appropriate social behaviour.

Pestle et al. (1998) explored the impact of TR participation on the appropriate behaviours of 6 persons with SCZ or SAD in a non-randomized time-series design with repeated measures. Observational data were collected during 15 months of TR sessions. Researchers grouped data into three-month intervals so that five different time periods could be compared. A repeated measures ANOVA was used to analyze the data. Significant changes were found between time periods one and four and time periods three and four respectively. Participation in structured TR sessions provided participants with regular opportunities to appropriately interact with others. Thus, the number of appropriate behaviours increased over time for persons with SCZ or SAD who were engaged in structured recreation.

Morris and colleagues (1999) compared appropriate behaviour scores on the TSBC for 9 persons with SCZ who participated in active and passive TR activities for a one-year period using a non-randomized posttest design. A mean total appropriate behaviour (TAB) score was calculated for each individual during the sessions. A t-test was employed to compare mean scores on the TSBC. Results suggested that there were no significant differences in appropriate behaviour between active and passive recreation participation. However, the TAB scores for individuals in both types of TR activities were above average when compared to national norms.

Thus, participation in structured TR sessions provided opportunities for persons with SCZ to interact with others and display more appropriate behaviours.

In summary, findings from the five behavioural modification interventions suggest that leisure interventions may provide opportunities for persons with SCZ or SAD to increase appropriate behaviours and decrease inappropriate behaviours. Participation in recreation activities provided opportunities for persons with these disorders to socially interact with others, initiate and respond to conversations, and display appropriate body language and facial expressions. Specifically, participation in structured recreation appeared to be more effective than unstructured free time, vocational rehabilitation, or no rehabilitation when intervening to influence inappropriate and appropriate behaviour.

Leisure Outcome

Wolfe and Riddick (1984) investigated the impact of a leisure-counselling program on the leisure attitude and self-esteem of adults with SCZ over a 10-week period using a non-randomized pretest-posttest design. Participants were divided into an experimental group (n=8) and a control group (n=8) for comparative purposes. Both groups received the same traditional outpatient services (e.g. psychoanalysis, recreation therapy, music therapy) but the experimental group received an additional 1-hour leisure counselling session, based on Pellett (1974), per week for 10 consecutive weeks. Leisure attitudes and self-esteem scores were compared to normative data and analyzed between groups with analysis of covariance (ANCOVA). Adults with SCZ had a significantly less positive attitude towards leisure in comparison to normative data while self-esteem scores appeared to parallel normative data. No significant differences were found between the experimental and control group on post-test leisure attitude or self-esteem scores. A pre-post evaluation of the experimental group suggested a positive shift in both leisure attitude and self-esteem. However, a closer examination of the experimental group results revealed that younger participants experienced a significant positive change to self-esteem as a result of the leisure-counselling intervention.

Card (1989) determined the effects of an organized recreation program on the perceived leisure functioning of six elderly adults with SCZ over a three month period using a non-randomized time-series design. The Comprehensive Leisure Rating Scale (CLEIRS) was administered at baseline, one month after the start of the recreation program, and post-program at the end of the third month. Study findings were inconsistent. One participant showed marked improvement in perceived leisure functioning over the three measurement time points while one participant showed a decrease in perceived leisure functioning over the same time. A third participant showed mixed results and the remaining three participants showed no change over time as demonstrated by the CLEIRS scores. It is important to take into consideration the age and years of institutionalization for each study participant. Each person was over 68 years and had been institutionalized for at least 10 years. The authors claimed the recreation program played a role in maintaining perceived leisure freedom of older adults with SCZ over the three-month period.

Gimmestad (1995) observed the behaviour of a woman with SCZ who participated in recreation sessions over a 15-month period employing a descriptive case study design. Initial observations at baseline suggested the study participant was non-verbal, withdrawn, and isolated from others. She displayed different emotions, responded to verbal interaction, actively engaged in activities, and accompanied the recreation group on several community outings after attending recreation sessions for several months. The participant’s active engagement in the intervention enabled her discharge into a long-term care facility with a strong psycho-social component.

Roder and colleagues (1998) explored the impact of recreation therapy on the learning and practice of recreational skills over a four month period for six people with SCZ. They compared pretest-posttest data from the LI and LQ questionnaires in a non-randomized time-series design with repeated measures. The LI findings suggested five participants significantly increased the amount of time spent actively pursuing recreational activities while two participants reported an increase in the number of active strategies used to cope with boredom. The LI results also suggested that all group members became concerned about wanting to spend their free time with others as opposed to being alone. The LQ findings revealed a significant change in the expectancy and appraisal of recreation competence and in the appraised relevance of the recreation issues targeted. Five out of six participants rated an increase in both their expectancy of recreation competence and appraisal of recreation competence at the end of therapy sessions. Conversely, five participants suggested that relevance was lower at the end of therapy. These findings suggested that as competence in recreation developed, greater amounts of self-directed recreation could be expected and the professional effort put towards recreation may be perceived as less important.

Barak et al. (2001) evaluated the effects of AAT over a 12 month period on elderly persons with SCZ in a closed psychogeriatric ward with a pretest-posttest design. Participants were randomly assigned to an intervention group (n = 10) that received AAT or a control group (n = 10) that received recreation sessions revolving around reading and current societal events. A within- and between- groups t-test was used to analyze change in Social-Adaptive Functioning (SAFE). The authors reported a significant increase in the total SAFE score for participants of the AAT group by 6 months (p=0.003) and at 12 months (p=0.001) when compared to the control group. The within group tests showed no significant changes for either group on the impulse control or instrumental and self-care factors of the SAFE. However, the social functioning dimension of the SAFE improved significantly for the AAT group (p=0.001). These findings suggested that AAT had a significant positive effect on the social functioning of older adults with SCZ in long-term care settings.

Bizub and colleagues (2003) explored the experiences of five participants with SCZ who took part in a 10-week THBR intervention using a qualitative research design. Semi-structured exit interviews were conducted to gain a rich account of participant experiences during the riding intervention. The results suggested that participants enjoyed their experience, bonded with the horse, and developed relationships with volunteers. They further put individual coping skills to the test when addressing fears of riding and gained insight about themselves and their abilities when learning how to ride. Results suggest that THBR may provide positive psychosocial gains for persons with SCZ. Follow-up discussions, conducted with participants six months after the completion of the intervention, led the participants to speak positively about the experience. For example, some participants mentioned interests in pursuing residential and financial independence as well as becoming more active clubhouse members.

Nathans-Barel et al. (2005) primarily explored the impact of AAT on ameliorating anhedonia for persons with SCZ during 10 weekly 1-hour sessions in a non-randomized pretest-posttest design. Participants were assigned to the AAT treatment group (n=10) or a control group (n=10) that was not provided with AAT. First an ANCOVA was conducted to compare between groups SHAPS scores on the post-treatment condition (e.g., hedonic tone). Significant differences were found in SHAPS scores (e.g., hedonic tone), with the AAT group improving when compared to controls (p = 0.02). A two-way repeated measures analysis of variance ANOVA was also conducted to determine if SHAPS test scores would improve more for the treatment group than the control group over the course of the intervention. Results suggested that SHAPS scores were significantly higher in the AAT group when compared to the control group ($p = 0.021$). A secondary purpose of the study was to explore AAT treatment impact on quality of life and clinical symptoms. Significant improvements were found for the AAT group on the QLESQ scores (e.g., utilization of the leisure factor) compared to the control group ($p = 0.01$). No significant differences were found for any other factors of the QLESQ or the SQLS. Further, no significant between group differences were found on the post-treatment scores for SANS (e.g., negative symptoms), positive factor of the PANSS (e.g., positive symptoms) and PANSS total score (e.g., general psychopathology).

Voruganti et al. (2006) explored the effectiveness of an adventure and recreation intervention over an eight month period for persons with SCZ or SAD in a randomized prospective case-control pretest-posttest design. Participants were divided into an experimental group ($n=23$) that received the intervention over an 8-month period while a control group ($n=31$) received standard clinical care that included usual recreation activities offered through the clinic. Separate repeated measures ANOVAs were used to analyze change in symptom severity (PANSS), social, occupational and psychological functioning (GAF), self-esteem (ASIS), self-appraised cognitive dysfunction (SSTICS) and health-related psychosocial adjustment (SIP) scores. No significant differences were found for any of the dependent variables at baseline. The authors reported no significant differences for the groups on symptom severity scores. They did find significant improvements, as a result of the intervention, in self-esteem and global functioning scores ($p < 0.05$) as well as marginal improvements in self-appraised cognitive dysfunction ($p < 0.04$) and health-related psychosocial adjustment scores ($p < 0.01$). Results from the 1-year follow up suggested that the benefits were sustained in self-esteem and global functioning scores. There was also a significant decline in body weight for the experimental group over the one-year period (mean = 12lbs) while the control group experienced a weight gain (mean = 9lbs). The authors stated that qualitative notes, compiled throughout the intervention, suggested experimental group participants enjoyed identifying with the group, felt a sense of accomplishment, experienced thrill, formed trusting relationships with others and became interested in future goal setting.

Corring and colleagues (2010) explored the experiences of six persons with SCZ or SAD who participated in a 10-week THBR intervention with a qualitative research design. Semi-structured interviews were conducted at a post-intervention phase to gain a deeper understanding of participant experiences. Interviews were conducted with each participant, recreation staff, and the riding instructor. Participant responses suggested they experienced enjoyment during the intervention but spoke to a lesser degree about bonding with the horse. Interview results from the recreation staff and the riding instructor also suggested that the participants with SCZ formed a unique bond with the horse and seemed to be experiencing enjoyment. Recreation staff also felt their clients were able to focus better, increase attention to riding and improve self-confidence. Further, a one-year follow-up interview was conducted with one participant. The participant recalled the experience positively and associated it with fun and relaxation. Results suggest THBR may be beneficial to persons with SCZ or SAD and address issues linked to anhedonia.

Snethen et al. (2012) explored the community participation of eight people with schizophrenia spectrum disorders over a 10-week period in a mixed-methods research design. Semi structured qualitative interviews and DRMs interviews were employed to measure daily community leisure participation, activity type, and motivation for participation. Participants suggested that the recreation intervention helped them to increase their level of community involvement, improve their ability to plan, and develop coping skills to help manage stress and anxiety. Increases in community involvement included accessing the community for goods and services, independently using public transportation, and identifying and engaging in local community recreation services. Prior to the intervention many of the participants also exhibited functional deficits in their ability to plan. Participants suggested the intervention helped them to identify personal activity goals and develop weekly plans. However, several participants suggested a continued need to improve on following through with their plans. Finally, many of the participants initially suggested that stress and anxiety was a significant barrier to community participation. The intervention helped participants to identify recreation activities that could be done at home or in the community that, in turn, could help to reduce anxiety and relieve stress. Despite these positive qualitative findings, it is important to note that the DRMs activity episodes for this group was significantly less than the average number of activities identified in typical DRMs studies. Moreover, the greatest number of activities that took place within the community occurred when the therapist was present (Snethen et al., 2012). Findings from the DRMs suggest that persons with SCZ may have limited opportunities to engage in community recreation and the recreation therapist may be the initial key to facilitating in community participation.

Corring et al. (2013) explored the experiences of six persons with SCZ or SAD who participated in a 10-week THBR intervention with a qualitative research design. Semi-structured interviews were conducted in the post-intervention phase to gain a deeper understanding of participant experiences. Interviews were conducted with each participant, assertive community treatment (ACT) staff member, and the riding instructor. Participants suggested the intervention was positive because they enjoyed riding, bonding with the horse and developing relationships with other participants and staff. Participants and the recreation staff talked about how participants increased their confidence and self-esteem as a result of learning how to ride. The staff also spoke about being surprised by the potential that their clients demonstrated for new learning and how they may have sheltered the clients more than required. Study results suggest that THBR may have positive benefits for ACT clients. The authors suggested these findings are positive since ACT clients tend to be some of the most psychiatrically disabled patients living in the community.

In summary, findings from the 11 leisure outcome interventions suggest that leisure may play an important role in the health and recovery of people with SCZ or SAD. Leisure outcome interventions included in this review showed positive impacts on the social, physical, and psychological health of people with SCZ or SAD. More specifically, leisure interventions increased self-esteem and self-confidence, developed coping and planning skills, improved daily functioning, increased socialization, ameliorated anhedonia, provided opportunities to experience enjoyment, increased community participation, and decreased body weight.

Discussion

This scoping review explored the role of leisure interventions for persons with SCZ or SAD. Important research design characteristics were presented in this review to answer our first research question. The majority of research designs were quasi-experimental and employed quantitative measurement instruments. Small sample size and wide age range variability were found across studies. A combination of males and females, who had received a formal diagnosis of SCZ or SAD participated in the studies. While half of the intervention studies reported the use of medication, little to no information was available about comorbid diagnoses in all of the 16 intervention studies. These findings are similar to the observations made in the field of adapted physical activity (APA) research where small sample sizes and participant variability were considered as major inherent research challenges (Watkinson & Wasson, 1984). Despite these challenges, scoping reviews are essential to the development of research knowledge in emerging disciplines such as APA, TR, and critical disability studies. These types of reviews may allow the reader to accumulate and categorize knowledge in an emerging field that, in turn, may lead to future discussions or research studies to help address gaps in the existing literature. Hence, future studies should try to recruit larger sample sizes where possible and provide as much information as possible about study participants (Sherrill & O'Connor, 1999). Fortunately, the combination of males and females in the research designs may be representative of the SCZ and SAD population (Ochoa, Usall, Cobo, Labad, & Kulkarni, 2012; Daniel, 2010).

Recreation therapists led half of the interventions in hospital settings that were mainly conducted in a group format with active and passive recreation program approaches. These findings make sense, given the time frame of many studies (e.g., 1980-1990's) For example, many people with SCZ would have been expected to receive treatment in psychiatric hospitals where TR services would be delivered. Finally, a majority of the studies were conducted from a quantitative research perspective where the research instruments were valid and reliable. More recent studies employed qualitative approaches to understanding processes related to leisure and persons with SCZ or SAD.

The main intervention outcomes, presented in this scoping review, address our second research question about the effects of leisure interventions on persons with SCZ or SAD. Findings suggest that leisure and TR interventions may positively impact the recovery efforts of people with these disorders. The implications of these review findings are discussed below.

Behaviour Outcomes. Five interventions increased the number of appropriate behaviours and decreased the number of psychotic behaviours displayed by participants with SCZ or SAD

(Finnell et al., 1997; Morris et al., 1999; Pestle et al., 1998; Wong et al., 1987; 1988). These studies provide strong support for the use of TR in positive behaviour change. The ability to display socially appropriate behaviours is key for people with SCZ or SAD who reside either in a hospital or community setting. For example, it is important for people to meet social norms and expectations in order to become engaged in the community and participate in social forms of leisure (Kopelowicz, Liberman, & Zarate, 2006). Thus, the provision of opportunities to learn about and practice appropriate behaviours may have a positive impact on socialization efforts with others. However, it is important to note that TR was delivered as part of a larger treatment program across all five studies. Treatment effects from other therapies may have had a positive impact on appropriate behaviour. For example, continuous contact with hospital staff or other interventionists may also positively affect behaviour change (Ellis et al., 2007).

Leisure Outcomes. Leisure interventions may have a significant positive impact on the leisure outcomes of elderly adults with SCZ who reside in long-term care. (Barak et al., 2001; Card, 1989). Older adults with SCZ are often deemed as a challenge to place in long-term care facilities, with additional social and psychological challenges associated with living in hospital contexts (Barak et al., 2001). Leisure interventions may encourage socialization and improve social and leisure functioning (Corring et al., 2010; 2013). For example, elderly participants with SCZ maintained their level of perceived leisure functioning, reduced feelings of helplessness and increased feelings of freedom through a leisure intervention (Card, 1989). These positive intervention effects may help to address the challenges associated with long-term placement and lead to greater feelings of autonomy for older adults with SCZ.

Leisure interventions may also positively contribute to the emotional experiences of persons with SCZ or SAD (Bizub et al., 2003; Corring et al., 2010; 2013; Gimmestad, 1995;

Nathans-Barrel et al., 2005; Voruganti et al., 2006; Wolfe & Riddick, 1984). Leisure interventions were reported to have a positive effect on the emotions of participants with SCZ or SAD. For example, anhedonia, or the inability to experience pleasure, often plays a significant role in the lives of people with these disorders (Ritsner, 2016). While traditional approaches to treat anhedonia have predominately been from psychotherapeutic or pharmacological perspectives (Hatzigiakoumis, Martinotti, Di Giannantonio, & Janiri, 2011), leisure interventions may help to ameliorate anhedonia (Nathans-Barel et al., 2005). Study findings also suggested that people with SCZ or SAD, who participated in leisure interventions, reported having fun, experiencing enjoyment, and feeling anticipatory joy (Bizub et al., 2003; Corring et al., 2010; 2013; Gimmestad, 1995).

Leisure knowledge and positive leisure experiences improved the self-esteem of people with SCZ or SAD (Corring et al., 2010; Voruganti et al., 2006; Wolfe & Riddick, 1984). These intervention study findings are important because persons with these disorders often experience low levels of self-esteem (Watson, Corrigan, Larson, & Sells, 2006). Perhaps improvements in self-esteem may address some of the major challenges of living with SCZ (Corrigan et al., 2013). Increased self-esteem and, potentially, greater amounts of confidence may lead to higher levels of motivation to participate in leisure and community living. For example, people with SCZ or SAD, who experienced success in THBR, reported feeling greater levels of self-confidence and self-efficacy (Bizub et al., 2003; Corring et al., 2010; 2013).

The development of coping strategies, improved self-confidence, and increased self-efficacy were identified through positive leisure experiences (Bizub et al., 2003; Corring et al., 2010; 2013; Roder et al., 1993; Snethen et al., 2012). Thus, leisure interventions may enable persons with SCZ or SAD to (a) develop active strategies to cope with boredom and stress

(Roder et al., 1998) or (b) identify and engage in activities that can help to lower stress and anxiety (Snethen et al., 2012). These intervention study findings are very important because persons with SCZ or SAD often experience high rates of distress, symptoms of anxiety and depression which affects daily living (Buckley et al., 2009; Daniel, 2010). For example, people with these disorders may experience significant impairments in the ability to work which, in turn, may lead to long-term unemployment (McGurk & Meltzer, 2000). The resulting increased amounts of free time may potentially contribute to stress, anxiety, and boredom. Hence, leisure interventions may help to address some of these major personal issues.

Leisure interventions also helped to develop planning skills for participation in the community (Snethen et al., 2012) which is an important finding since people with SCZ or SAD may experience deficits in planning abilities (Holt, Wolf, Funke, Weisbrod, & Kaiser, 2013). Findings suggest that interventions, that develop recreational skills, may help people with these disorders to purse active leisure participation (Snethen et al., 2012) and develop leisure relationships (Roder et al., 1998). Since leisure engagement may be dependant on the acquisition of these skills (Kleiber, 2012), planning and decision-making skills are fundamental to the development of a healthy leisure lifestyle (Datillo, 2008). For instance, individuals with SCZ or SAD may identify and set future leisure goals through leisure interventions (Roder et al., 1998; Voruganti et al., 2006). Furthermore, Nathans-Barel et al. (2005) suggested positive leisure experiences led to improvements in how persons with these disorders chose to spend their leisure time (Nathans-Barel et al., 2005). Thus, leisure may play a key role in helping people with SCZ or SAD to live empowered and engaged lives (Iwasaki et al., 2015).

Leisure interventions also provided greater opportunities for persons with SCZ or SAD to gain access to their communities. In fact, they played a positive role in helping people with SCZ or SAD to increase community participation (Gimmestad, 1995; Snethen et al., 2012), engage in new leisure activities in the community (Roder et al., 1998), and take a greater role in community mental health organizations (Bizub et al., 2003). These findings are positive especially since persons with these disorders are expected to become active members of their home communities. For example, the recovery model in mental health focuses on the importance of social inclusion and self-determination where people with MHPs are expected to become increasingly more involved and empowered in the decision-making process related to individual treatment and inclusion in community living (Davidson & Roe 2007, Onken, Dumont, Ridgway, Dornan, & Ralph, 2002). Therefore, positive leisure experiences may contribute significantly to the psychosocial rehabilitation of persons with SCZ or SAD.

A significant weight loss was also attributed to a leisure intervention (Voruganti et al., 2006) that, in turn, is an important finding because persons with SCZ or SAD are often at greater risk for unhealthy weight gain that may negatively impact health and recovery (Brown et al., 2006). For example, significant weight gain can increase the chances of obtaining type 2 diabetes, cancers, cardiovascular conditions, and metabolic syndrome (Kohl & Murray, 2012). Further, persons with SCZ may also experience difficulty adhering to physical activity and exercise programs (Archie et al., 2003). Adventure and recreation based interventions may be an alternative to more traditional exercise programs that attempt to address physical health issues linked to SCZ or SAD (Voruganti et al., 2006). These types of interventions may provide opportunities for persons with SCZ or SAD to stay engaged in novel forms of physical activity over longer periods of time.

Finally, findings from the leisure interventions may also highlight the role of TR professionals for people with SCZ or SAD in either hospital or community settings.

Roder et al. (1998) suggested that as competence in recreation developed, greater amounts of self-directed behaviour could be expected from people with SCZ and less dependence on recreation professionals would be required. This finding is important because many with SCZ or SAD may still be living in a hospital context but efforts would be made to increase personal autonomy. Persons with SCZ, receiving inpatient treatment, may benefit significantly from involvement in TR services. Interestingly, more recent leisure studies have demonstrated there may be an increased reliance on TR professionals when developing leisure interventions in the community (Bizub et al., 2001; Corring et al., 2010; 2013). This shift is important to note in the current transition of people with SCZ or SAD where the recovery model emphasizes the active involvement of a person with MHP when making decisions in the community (Davidson & Roe 2007, Onken, Dumont, Ridgway, Dornan, & Ralph, 2002). It seems that autonomy support may be required from TR professionals for people with SCZ or SAD to participate in community leisure experiences (Harvey et al., 2010).

Future Studies

This scoping review provides insight into the effects of leisure interventions for people with SCZ or SAD. Future research is needed to continue to investigate the potential benefits of leisure interventions for this group of people. First, the effects of leisure interventions for elderly people with these disorders in hospital, long-term care, and home community should be explored. These types of investigations may produce new understandings of leisure interventions across different settings that may produce varying results for elderly persons with SCZ or SAD. For example, research studies may demonstrate similar treatment intervention effects across settings or perhaps there may be differences in treatment outcomes that need to be studied from varying contextual perspectives. Second, research is needed to further explore how leisure can play a role in ameliorating anhedonia. Since traditional interventions to treat anhedonia have produced mixed results (Hatzigiakoumis et al., 2011), leisure researchers should attempt to further explore how leisure interventions may enable people with SCZ or SAD to experience pleasure in daily life. Third, future leisure interventions should be conducted to explore relationships between leisure participation, competence, self-esteem, and self-efficacy as well as the development of coping skills for persons with SCZ or SAD. While actual and perceived stigma may lead persons with SCZ or SAD to feel inadequate, undervalue their skills, and question their ability to succeed (Watson et al., 2006); positive leisure experiences may provide opportunities to develop individual skills and experience greater success and self-efficacy. Thus, future studies should continue to explore how leisure interventions may address and improve self-esteem and self-efficacy.

Fourth, future studies should investigate the role of leisure education and programming on planning deficits of people with SCZ or SAD. Since the ability to plan is an issue that affects many people with these disorders (Holt et al., 2013), leisure education interventions may provide more opportunities to practice planning skills and follow through on identified plans. Finally, much more research needs to be conducted to uncover relationships between leisure interventions and community access for people with SCZ or SAD. For example, what role may leisure interventions play in the shift to community recovery for people with these disorders? Clearly, the role of leisure interventions and leisure professionals need to be investigated in relation to community recovery and client care. Perhaps a community-based participatory research approach could be utilized to enable people with serious MHP to have a platform to voice their concerns about community leisure and have opportunities to self-actualize in their home communities (Harvey, Varriano & Wilkinson, 2016). Furthermore, longitudinal studies could be performed to explore the long-term implications of community leisure interventions.

Limitations

This review had several limitations. First, the review included only interventions in the English language. Future literature searches, accounting for studies in different languages, may provide additional information on the role of leisure and TR interventions for people with SCZ or SAD. Second, a focus on homogeneous samples excluded a number of studies that included persons with and without these disorders in leisure and TR. The purpose of this review was to focus specifically on persons with SCZ or SAD to better understand the effects of leisure interventions on these marginalized people. Future reviews may incorporate leisure and TR interventions using heterogeneous samples for comparative purposes to: (a) observe if different treatment approaches exist for people with other serious MHP (e.g., depression, anxiety, etc.) and (b) produce new understandings of how leisure interventions may impact people with a variety of different mental health diagnoses in individual and group formats. Third, many of the studies were dated and focused on the role of interventions in the lives of people with SCZ or SAD who lived in long-term hospital settings. Since there has been a transition for people with these disorders to live in the community, there is a current dearth of knowledge about the role of leisure and TR within community mental health services. Finally, the review included only interventions for persons 18 and older. Future reviews could include studies of adolescents, who are between 14-18 years and experiencing first-episode psychosis, to gain a preliminary understanding of the role that leisure and TR interventions may play in early intervention efforts for persons with psychosis. Despite these limitations, the use of leisure and TR interventions show promise as an adjunct therapeutic approach for persons with SCZ or SAD.

Conclusion

Findings from this review suggest that leisure and TR interventions may play a positive role in the recovery of persons with SCZ or SAD. More specifically, leisure and TR interventions may help persons with these disorders to increase community engagement, plan leisure activities, cope better with stress and anxiety, experience positive emotions, modify behavior, increase self-esteem, increase their understanding of leisure in the community, and potentially address comorbid health issues. However, relatively small sample sizes, variations in study design, different outcome measures, and the use of varying treatment approaches make it challenging to draw any significant conclusions about the effects of leisure interventions for people with SCZ or SAD. This review was presented in a format to encourage the reader to determine the scope and depth of research findings from each individual study. The reader's interpretation will be influenced by her or his own epistemological, ontological, and methodological views. Much more research needs to be conducted to provide additional support for the use of leisure and TR interventions in psychiatric rehabilitation. Future research on the effectiveness of leisure and TR interventions in the recovery of people with SCZ or SAD may help to increase its relevance and clinical validity in mental health practice. More importantly, people with SCZ or SAD may be provided valuable autonomy support through leisure in order to be able to live healthy and happy lives in the community.

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Bridging Text

Chapter three presented a scoping review of leisure interventions for persons with SCZ or SAD. The review was conducted to gain a better understanding of the design characteristics and outcome effects of leisure interventions for persons with these disorders. Results from the review suggest leisure interventions may help persons with these disorders to increase community engagement, plan leisure activities, cope better with stress and anxiety, experience positive emotions, modify behaviour, increase self-esteem, increase individual understanding of leisure in the community, and potentially address comorbid health issues. Future research needs to be conducted to provide additional support for the use of leisure in psychiatric rehabilitation. Chapter four explored the complex relationships between leisure, health and SCZ by asking nine people with SCZ to speak about their community leisure experiences.

Chapter 4

Schizophrenia & Leisure: Personal stories of struggles and triumphs.

Abstract

Leisure is a key construct to explore for all persons with mental health problems (MHP) because engagement in an active and healthy lifestyle is essential for improved mental health and physical well-being. However, relationships between leisure and the overall health of persons with MHP are not well understood. A mixed methods case study design investigated complex relationships between leisure, health and schizophrenia (SCZ) by asking nine people with SCZ to speak about community leisure experiences. They spoke about setting goals to help achieve a sense of normalcy and community belonging. While the participants were aware of the complex health issues associated with SCZ, they desired to lead more healthy and active lives. Finally, the participants spoke about underlying leisure knowledge and perceived challenges experienced with leisure engagement. This investigation led to an in-depth understanding of leisure and persons with SCZ which, in turn, should assist in the production of leisure education (LE) programs to encourage self-determined community leisure opportunities.

Introduction

Schizophrenia (SCZ) is a severe and profound mental health problem (MHP) that affects approximately 1% of people worldwide (Compton & Broussard, 2009). This disorder results from a complex interaction between biological and environmental factors that cause a disturbance in brain functioning (Tsuang, Faraone, & Glatt, 2011). People diagnosed with SCZ often experience a range of cognitive, behavioral, and emotional dysfunctions (American Psychiatric Association [APA], 2013). SCZ can affect an individual's ability to think, feel, perceive, and act; often resulting in a significant distortion or disconnection from reality (Compton & Broussard, 2009). Specifically, a psychiatrist makes a diagnosis of SCZ when: (a) two or more of the following symptoms [(1) delusions, (2) hallucinations, (3) disorganized speech, (4) grossly disorganized or catatonic behavior, (5) negative symptoms] are present for a significant portion of time during a 1-month period and at least one symptom must be (1, 2, or 3); (b) the person's functioning level in one or more major life areas is markedly below the level achieved prior to the onset of the disorder; (c) continuous signs of the disturbance persist for at least six months; and (d) the disturbance is not attributable to another psychiatric or organic disorder (APA, 2013).

People, who experience SCZ may also often present with significant medical co-morbidities (Smith, Langan, McLean, Guthrie, & Mercer, 2013; Buckley, Miller, Lehrer, & Castle, 2009). For example, they are at greater risk for unhealthy weight gain (Brown, Goetz, Van Sciver, Sullivan, & Hamera, 2006), cardiovascular disease (Citrome, 2005; Hennekens, 2007) and diabetes (Alvarez-Jimenez, Hetrick, Gonzalez-Blanch, Gleeson, & McGorry, 2008) that, as a result, may significantly reduce life expectancy (Laursen, 2011). High rates of smoking (McCreadie, 2003), poor dietary choices (Strassnig, Singh Brar, & Ganguli, 2003), co-morbid substance dependence (Susce, Villanueva, Diaz, & de Leon, 2005) and limited amounts of physical activity (Mason & Holt, 2012) may also exacerbate the poor health outcomes of people with SCZ. Furthermore, people with SCZ often face stigma impacting their ability to socialize with others (Compton & Brossard, 2009).

Community Recovery

Early detection and intervention are keys to the short-term symptom reduction and treatment adherence of individuals with SCZ (Compton & Brossard, 2009). The person is usually considered to be in remission once the major symptoms of SCZ are under control which, in turn, is an important step to recovery (Compton & Broussard, 2009). The concept of recovery, however, is much more than symptom reduction. For example, Davidson and Roe (2007) defined recovery in two different ways. The first definition, 'recovery from mental illness', is when an individual is cured of their serious mental illness and s/he gains back their previous life. The second definition, 'recovery in mental illness', refers to approximately 35-75% of people with mental illness who are (a) not cured and (b) currently living with symptoms of their disorder while being treated in the community (Davidson & Roe, 2007). The latter definition emphasized the importance of social inclusion and self-determination where people with MHPs are expected to become increasingly more involved and empowered in the decision-making process related to individual treatment and inclusion in community living (Davidson & Roe, 2007, Onken, Dumont, Ridgway, Dornan, & Ralph, 2002). Since engagement in an active and healthy lifestyle is essential for improved mental health and physical well-being of people with MHP (Harvey, Delamere, Prupas, & Wilkinson, 2010); leisure is a key construct to explore for all persons with MHP (Iwasaki, Coyle, & Shank, 2010), including individuals with SCZ (Iwasaki et al., 2014).

Leisure & Schizophrenia

Leisure may be conceptualized as “a relatively freely chosen humanistic activity and its accompanying experiences and emotions that can potentially make one’s life more enriched and meaningful” (Iwasaki et al., 2010, p. 485). Research suggests that leisure may play an important role in promoting mental health recovery (Iwasaki et al., 2014, Swarbrick & Brice, 2006) and it may have a positive impact on the health and well being of persons diagnosed with severe mental health problems (Harvey et al., 2010). Persons with SCZ, recovering in the community, reported that leisure helped them to transition into and become more active members of their neighborhoods (Snethen, McCormick, & Van Puymbroeck, 2012). Moreover, persons with SCZ, who reported high levels of motivation to engage in leisure, functioned at a higher recovery level (Lloyd, King, McCarthy, & Scanlan, 2007).

Persons with SCZ also reported that leisure interventions stimulated individual pursuits of more active leisure in the community (Roder, Jenull, & Brenner, 1998). Additionally, leisure engagement has enabled individuals with SCZ to improve self-efficacy (Pegg & Patterson, 2002), increase self-esteem (Corring, Lundberg, & Rudnick, 2013), enhance overall quality of life (Pitkanen, Hataonen, Kuosmanen, & Valimaki, 2009), improve well-being (Ponde, Pereira, Leal, & Oliveira, 2009) and lead more meaningful and engaged lives (Iwasaki, Messina, Shank, & Coyle, 2015). Moreover, leisure has been associated with significant changes to both positive and negative symptoms for persons with SCZ. For example, leisure participation has helped to ameliorate anhedonia (Nathans-Barel, Feldman, Berger, Modai, & Silver, 2005) and decrease reported levels of negative emotions (McCormick, Snethen, Smith, & Lysaker, 2012). Mausbach and colleagues (2006) also identified a significant inverse relationship between negative symptoms and leisure. For example, participants with SCZ demonstrated higher levels of negative symptoms and depression when they reported low levels of leisure satisfaction.

While positive recreation and leisure opportunities for individuals with SCZ may contribute to better overall health (Caldwell, 2005) and play an important role in the recovery process (Swarbrick & Brice, 2006); people with SCZ are less likely to engage in active leisure lifestyles because they have, traditionally, not had the same leisure opportunities as people without a serious MHP (Nagle, Valiant Cook, & Polatajko, 2002). Moreover, people with MHP often find it challenging to access community-based services where they can engage in recreation and leisure opportunities (Graham, Arthur, & Howard, 2002; Harvey et al., 2010). Furthermore, few studies have explored the complex relationships between leisure and the choices that people with SCZ make for themselves in the community (Chugg & Craik, 2002, Iwasaki et al., 2015, Lloyd, King, Lampe, & McDougall, 2001, Pieris & Craik, 2004, Ponde et al., 2009). Thus, the purpose of this study was to better understand the complex relationships between leisure, health, and persons with SCZ living in the community.

Method

Participants

Nine adults with SCZ, between 20-35 years, participated in the study. They were identified through a SCZ outpatient clinic at a mental health institute located in a major city in Quebec, Canada. A clinical diagnosis of SCZ was made for each participant by a senior psychiatrist. Thus, each participant met the criteria for SCZ outlined in the Diagnostic and Statistical Manual of Mental Disorders (APA, 2013). Table 1 (See Appendix G, p. 189) provides specific demographic information for each participant. Information pertaining to medication status was not obtained or reported for the purposes of this study. The rationale behind this decision was that we did not want the use of medication to lead our views of participant behaviour from a positivistic perspective. Note that all names and places used in the text and tables are pseudonyms to ensure participant anonymity and confidentiality. Approval from the Institute Research Ethics Board was obtained before any communication was established with the clinical team or potential study participants. The principal investigator (PI) met with the clinical team to introduce the study and address study questions and concerns. Participants were then informed of the study by their individual caseworkers and recruited to participate in the study by the PI. Each potential participant was provided with a copy of the consent form (See Appendix H, p. 190). Study participants were English, French, or bilingual speaking and they were all receiving treatment from the outpatient clinic.

Data-Gathering

A mixed-methods case study design was employed to better understand how people with SCZ experienced and understood leisure in their daily lives. Yin (2003) suggested that a mixed methods approach is suitable for case study research because it is often utilized to explore a phenomenon and the real-life context in which it occurs (Yin, 2003). Thus, a mixed methods approach was used to collect concurrent quantitative (i.e. questionnaires) and qualitative (i.e. interviews) data (Creswell, 2007).

Quantitative

The quantitative research component was conceived to gain an in-depth understanding of the participants' attitudes towards leisure activities. The Leisure Satisfaction Measure (LSM) (See Appendix I, p. 197) and Leisure Motivation Scale (LMS) (See Appendix J, p. 199) were selected for this study because they are reliable and valid instruments for assessing the leisure satisfaction and motivation of adults (Beard & Ragheb, 1980; 1983). The LSM measured the degree to which a participant perceived if his or her general ‘needs’ were being met through leisure (Beard & Ragheb, 1980). The LSM consists of 24 statements, related to an individual’s leisure satisfaction, that are rated on a 5-point Likert scale. Specifically, the LSM divides an individual’s leisure satisfaction into six subcategories: psychological, educational, social, relaxation, physiological, and aesthetic. The six subcategories consist of 4 questions per category. For example, the relaxation section questions include (1) My leisure activities help me to relax, (2) My leisure activities help relieve stress, (3) My leisure activities contribute to my emotional well-being, and (4) I engage in leisure activities simply because I like doing them. The PI read each individual LSM statement and the participant was asked to choose the Likert-scale response that best fit her or his situation. The PI explained the 5-point Likert scale, that ranged from ‘1’ (almost never true) to ‘5’ (almost always true), to each participant. The PI and the participant reviewed the meaning of each individual Likert response (e.g., 5 is greater than 1) and checked for individual understanding for each corresponding statement.

Raw scores from each subcategory were summed and divided by the number of questions per subcategory to obtain an overall score (Burlingame & Blaschko, 2010). High subcategory scores identified the leisure areas that the participant considered to be most satisfying. Low subcategory scores identified the leisure areas that the participant was least satisfied with. For example, a score of less than two in a subcategory demonstrated low satisfaction while a score of four indicated a high satisfaction level for a subcategory (Burlingame & Blaschko, 2010).

The LMS determined what components of leisure activities needed to be present for a person to be motivated to participate (Beard & Ragheb, 1983). Specifically, the LMS is divided into four primary factors that may motivate individuals to engage in leisure (e.g., intellectual, social, competence-mastery, and stimulus–avoidance). Each of the four primary factors is comprised of 12 questions based on a 5-point Likert scale. All 48 LMS items begin with the phrase ‘One of my reasons for engaging in leisure activities is...’. For example, the intellectual component contains the phrases: ‘One of my reasons for engaging in leisure activities is’: (1) to expand my interests, (2) to seek stimulation, (3) to make things more meaningful for me. The PI read each individual LMS statement and the participant was asked to choose the Likert-scale response that best fit her or his situation. The PI explained the 5-point Likert scale, that ranged from ‘1’ (almost never true) to ‘5’ (almost always true), to each participant. The PI and the participant reviewed the meaning of each individual Likert response (e.g., 5 is greater than 1) and checked for individual understanding for each corresponding statement.

Raw scores were summed within each individual subscale to determine the participant’s primary factor scores. The highest of the subscale scores indicated the primary motivating force in the participant’s leisure activities (Burlingame & Blaschko, 2010). For example, a subscore of 35-40 on the intellectual component would indicate that the participant was highly motivated to engage in leisure for intellectual reasons. The lowest of the subscale scores indicated the least motivating forces for leisure participation (Burlingame & Blaschko, 2010). For example, a subscore of 15-20 on the social component indicates that the participant was less motivated to engage in leisure for social reasons. Moreover, very low scores further indicate that an individual may avoid the leisure activity altogether (Burlingame & Blaschko, 2010). For example, a subscore of 12 on the competence-mastery component indicates that the participant avoids leisure activities that test physical skills and abilities. It was not recommended to add the subscale scores together because a total score has not been shown to have any clear meaning (Beard & Ragheb, 1983).

The LSM and LMS both have a summary section, which includes 8 areas of behavioral observation during questionnaire administration (e.g., appearance, attention span, attitude, body posture, eye contact, frustration/agitation, apparent comprehension, & response time). The interviewer can provide additional assessment observations (e.g., date, medication, length of time). The PI used these summary sections and hand written interview reflections to document each participant’s appearance and interactions.

Qualitative

The qualitative research component consisted of individual semi-structured interviews (See Appendix K p. 201) to discuss personal experiences and understand leisure in each participant’s everyday life. Interviews are valuable sources of case study evidence as they provide in-depth personal insight into the phenomenon and context of interest (Yin, 2003). Thus, the interviews were used to obtain a deep and rich description of each participant’s community leisure experiences. The semi-structured interview process was similar to an everyday conversation, enabling for flexibility in participant responses (Jackson, Drummond, & Camara, 2007). The participants were asked the following questions. Could you please describe what a typical day is like for you? What do you do during your free time? Why do you do these activities? How do you plan these activities? Why do you participate in these activities? What types of new activities would you like to try? Why? What would encourage you to try a new activity? What, if anything, prevents you from trying a new activity? Leisure may mean different things to different people. What does leisure mean to you? What does leisure have to do with health? Follow-up probes explored participant responses in greater depth and clarified descriptions of leisure opportunities. The PI also kept hand-written reflections from each interview in a separate journal, which helped to recall details of the interview process. For example, the PI noted participant body language, the interview pace and participant behaviors.

Procedures

Each participant was interviewed separately in a private office at the outpatient clinic on the grounds of the mental health institute. Interviews were scheduled on the same day as each participant's monthly health check for convenience and to take into consideration the daily obligations of each participant. Interviews were audio-recorded using a digital voice recorder. Each interview took approximately 20-35 minutes and the PI conducted each interview in either English or French. The LSM and LMS questionnaires were administered following the completion of each interview. In total, the questionnaires took approximately 15-20 minutes to complete. The total data gathering process took approximately 35-55 minutes to complete.

The PI scheduled a follow-up date and time once the data gathering process was completed so that each participant could receive feedback concerning the interview and both leisure questionnaires. There were two purposes of each follow-up session. First, each participant was given a copy of their original interview transcript and a summary document for their personal file. Each participant was encouraged to review both documents in order to add any additional information or remove any sensitive information they wished not to share. Next, the PI provided each participant with a brief leisure education (LE) session. Each participant's definition of leisure as well as LSM and LMS scores were reviewed. A list of web resources was provided to inform each participant of community leisure opportunities. Web resources were individually tailored and based on interview and questionnaire feedback. For example, participants, who expressed a desire to socialize more and scored low on the social section of the LSM, were provided with a resource list that identified different social community groups.

Follow-up sessions were conducted approximately 2-3 weeks after the initial interview. Each follow-up session took 25-35 minutes to complete and was conducted in a private office in the outpatient clinic.

Data-Analysis

*Quantitative***.** Descriptive statistics were used to gain an in-depth understanding of the participants' attitudes towards leisure activities. Individual scores from the LSM and LMS were reviewed in relation to the qualitative data once individual interviews were completed. Potential relationships were identified between individual stories and questionnaire scores. This review determined the LE content and leisure resources used for the follow-up sessions.

Qualitative. Interviews were analyzed using a six-phase thematic analysis (Braun & Clarke, 2006; 2013). This qualitative approach identifies, analyzes, and reports thematic patterns within data (Braun & Clarke, 2006). The leisure views of persons with SCZ living in the community were analyzed and reported. Specifically, an inductive data-driven semantic approach was used to conduct the analysis. First, the PI transcribed each interview verbatim and read the transcripts several times to become more familiar with the language of each participant. Next, the entire data set was reviewed and initial codes were generated. Third, individual codes and relevant data were collated and placed into potential themes. Potential themes underwent an initial review process and a thematic map was drawn to help organize the data set in phase four. Phase five consisted of an ongoing analysis to refine each theme and generate clear thematic names and definitions. Finally, the PI selected various data extracts to write this scholarly report of participant experiences (Braun & Clark, 2006).

Trustworthiness

Researcher reflexivity, member checking and data triangulation were adopted to promote trustworthiness (Cope, 2014). Researcher reflexivity refers to 'the awareness that the researcher's values, background, and previous experience with the phenomenon can affect the research process' (Cope, 2014 p., 90). The PI conducted an autoethnography, prior to engaging in this research study, to better understand how his personal experiences and assumptions may influence the study results (Wilkinson & Harvey, 2016). The PI also kept a reflexive journal to note his feelings and perceptions during this study. These strategies were implemented in an effort to bracket his perceptions and assumptions during data analysis. Next, interview data were member checked as each participant and the PI read through the original transcript and summarized the document to suggest whether or not the interview had been captured accurately (Groenewald, 2004). Modifications were made if participants wished to add to or did not agree with the transcript or summary text. Finally, data triangulation was established through the use of multiple methods of data collection. Questionnaire data, interview data, reflexive journal notes, and feedback from the follow-up sessions were used to gain a more complete understanding of how people with SCZ experience and understand leisure in their daily lives.

Results

Quantitative

The LSM results can be found in Table 2 (See Appendix L, p. 203). Mean LSM scores indicated participants were moderately satisfied with their leisure. A majority of LSM category scores, ranged between 2.1 - 3.9, to indicate participants were neither significantly satisfied nor dissatisfied with current leisure pursuits. These scores do suggest some participants' general needs were being met through leisure while others were not. For example, the highest satisfaction level was identified in the aesthetic category (mean = 4.1). Six clients identified a high satisfaction level or a score greater than four in this area. High scores in this area suggested that participants viewed the places, where they engaged in leisure, as interesting and pleasing. Thus, participants seem to be satisfied with the community venues they were currently accessing. However, it is important to note that participants identified a limited number of community venues that were frequented. For example, many participants spoke about only engaging in leisure at home or close to home. Thus, participants may have been satisfied with their current living conditions which, in turn, may have lent to an increase in overall aesthetic satisfaction. The lowest level of satisfaction was identified in the social category (mean = 3). Five participants scored between 2-3 on this category that would suggest social needs were not completely being met through leisure.

The LMS results can be found in Table 3 (See Appendix M, p. 204). Six out of nine participants identified competency-mastery as the primary motivating force behind their leisure. High scores in this area suggested that participants were motivated to engage in leisure activities, which may have allowed them to master physical skills, challenge themselves, or compete with others.

Interview Data

Four main themes were identified through thematic data analysis. The ‘search for normalcy’, ‘life can be cruel’, ‘I want to be fit and healthy’ and ‘leisure and life’ themes tell a unique story of the struggles and triumphs that persons with SCZ may face when recovering in the community. Each theme is described in detail below with references made to specific passages from the interview text.

Search For Normalcy

Many of the participants talked about their recovery in the community and a search for a more normal life. Participants spoke about setting short and long-term goals that would help to achieve a sense of normalcy and community belonging. For example, Carter spoke about his short-term goal to socialize more with young adults, of his own age, so he could show his recovery efforts to his family.

> "In fact I would like to have more outings with friends because it's a problem that I have. I want to show my parents that I am starting to reestablish myself. Show my parents that I am starting to come back to excellent mental health."

Several participants also shared long-term recovery goals like wanting to finish their education and start a career. For many of the participants taking on additional responsibility was important to their recovery. Some participants felt that university studies or a career would help them to develop a positive self-image or greater independence. For example, Joe talked about how work would give him greater independence.

> "I don't want to be sitting on my ass not doing anything. At the same time, I am not the person who wants to go out there and be involved in things. I just want to do something that pays me so I can pay my own rent … so I don't have to depend on my mom anymore. I want something that's serious. We pay you for this because you are doing a good job. Thank you, I appreciate you are paying me because I am doing a good job. Finally, I can pay my own apartment. I can do my own things. I don't want to depend on anyone anymore."

Life Can Be Cruel

One of the most interesting stories was the participants' desire to talk about the 'cruel' nature of SCZ and how living with the disorder has been 'a real bitch'. They shared similar stories of the negative impact that a diagnosis of SCZ had on their physical and mental health.

For example, Joe talked about how hard it was to cope with the physical pain associated with SCZ.

> “Oh My God! What got hard for me? A lot of things got hard for me. I can’t concentrate. I can’t sleep well. I’m anxious, not anxious as in stressed, I’m in pain. I’m tired and I feel sore you know. I feel sour and my muscles are always like blocking and I just feel old. I don't feel like a person who is 25 should be feeling. I feel like I’m 80 years old when I’m 25 so that's a problem there.”

Participants also spoke about how positive symptoms, like auditory hallucinations, had a significant negative effect on their mental health.

> “Well there is this girl in my head and she’s there all the time. She is very judge...what do you call that? Judgmental. I know her. She is a girl I went to school with before. Basically she stayed with me for several years. Over the years she stayed with me in my head. She tries to see herself as my girlfriend trying to make me look good with my other voices. So she judges me and she tells me “you have to lose weight” and I agree with her because I do have to lose weight. You know regardless of the voices people outside I want them to see me not being obese.” (Chris)

Participants also spoke candidly about how the diagnosis of SCZ had an impact on their social health. Although a few of the participants spoke about having one or two friends they could rely on, seven of the participants talked about how it was difficult to develop and maintain friendships. Thus, they also felt socially isolated.

> “I don’t have many friends. I have a few friends I can confide in who took care of me while I was sick. I don’t have many friends, maybe two, but they are my best friends and we go out. We see each other when we go out but we don’t go out very often.” (Bonnie)

> “Well I mean you know when you’re schizophrenic and you’re paranoid, you always think that people say bad things about you in a negative way. Sometimes it’s not that I hate people, it’s just that you’re so angry. You are afraid that your frustration might explode on other people. So I am very careful with that and that is why I stay to myself most of the time. I’m not a loner a lone wolf. I’m not antisocial. It’s just that I don't want my frustration...I don't want to share my sickness with other people. I don't want them to experience what I’m experiencing. When people haven’t done anything wrong to me why should I blame other people for what they didn't do to me. You know?” (Joe)

I Want To Be Fit and Healthy

Many of the participants said that leading a healthy and active lifestyle was an important part of their recovery. They spoke about health-related topics such as engaging in exercise, making healthy decisions and experiencing various health-related challenges. For example, Peter commented on the importance of exercise and how it could be used to combat health problems.

> "I cycle in my basement. It's an exercise machine and I do it to avoid getting other illnesses other than schizophrenia that I already have. I think it's an exercise that decreases my chance of getting diabetes, blood pressure, thyroid, and other illnesses."

Participants also linked exercise directly to performance in other areas of their lives. Brian, a competitive billiards player, mentioned how swimming increased his endurance during competitions.

> "I swim very slow but I enjoy myself. I try to learn the best way to swim without getting tired so that I can do more and more in order to get my lungs a little bit more healthy and my body a little bit stronger. I can perform better when I play pool. So instead of getting tired after the 4th or 5th hour I can easily, after that, compete for 7 or 8 hours without getting tired. That doesn't give me the right to tell others that I'm going to be better competitively but at least my health is better and my physical endurance is higher."

Meg also commented on how exercise has helped her take on more responsibility at work.

> "Well if you stay fit and healthy you perform better at work and at school. It's been proven I think. I feel more energetic and I feel that I can take more work than before when I didn't do that and I have to shed some weight anyways."

The participants also spoke about making better health decisions. For example, Bonnie talked about healthy food choices and how people need to take responsibility for what they eat.

> "We eat for health so we need to eat well. To be in good health, we can't eat whatever we want. We need to cook. I'll give you a typical example. You go to McDonalds and you buy and you buy so when you become fat, it's not McDonalds problem. It's your problem. You did not control what you ate but if you eat fruit, it's better for your health."

Joe also talked about how people with SCZ need to organize their lives and make health conscious decisions so that they can be living on their own in the community.

> "I knew that I had to branch out and be on my own so I had to organize myself. So I made a list of things that I have to do. Things I can do and things I cannot do. I can't smoke cigarettes. I can't drink alcohol and I can't do drugs. I have to eat three square meals a day and vegetables and fruits everyday. I can eat some junk food once a week on weekends. I can go buy a poutine or a hamburger cause it's not necessarily a bad thing. I pray everyday at night and that is how I organize myself."

Although many of the participants seemed to be aware of the benefits of a healthy and active lifestyle, they also revealed that following the doctors' orders and making healthy choices were often challenging. For example, they were aware of the adverse effects of smoking but continued to engage in the behavior anyway.

> "Smoking really helps me. It is very therapeutic for me. I know that my family doesn't approve, well, my sisters don't approve anyway. I find every time I smoke a cigarette I am so calm and it really helps me. They say the consequences outweigh the benefits but the benefits are really...I like it. It's something I can look forward to. It keeps me occupied." (Chris)

Similarly, many of the participants knew that alcohol mixed with medication could have adverse effects but they chose to drink occasionally anyways.

> "I went into the hospital because I got into a little incident. I was drinking alcohol and I was on the medication, which is not good. My mom found out and she called the doctor and the doctor said you have to get him to a hospital." (Joe)

Leisure and Life

The fourth and final theme was called 'leisure and life' because the participants spoke about the meaning of leisure and the role that leisure played in their lives. Specifically, they talked about what leisure meant to them, the leisure activities they engaged in and how they felt leisure linked to health and recovery.

Leisure is often understood in relation to time, activity, or the subjective perspective of the individual (Blackshaw, 2010). Participants reaffirmed this understanding as they shared their personal definitions of leisure with the PI. For example, several participants defined leisure in relation to free time or pastime.

> "Leisure is free time. Free pastime to anyone who has it. It's the things that someone likes to do most. That's probably it for me" (Brian)

> "Leisure is a pastime. It's free time. Time that you take for yourself." (Bonnie)

Participants also defined leisure as specific activities that they enjoyed engaging in.

> "Leisure means to me an activity that you enjoy doing. For example playing chess, reading books on how to be happy, or surfing the Internet." (Peter)

A few participants defined leisure in relation to subjective emotions experienced during leisure.

> "Leisure means you have a good time. For example, it means you have no attitude and the time passes, you feel good, and you are happy, and you like the people who are around you." (Carter)

Several of the participants spoke about having a significant amount of free time because they were not working or enrolled in school. Many participants found it challenging to fill free time appropriately. For example, Brian talked about how stressful free time could be.

> "So I have to create my own situation and try to get the best for me during the day you know. I think it's much harder than if I have to go to work. I am not working now. It's harder because it's more stressful. More stressful without knowing which hour I'm going or what I'm doing. I have to always think ahead a little bit. If I go to work, like I use to go to work for 8 or 12 hours shifts, you know I'm working. I know how I'm going to pass my day without doubt. So it's more easy for the brain."

However, some of the participants engaged in leisure activities regularly. Most activities were individual which may suggest participants seldom engaged in more social forms of leisure. For example, Meg talked about how she spent most of her free time alone.

> "On Saturday and Sundays I like walking in the park and going to the swimming pool. After I'm done making supper, during the weekdays when I work, I go on the internet and surf and I play video games. Usually I don't' do this with anyone but myself because I like to stay calm and alone."

On the contrary, Brian acknowledged his desire to go out and socialize with others but talked about how rarely this behavior actually occurred.

> "Well, my free time, I like to go out with friends and sometimes I go out to the cinema and play bowling from time to time. It's a nice experience for me … something new for

> me …bowling and the movies are always fun. But it happens rare though because most of my friends there are not too many and they are working right so otherwise I don't have people to go out with so that's why I fix my own program always."

Although many of the participants talked about engaging in different leisure activities, there seemed to be a lack of formal planning around leisure.

> "I don't plan. Like I said I wake up in the morning and I just tell myself ok, Joe, get up, go take a shower and when you're done your shower, eat your breakfast and when you're done with your breakfast, go take a walk. That's how I know...it just comes to me. I improvise." (Joe)

Francis also talked about the challenges of planning. For example, when asked how activities were planned, he said:

> "I have no idea! Planning I don't know. There are days when I am able to plan like today. You know how you see people out jogging, and you see them out there running with their Walkman, well, that is just not me."

Several participants were also aware of the potential health-related benefits leisure engagement can bring. They were able to identify a relationship between leisure and health as well as the type of impact it could have. For example, Peter talked about relationships between leisure and mental health.

> "Leisure is something that makes you happy. It makes your depression go away and leisure makes you get away from some mental illnesses like depression. When you do leisure, you enjoy your time. Someone who has depression can't enjoy his time because he is always thinking about how cruel life is and how sad life is. So when you enjoy your time doing leisure, you forget these thoughts and it has a positive affect on your brain.

Similarly, Chris talked about how leisure could potentially relieve stress:

> "Yes, leisure is very therapeutic for health. It relieves stress and you need it. If you don't give yourself a break, your mind tends to not change and you know it deflates you. You know if your mind was too stimulated and you need time to take it back to normal, you need a sense of relax so yeah."

Stewart commented on how leisure increased his happiness and what type of effect that leisure had on his overall ability to function.

> "I think it's good for mental and physical health. I am kind of an example of it you know. Really, damn man, I breathe well when I do sports or leisure. I am more happy and I can manage more things. I can manage things longer you know. Have longer conversations or a longer walk. It's mental to eh. It puts something into your brain...kind of a euphoria you know? This is a good euphoria … let me tell you about that because I take things more simple for sure."

Discussion

This study explored the perceived leisure experiences of persons with SCZ to better understand the complex relationships between leisure, health and recovery in the community. The study findings suggest the participants engaged in goal setting to achieve a greater sense of community belonging, were less motivated to engage in leisure, were cognizant of the complex health issues surrounding SCZ, wanted to lead more healthy and active lives, and possessed fundamental understandings of leisure. The implications of these five research findings are discussed below.

First, similar to past research, the participants expressed desires to achieve a greater sense of normalcy and community belonging (Snethen et al., 2012). They discussed setting both short- and long-term goals to potentially help them to lead more 'normal' lives. However, many participants had substantial difficulties achieving the goals, given their current state of mental and physical health. The challenges associated with forming meaningful relationships, attending school, or finding a job left participants feeling disconnected and socially isolated (Harvey et al., 2010). Thus, the finding of lower social satisfaction scores on the LSM was not surprising, given that a majority of the participants spoke about a lack of friendship, social isolation, and individual leisure pursuits during the interviews.

Next, motivation was also a key part of the findings (Lloyd et al., 2007). Similar to past research, a lack of motivation may be a potential barrier to leisure engagement (Pieris & Craik, 2004). The LMS scores indicated that participants were less motivated to engage in leisure for social reasons. Yet, a lack of motivation to engage in leisure for social reasons is surprising given the fact that the majority of participant's social needs were not being met through leisure. For example, many of the participants spoke about wanting to develop more rewarding and meaningful relationships during the interviews. Similar to past research, the desire to develop more meaningful relationships may be based on 'ideal values that are linked to the expectations of others' and not a desire of the individuals themselves (Ponde et al., 2009 p., 337). Based on the discussions with our study participants, lower levels of social motivation may also be a direct result of (a) the effect that positive symptoms can have on social situations, (b) the impact of negative symptoms (e.g., anhedonia & avolition) on self-directed purposeful behavior (c) a lack of self-confidence in social situations, (d) limited social skills, or (e) limited knowledge about how to engage in new social situations. Failure to develop and maintain meaningful relationships may lead to increased feelings of learned helplessness and self-stigmatizing behavior, resulting in the avoidance of future opportunities to socialize.

Participants also seemed less motivated to engage in leisure to relieve stress or escape daily responsibilities. Lower scores in the stimulus avoidance section of the LMS suggest that participants may be more motivated to seek out active and engaging forms of leisure. Moreover, many participants spoke about challenging themselves and working to improve different life skills and personal abilities through leisure. These findings are positive as we continue to encourage all participants with a MHP to play a more active role in their leisure activities and in their communities. Interestingly, leisure participation may help persons with severe MHP to develop social skills, improve community functioning, and accomplish life goals (Lloyd et al., 2001; 2007). Thus, participants may benefit from LE interventions to (a) develop knowledge related to self-confidence and social engagement (Dattilo, 2008) and (b) acquire the necessary skills and competencies needed to combat the stress associated with increased community belonging (Lloyd et al., 2007).

Third, the findings support existing research that highlighted the complex health issues associated with severe MHP (Chugg & Craik, 2002). For example, participants spoke about the negative effects that SCZ had on their physical, mental, and social health. The complex nature of comorbid health issues may also pose unique leisure challenges for persons with SCZ and professionals who develop community-based leisure interventions (Harvey et al., 2010). For example, similar to past research, study participants discussed how the side effects of medication, increased weight gain, and pain had a negative impact on their ability to engage in physical activity and exercise (Chugg & Craik, 2002; Pieris & Craik, 2004). Moreover, hallucinations and negative body image issues also impacted their feelings of self-worth and ability to interact with others in the community. However, persons with severe MHP reported significant benefits related to physical and mental health, social connectedness, and identity formation after engaging in meaningful leisure activities (Iwasaki et al., 2010). Therefore, greater links between LE and health education may be required to enable our participants with SCZ to develop the necessary knowledge and strategies needed to address health concerns through leisure. A greater understanding of the potential for leisure to address health issues may lead to more active engagement in healthy leisure activities.

Fourth, the participants expressed sincere desires to lead more healthy and active lifestyles in order to prevent and combat complex health issues. Several participants identified links between exercise, healthy choices, and positive health outcomes (Faulkner & Sparkes, 1999; Pelham & Campagna, 1991). However, many participants also spoke about the challenges associated with making healthy decisions (Roick et al., 2007). For example, our study participants chose to engage in unhealthy decisions despite being aware of the negative health complications associated with substance use. This finding is not surprising, given substance use among individuals with SCZ is a ‘remarkably common phenomenon’ (Buckley et al., 2009 p., 394) and it may have a direct effect on leisure engagement. Persons with SCZ may choose to engage in leisure time substance use, which could have a negative health impact, or conversely, they may choose to avoid leisure opportunities all together where substance use is commonplace. Furthermore, similar to past research, our study participants talked about challenges associated with an excessive amount of free time (Lloyd et al., 2001). We suspect that substance abuse issues, coupled with an excessive amount of free time, may lead to a negative cycle of leisure engagement for persons with SCZ. Therefore, it is imperative that people with SCZ learn how to increase positive leisure time use and decrease substance use.

Fifth, similar to previous research, the participants spoke about the meaning of leisure and the role that leisure played in their lives (Ponde et al., 2009). More specifically, participants (a) shared their conceptual understanding of leisure, (b) discussed the specific leisure activities they engaged in, (c) talked about the challenges associated with leisure planning, and (d) spoke about relationships between leisure and health.

Many participants defined leisure as free time or as an activity they engaged in; a definition of leisure that Dattilo (2008) suggested may be problematic. For instance, there may be a misunderstanding between the concepts of leisure and recreation for some study participants. Recreation is a term often used to define an activity that a person engages in primarily for enjoyment and fun (Kelly, 1990). However, some activities that participants engage in may lead to feelings of frustration and failure (Dattilo, 2008). Therefore, these activities may lend to a negative view of leisure for our participants. Further, leisure defined as free time may minimize the ‘importance of leisure as an opportunity for fulfillment’ (Datillo, 2008 p., 5). People may devalue the idea of leisure if their free time is consistently boring and uneventful. Therefore, our participants may benefit from LE to develop a deeper understanding of the concept of leisure and its relationship to lifestyle habits.

Participants also talked about the specific leisure activities they chose to engage in. They shared stories of active and passive forms of leisure engagement. However, the majority of participants spoke only about engaging in individual leisure activities. This finding is also not surprising because persons with a severe MHP may find it challenging to engage in social activities (Harvey et al., 2010). Moreover, persons with SCZ, who chose to avoid social activities, reported higher levels of social isolation (Graham et al., 2002). Fortunately, Coleman and Iso-Ahola (1993) found social interaction and leisure-generated social support may play an important role in the health and recovery of persons with MHP. Thus, people with SCZ may benefit greatly from leisure interventions to develop social interaction skills and increased opportunities for social engagement.

Third, participants also discussed the challenges of leisure planning which is key to the development of a rich and satisfying leisure lifestyle (Stebbins, 2013). Limited leisure planning may be the result of a lack of formal planning skills or the inability to make individual decisions needed to engage in leisure experiences. Planning and decision-making skills are fundamental skills needed to engage in independent leisure (Dattilo, 2000). According to Mahon (2003), these skills can be taught to participants through well-tailored LE interventions. Moreover, participants can be included in the planning process, which may have a positive impact on perceived control (Kunstler & Stavola Daly, 2010). Participants who feel increasing amounts of control over their leisure may become more self-determined and they may be more inclined to take on increased amounts of leisure autonomy (Dattilo, 2000).

The participants also spoke about relationships between leisure and health (Ponde et al., 2009). Our participants linked leisure to stress relief, relaxation, euphoria, and decreased symptoms of depression. This finding suggests that participants have a fundamental understanding of the unique health benefits that leisure may provide for a person with SCZ. However, participants found it challenging to identify specific leisure activities that contributed directly to their own health. This finding may suggest that, while participants possess a conceptual understanding of the leisure-health relationship, they may lack the knowledge to use leisure activities to address their own health issues. Moreover, researching health issues (e.g. anhedonia) and leisure from an "embodied perspective" may help to provide greater insight into the complexity of the leisure - health relationship from the perspective of persons with a disability. Furthermore, none of the participants identified a link between leisure and social health which may be the result of limited social opportunities or a lack of understanding of how leisure can contribute to social health. Participants would therefore benefit from increased opportunities to engage in different forms of leisure to develop stronger links between leisure benefits and individual health needs.

Future Research

Future research recommendations are related to the role of participants' families, the potential relationship between caseworkers and leisure, and the design of community leisure interventions for persons with SCZ. This study explored the leisure experiences from the sole perspectives of persons with SCZ. The leisure experiences of other people directly involved in the participants' lives (e.g., parents, friends, significant others) could also be sought to gain insights into the attitudes and beliefs of leisure that family members and friends hold about people with SCZ. For example, relatively little is known about how family members and friends impact the leisure experiences of people with SCZ (Ponde et al., 2009). For instance, how do the leisure attitudes and beliefs of significant others guide and impact leisure engagement for persons with SCZ? How would self-determination and decision making be affected by the presence of significant others during leisure?

The potential relationship(s) between a participant's caseworker and leisure is also an important area to research. Caseworkers play an important role in the lives of persons with SCZ during recovery. These professionals spend a significant amount of time with persons with SCZ and they often act as a liaison between their client and other essential services (e.g., work programs, medical appointments). For example, caseworkers monitor individual health and well being, help the client to develop knowledge and skills related to recovery and work closely with other members of the treatment team to provide the best possible care (Adamou, 2005). To the best of our knowledge, leisure does not seem to be an area that caseworkers and participants always explore together. Thus, it would be important to gain a better understanding of the attitudes and beliefs of leisure that caseworkers possess and how those attitudes and beliefs may potentially impact the leisure lives of persons with SCZ recovering in the community.

Community leisure interventions for persons with a severe MHP are often challenging to design, develop, and facilitate (Harvey et al., 2010). Findings from this study suggest that our study participants may benefit from LE interventions to address leisure and self-awareness, social and leisure-related skills, improved health outcomes through active leisure and increased opportunities for social leisure engagement. These types of interventions may help to gain a deeper understanding of the complexities surrounding leisure and SCZ, address a lack of leisure opportunities for people with SCZ living in the community, and develop a stronger rationale to create autonomy support networks for all persons with a MHP living in the community (Harvey et al., 2010).

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Bridging Text

Chapter four employed a mixed-methods case study design to explore complex relationships between leisure and persons with SCZ from the perspective of individuals with the disorder. Questionnaire results suggested the participants were moderately satisfied with their leisure and motivated to participate in individual leisure pursuits. Participants were much less motivated to engage in leisure for social reasons but were concerned about limited social interaction. Still, they expressed a desire to develop more healthy social relationships. Participants spoke candidly about how serious physical and psychological health problems impacted their ability to lead active daily lives. They also shared hopes and dreams for the future and how they may engage in leisure to work towards improving health and well-being. This investigation led to a deep understanding of complex relationships between leisure and health for persons with SCZ which, in turn, set the stage for the production of a LE program. Chapter five investigated the implementation of the LE program for persons with SCZ or SAD living in the community.

Chapter 5

Leisure Education and Active Participation for Persons with Schizophrenia and Schizoaffective Affective Disorder

L.E.A.P.S.

Abstract

Leisure education programs may provide opportunities for persons with schizophrenia and schizoaffective disorder to learn or re-acquire leisure-related knowledge, attitudes and skills. Yet, approximately 50% of persons with schizophrenia and schizoaffective disorder have dropped out of leisure programs. A qualitative case study design explored the community leisure experiences and factors that impacted the participation in a 5-week leisure education program for 10 persons with schizophrenia and schizoaffective disorder. The program consisted of leisure education and recreation participation in the community. Three semi-structured audiotaped interviews were used over the course of the program to construct an in-depth picture of each participant's leisure experiences and factors that impacted program adherence. Thematic analysis of the data suggested an understanding of leisure, developing relationships, community engagement, and autonomy support were key to participation. This study offers a unique qualitative perspective for the factors that may impact adherence to community-based leisure for people with schizophrenia and schizoaffective disorder.

Introduction

Schizophrenia (SCZ) and schizoaffective disorder (SAD) are serious psychotic illnesses that may profoundly impact an individual's psychological, behavioral, and emotional functioning (American Psychiatric Association [APA], 2013). Individuals with these disorders may gradually develop a variety of clinically significant signs and symptoms during late adolescence or early adulthood (APA, 2013). For instance, they may experience a range of disorganized, positive, and negative symptoms (APA, 2013; Compton & Broussard, 2009). Disorganized symptoms are identified by a disruption in the normal flow of thought, speech, or behavior (Compton & Broussard, 2009). These symptoms may have negative impacts on goal-directed behavior and can lead to self-care impairments (Compton & Broussard, 2009). Positive symptoms are defined as something that has been added to an individual (e.g. hallucinations, delusions, paranoia) that people do not usually experience (Compton & Brossard, 2009). Negative symptoms subtract or remove something from an individual's normal everyday experience (Reid, Barker, & Smith, 2010). For example, a loss of interest or pleasure in life (e.g., anhedonia), a tendency not to care about what happens in life (e.g., apathy) and little to no sign of outward emotion (e.g., blunted/flat affect) are negative symptoms associated with SCZ or SAD (Reid et al., 2010). These symptoms are considered to have significantly adverse effects on the individual and they tend to be associated with poorer long-term functional outcomes (Compton & Brossard, 2010).

Individuals with SCZ or SAD may also experience increased feelings of anxiety (Daniel, 2010; Tandon, Nasrallah, & Keshavan, 2009), deficits in social cognition and anosognosia (APA, 2013). Moreover, people with these disorders are often at greater risk for unhealthy weight gain (Brown, Goetz, Van Sciver, Sullivan, & Hamera, 2006), cardiovascular disease (Citrome, 2005; Hennekens, 2007), diabetes (Alvarez-Jimenez, Hetrick, Gonzalez-Blanch, Gleeson, & McGorry, 2008), substance abuse issues (Buckley, Miller, Lehrer, & Castle, 2009) and lower levels of physical activity (Mason & Holt, 2012). For example, 90% of persons with SCZ or SAD dropped out of exercise programs within the first six months (Archie, Hamilton Wilson, Osborne, Hobbs, & McNiven, 2003).

Fortunately, leisure may play an important role in promoting mental health recovery (Iwasaki et al., 2014) and it may enable people with SCZ or SAD to lead empowered, engaged, and meaningful lives (Iwasaki, Messina, Shank, & Coyle, 2015). For example, leisure interventions may help to ameliorate anhedonia (Nathans-Barel, Feldman, Berger, Modai, & Silver, 2005), increase self-esteem (Corring, Johnston, & Rudnick, 2010; Wolfe & Riddick, 1984), improve recreational skills (Roder, Jenull, & Brennar, 1998), decrease body weight (Voruganti et al., 2006), enhance community functioning (Snethen, McCormick, & Van Puymbroeck, 2012) and assist people with SCZ or SAD to increase appropriate behaviors and decrease inappropriate behaviors (Finnell, Card, & Menditto, 1997; Morris, Card, & Menditto, 1999, Pestle, Card, & Menditto, 1998; Wong et al., 1987,1988).

Despite these potential health-related benefits, people with SCZ or SAD may be less likely to engage in leisure because they have, traditionally, not had the same opportunities to develop leisure knowledge and skills as people without a mental health problem (Nagle, Valiant Cook, & Polatajko, 2002). Since leisure engagement may be dependent on the acquisition and development of leisure-related knowledge and skills (Kleiber, 2012), persons with mental health problems (MHP) may need to acquire the leisure knowledge and skills required to adapt to the effects of their illness (Stumbo & Peterson, 2009). Leisure education (LE) programs may provide an opportunity for persons with MHP to acquire leisure-related skills, attitudes, and knowledge (Dieser, 2013). Therefore, it is important to explore what factors impact participation in a LE program for persons with SCZ or SAD. Thus, the following central research questions guided this exploratory study: How do persons with SCZ or SAD experience leisure in the community? What are the factors that may influence adherence to a LE program?

Leisure Education & Active Participation for Persons with Schizophrenia-Schizoaffective (L.E.A.P.S.)

LE is a developmental process that teaches various recreation and leisure-related skills, attitudes and values (Kleiber, 2012). It may develop self-directed, freely chosen, and intrinsically motivated leisure participation patterns (Dattilo, 2008). LE can introduce all people to leisure capabilities and the possibilities that leisure may hold for individuals to lead creative, healthy and active lifestyles (Kleiber, 2012). For example, Heasman and Atwal (2004) suggested LE played a significant role in enhancing the quality of life and social inclusion of people with MHP. Research has also suggested that LE may help people with MHP to improve and maintain social skills (Parsons, 2006), ease community reintegration (Mahon, Bullock, Luken, & Martens, 1996), increase perceive control over leisure (Pegg, 2003), decrease social emotional problems that impact leisure (Yang, Huang, Schaller, Wang, & Tsai, 2003) and cope more effectively with the distress associated with recovery (Rancourt, 1991). More specifically, persons with SCZ who engaged in LE reported an increase in the amount of time spent actively pursuing recreational activities, developed active strategies for coping with boredom and experienced positive shifts in their self-esteem and attitudes towards leisure (Roder et al., 1998; Wolfe & Riddick, 1984). Given these positive benefits, it is important to continue to explore the effects of LE interventions for persons with SCZ or SAD. A more in-depth understanding of the factors that impact participation and adherence in LE programs may help to develop strong LE programs for persons with these disorders. LE programs may be viable intervention approaches that may have positive effects on the community transition and well-being of persons with SCZ or SAD.

Program Description

L.E.A.P.S. was designed as a five-week exploratory leisure program consisting of LE and recreation participation in the community. The goal of the program was to develop community leisure experiences for persons with SCZ or SAD. The entire program consisted of 3 LE sessions, 3 community recreation activities and 1 follow-up session. Please refer to *Appendix N* (p. 205) for a detailed breakdown of the 5-week LE program.

Leisure Education Content Model

The Leisure Education Content Model informed LE sessions. Please see *Appendix O* (p. 206) for a copy of the Leisure Education Content Model that has been commonly used in the design of LE programs for diverse populations across various settings (Stumbo & Peterson, 2004). Leisure awareness, social interaction skills, leisure activity skills, and leisure resources were the four major model components that were considered as crucial to the enhancement of individual LE (Dattilo, 2008). The specific content selected for each session was tailored to individual participants and associated leisure needs from each major model component. Hence, a person-centered approach to LE was employed (Dieser, 2013). For example, the principal investigator (PI) spoke with each program participant about leisure knowledge, past leisure experiences, leisure interests and leisure needs. This information was then used for the planning of LE sessions, preparation of community leisure activities and provision of information resources for follow-up sessions.

LE Sessions

Three 45-minute sessions took place during the first, second, and third week of the LE program. Each session was conducted individually in a private office at the outpatient clinic on the grounds of the institute. Sessions focused on leisure awareness (e.g., week 1) (See Appendix P, p. 207), social skill development (e.g., week 2) (See Appendix Q, p. 210), and community leisure resources (e.g., week 3) (See Appendix R, p. 213). Results from a previous study, conducted at the clinic prior to the development of L.E.A.P.S., identified these three content areas as important leisure needs of people with SCZ or SAD (Wilkinson, Harvey, & Tabbane, 2016). Discussions with clinical case managers and the senior psychiatrist of an outpatient unit for people with SCZ or SAD also confirmed these key content areas for participation in community activities.

Each LE session consisted of a specific content goal, leisure information and several questions to better understand the leisure knowledge and experiences of people with SCZ or SAD. A similar process occurred for each of the three LE content areas. For example, the goal of the first session (e.g., leisure awareness) was to learn more about leisure, potential advantages and disadvantages of leisure engagement, and individual leisure habits. First, the PI and each participant were expected to share their own unique definitions of leisure as well as the potential advantages and disadvantages of engaging in leisure. Second, the PI asked the participants to speak a bit about themselves, individual daily routines and the recreation activities they engaged in. This discussion led to a better understanding of each individual's leisure repertoire. The PI then asked each participant to share their beliefs about leisure and what they felt was important about leisure in their lives. Finally, the PI engaged in a conversation with each participant about decision-making and the role that choice may play in deciding one's leisure. The participant was further provided with an opportunity to apply their decision-making skills. For example, each participant's final task for session one was to identify 10 community recreation activities that she or he would be interested in participating in. The list was created in rank order from most to least desirable. The PI then collaborated with each participant to choose and schedule three community recreation activities for participation during weeks 2-4 of the LE program.

Community Recreation Activities

Participants engaged in three individual community recreation activities with the PI. The PI and the participant identified the activity, located the destination and determined the appropriate route to take via public transportation for a community outing from the clinic. Participants were invited to accompany the PI back to the clinic once the activity was completed or they could choose to go directly home from the activity. Examples of community activities included a nature walk, bike ride, visit to the museum, yoga, a movie, and billiards. Community activities took approximately 2-3 hours depending on the nature of the activity and distance from the clinic. The research team covered the cost associated with each individual activity. Hence, each participant incurred no cost for travel, activities, food, or beverages.

Follow-Up Sessions

Each participant was asked to attend an individual follow-up session at the end of the LE program so that she or he could be provided with a LE summary document and a leisure resource file. The summary document included a synopsis of the participant's views on leisure, past community leisure involvement and recommendations for future leisure engagement. It also included each participant's views towards social experiences, a past history of social leisure activities and recommendations to identify and attend future social leisure opportunities in the community. The PI and the participant reviewed each web-resource and the PI answered any questions the participant had about accessing or navigating web resources. The PI also provided information about similar activities, based on the three community recreation activities, in the participant's own neighborhood. For example, if the PI and the participant attended a movie, the PI located movie theaters in the participant's neighborhood, provided information about the hours of operation, how to access those theaters using public transportation, and what the prices were to attend those theaters. Furthermore, the PI reviewed the original 10 recreation activities identified by the participant during the profile interview. Information was then provided to the participant about the seven activities that the PI and the participant did not engage in. For example, if the participant identified music as an activity, then the PI provided a list of potential musical events or music classes that the participant could attend. Moreover, the PI provided information about location, accessibility, costs, and scheduling. Each follow-up session took 35-45 minutes to complete and was conducted in a private office in the outpatient clinic.

Method

This research study employed a case study design because it explored a phenomenon and the real-life context in which it occurred (Yin, 2003). Hence, this study explored the community leisure experiences of persons with SCZ or SAD and attempted to gain an in-depth understanding of factors involved in adhering to a LE program for persons with these disorders.

Participants

Participants were receiving outpatient services at a psychotic disorders program from a mental health institute located in a major city in Quebec, Canada. The program was serving approximately 800 clients who, in turn, were followed by 21 case managers at the time of this study. Clients, who received service from the program, were recovering in the community. Based on the level of care and services required, case managers worked with senior psychiatrists to provide services to the clients in the community or at the clinic. Case managers spend a significant amount of time with clients and they often act as a liaison to other essential services. For example, case managers monitor individual health and well being, help the client to develop knowledge and skills related to recovery and work closely with other members of the treatment team to provide the best possible care (Adamou, 2005).

Approval from the institutional research ethics board was obtained before any communication was established with potential study participants or any data were collected. Study participants were identified from the psychotic disorders program through the collaboration of a senior psychiatrist and clinical case managers. The PI initially presented the study to the clinical team and answered any questions that case managers posed. Individual case managers then presented the study to their clients to determine if they were interested in participating in the study. Interested clients were asked to meet individually with the PI in the outpatient clinic on the grounds of the institute. They were provided detailed study information and the expectations for both the participants and the PI. Each potential participant was provided with a copy of the consent form (See Appendix S, p. 216). The PI answered all study questions at that time.

The criteria for inclusion into the study were males and females who were (a) between the ages of 20-50 years, (b) French or English speaking, (c) clinically diagnosed with SCZ or SAD, and (d) receiving treatment from the outpatient clinic. Eleven adults originally agreed to participate in the study. One person dropped out of the study after the second week and before the start of week three. The participant was traveling out of town for two months. Ten adults with SCZ or SAD participated in the study (See Table 1, Appendix T p. 224). Nine males and one female took part. Eight participants were diagnosed with SCZ and two others were diagnosed with SAD. Seven of the participants identified as white, two identified as aboriginal, and one identified as Indian. All 10 participants were unemployed and received government financial assistance at the time that the study was conducted. The average annual income of the participants was approximately $11, 500 (Can). One participant had obtained a Bachelor of Arts degree, two had high school diplomas and seven other participants did not complete high school education. None of the participants were married and they all self-reported as being single. One participant reported being married previously and having two children who were now in their mid-twenties. Nine participants reported having no children. Five participants were residing in an assisted community living arrangement, three were living with family members, and two were living on their own. Information pertaining to medication status was not obtained or reported for the purposes of this study. The rationale behind this decision was that we did not want the use of medication to lead our views of participant behaviour from a positivistic perspective.

Data Gathering

Profile Interviews. A profile interview was used to capture demographic information and begin to understand the leisure knowledge and experiences of each participant. (See Appendix U, p. 225) This information helped to develop and shape the LE content that was used for the L.E.A.P.S. program. Demographic questions were used to address participant age, sex, level of education, employment, income level, marital status, family status, and current place of residence. Leisure questions were used to gather information on the participant's leisure knowledge and participation. These questions included: What does the word leisure mean to you? What do you do during your free time? What types of new leisure activities would you like to try? What may prevent you from trying a new leisure activity?

Audiotape Interviews. Three semi-structured audiotape interviews were conducted to construct an in-depth picture of each participant's leisure knowledge, community participation, and experiences in the L.E.A.P.S. program. The semi-structured interview process was similar to an everyday conversation, enabling for flexibility in participant responses (Jackson, Drummond, & Camara, 2007). The semi-structured interviews occurred at the beginning of program weeks two, three, and four. Each interview was designed to explore the community leisure experiences of the participants and identify their impressions about the LE sessions and community outings. This information allowed us to better understand how the participants experienced leisure, what factors they enjoyed, and what the participants would change about the program. Some of the interview questions included: Can you please tell me how you feel about leisure? Can you please tell me how you feel about social situations? Can you please tell me how you feel about community leisure activities? Last week we went on an outing. Can you please describe your experience during this outing? What did you like about this outing? Why? What did you not like about this outing? Why? What if anything would you change about this outing? Why? (See Appendices V, p. 226, W, p. 227, X, p. 229) for all three interview guides. Member checks were also conducted throughout the interview process. For example, the interviewer discussed each response with the participant to make sure that the information reflected what she or he wished to say.

Data Analysis

Separate thematic analyses were conducted to analyze responses from the leisure profile interview and three audiotape interviews respectively (Braun & Clarke, 2006). The data sets were not combined for analysis. First, the PI made hand-written notes for the leisure profile interviews and transcribed each audiotape interview verbatim. He read both sets of transcripts several times for familiarity with the texts. Next, each entire data set was then examined and initial codes were identified. Third, individual codes were combined and placed into potential themes for each analysis. Potential themes underwent a review process and a thematic map was developed to help organize the data sets in phase four. Phase five consisted of ongoing analyses to refine each theme and generate clear thematic names and definitions (Braun & Clark, 2006). Finally, the PI identified different data extracts to write this story about the community experiences of persons with SCZ or SAD in LE and associated program adherence.

Results

Leisure Profile

This profile interview information shaped the LE sessions on leisure awareness, social skill development, and community leisure resources. All names and places used in this text are pseudonyms to ensure participant anonymity and confidentiality.

Leisure Means Activity

Most of the participants possessed a basic understanding of leisure and they defined leisure in relation to the types of activities they engaged in.

> “Leisure means doing activities and spending time walking or going to the park or watching movies.” (Mia)
>
> “Leisure is your preoccupation. It is something you do everyday. It could be just about anything like walking or arts and crafts.” (Roger)

My Activities Are Mostly Passive

Participants discussed different activities that they engaged in during their free time. The majority of activities were passive and occurred at or around home. For example, Jimmie talked about how his anxiety often kept him at home.

> “I draw or paint once per month. I have lots of excessive thoughts. I deal with lots of anxiety so I don't really do much else.”

Similarly, Roger expressed that he spent most of his time at home on the internet.

> "I've lived in the same place for a long time and I practically never go out. I am on the net a lot. I use to dream of having a computer. What's on-line fascinates me. I spend a lot of time on-line now."

Paul also talked about how he spent most of his time engaged in passive activities.

> "I play chess on the computer. I go on the Internet and sometimes I go to the library to read."

A New Leisure Activity?

Some participants found it challenging to identify a new leisure activity that they would like to engage in. For example, Brett spoke about new activities that he may potentially be interested in: 'If the activities are new then how do I know them?' Marsellus mentioned: 'New activities? I really don't know about new activities.' Jules said, 'I don't really know. Pool maybe?' However, a few of the participants identified and discussed new activities to engage in.

> "I would like to go to the zoo or go to places that I can't afford. I would like to go to restaurants more or go to the movies more." (Vincent)

> "There is one thing that I have been focused on and that is initiating a walk everyday. That would be great." (Roger)

Nothing Is Going To Stop Me Now...Except

Four participants said 'nothing would prevent me' from taking part in a new leisure activity. The remaining participants identified different issues they felt might prevent them from engaging in a new activity. For example, Lance was concerned about not having the knowledge to engage in leisure or someone to accompany him.

> "Not knowing how to do an activity would prevent me. Not knowing how to exercise. I would also like some company to do the activities."

Similarly, Jimmie expressed that he was unsure how to become engaged in new activities.

> "I find that I am not participating because I didn't participate much all my life. I really don't know how to participate. So for now I have some activities at my place. I am very much alone and I want to learn how to participate. I think I came to this research project wanting some feedback to come back to me to say, well, this is how we suggest you can improve your leisure repertoire."

Marsellus and Paul cited personal health problems as potential issues preventing engagement in new activities.

> "My illness would prevent me from doing a new activity." (Paul)

> "I guess weakness and pain from accidents would prevent me." (Marsellus)

Vincent mentioned daily scheduling and financial constraints as potential issues that may prevent him from taking part in a new activity.

> "Time and my schedule because I have many hospital visits. Budget also. I would try everything if budget did not matter. I would go to a movie everyday."

Finally, Roger mentioned how he was not really motivated to engage in a new activity because he was satisfied with his current routine and passionate about his current activities.

> "I have been doing the same thing everyday for a long time. I like arts and crafts. I could build small things out of wood. But will I be happy? I am the type of guy who likes the net and I like to play bridge. I have a passion for that."

Interview Data

Four main themes were identified through thematic analysis of the audiotape interviews. The 'you need leisure in your life', 'relationships are complicated', 'leisure in my community', and 'I really believed you helped me' themes emerged. The participants discussed their community leisure experiences and factors involved in adhering to a LE program. Each theme is described in detail below with references made to specific passages from the interview text.

You Need Leisure In Your Life

A majority of the participants were enthusiastic about leisure and felt it played an important role in their recovery. Participants spoke about the positive relationships between leisure and health and how leisure presented opportunities to engage in self-awareness and decision-making. They spoke candidly about the positive impact that leisure had on their health. For example, Paul, a 23 year-old who was recently diagnosed with SCZ, felt that leisure engagement provided a distraction from being ill.

> “Leisure is something that makes you forget about your problems and your sadness. It gives you a chance to enjoy what you love doing. It makes me forget about my illness and my sad thoughts. It makes me concentrate on the activity that I am doing. So that's what I like about it.”

Similarly, Winston, who was 35 years-old and busy with job interviews as well as clinical appointments, felt that leisure provided him an opportunity to decompress.

> “I enjoy leisure in general. That’s the reason I do it. If I don't enjoy it, I stop doing it. I like to take walks personally to clear my head because I am taking antipsychotic injections. I am taking happy pills and sleeping pills and it stresses my immune system quite a bit. It’s stressing my stomach also. It’s always good for me to get out, get some fresh air, and clear out my head.”

Participants also identified a positive link between leisure and individual health. For example Mia, who was 36 years-old, discussed how leisure helped her to stay calm.

> “Leisure is good because we do activities and it keeps our mind busy. It helps us to stay out of trouble and it keeps us feeling good and we stay calm.”

Marsellus, who was 48 years-old and lived with MHP for most of his life, talked about how leisure has helped to bring joy into his life and the positive impact that it had on his health.

> “Leisure is joy. It brings joy. You know you are happy. You are in good health and you have less pain. For sure if you play sports you can be injured but you have less of a risk of catching a sickness like cardio problems or respiratory problems.”

Participants also talked about how leisure presented an opportunity to engage in the practice of self-awareness. For example, they spoke about how self-awareness helped to define them personally and shape their leisure.

> “Self-awareness builds confidence. It actually shows you what you like to do in life. So if you like listening to music, you know you like listening to music. It helps us to better

> understand who we are as a person and that is very important. Confidence, you know, is about saying you love this type of sport or this type of music and no matter what people say about it, you know in your heart its for you. So, technically, nobody can fuck with that." (Vincent)

> "Self-awareness is when I check myself in the mirror or mentally just to see if I am the right person for the place where I am going. I am trying to make it as easy as possible for everybody to have my company or if I have someone else's company I try to make it easy. I don't know how it's important but it seems like it's more socially expectable to have a presentable image I guess." (Winston)

Participants also felt that leisure provided an opportunity to make decisions. Several of the participants spoke about relationships between leisure and choice.

> "Leisure is a choice that you make on your own. If you don't choose to do leisure then you are not going to have fun. You decide what you want to do so that helps." (Paul)

> "What does leisure have to do with choice? It's a personal choice as to what you do with your time. Making decisions is important because it defines your leisure. It helps you to prepare to do a leisure activity." (Jimmie)

Similarly, Vincent felt that choice helped to define what leisure is:

> "Decision making (pause) marks the fact that you really want to do something. Choice is about your habits and your taste. It's (choice) the difference between leisure and recreation right?"

Relationships Are Complicated

Many participants spoke about the challenges associated with establishing personal relationships in their lives. They were clearly aware of the importance of developing relationships, provided ideas about how to develop and maintain relationships, and voiced some concerns about relationships. For example, many participants identified relationships as being an important part of one's life.

> "Relationships are important. They can open doors for you. In life if we know more people, we can have more friends and we can know more things." (Brett)

> "Relationships are important because you get to share part of yourself with someone else, which in turn builds confidence. It builds trust. It builds communication. More importantly, it builds a willingness to be part of society." (Jimmie)

> "Relationships are important and so is love, especially when you are young. When you get older, it seems that road is harder to go down and you may have to live in solitude until the end." (Marsellus)

Participants also discussed important steps to developing and maintaining relationships. For example, they talked about establishing trust when developing a relationship.

> "To build a good relationship, it takes a lot of trust and it takes a lot of understanding and sometimes it takes sacrifice. You know? It takes compromise and it takes a willingness to get to know someone." (Jimmie)

> "Trust! I think trust is the most important thing. It is the foundation of all relationships." (Vincent)

Participants also talked about the importance of communicating your needs and understanding the needs of others when maintaining a relationship.

> "Communication is an important tool between two people. The clearer the communication, I find the better it is because the wants and needs are communicated clearly. There is no misperception or misunderstanding if communication is clear at all times. So communication is very important I find." (Winston)

> "Communication is important because if you don't communicate your needs, it's not very good. I believe that the most important thing to do in life is to advise people about your needs and those things are very realistic." (Roger)

Despite providing positive ideas about how to develop and maintain personal relationships, participants seemed to avoid initiating relationships with other people. For example, when we talked to Jules about starting new friendships, he expressed how others should approach him: "Well if others would come talk to me, we would probably be friends". Winston also talked about how he had been unsuccessful when approaching others and how he lets people come to him.

> "Usually people meet me for some reason in my life. I get enough attention like that. If I really want to meet somebody and I approach them, I am not always successful at that. I let life come to me."

Jimmie expressed a willingness to initiate relationships but also found it challenging when it came time to approach others.

> "The willingness is there. You know if a person approaches me and starts talking to me it's much easier. I practically never approach someone and start a conversation. That is something I don't like about myself. I have to work on that Quentin. I really have to work on it because I am creating barriers within myself."

Further, when we talked to Mia about how she could develop a relationship with others, she expressed that she does not approach others and others do not approach her.

> "By introducing yourself to somebody but I am not introducing myself to people, Quentin, I'm not. People in public are not talking to me either."

The participants also discussed concerns about maintaining relationships. For example, they were not comfortable with sharing personal information with others, including those people they may consider friends.

> "Social situations are complicated. There is a lot of information going on. People talk. Certain things you want to keep a low profile on. These things might actually become part of somebody's conversation." (Vincent)

> "I think it's important to not talk about personal questions with a friend. It could have an impact on your friendship. You should not talk about how sad your life is or about all your problems because he or she will get sad." (Paul)

Participants also expressed concerns about not being able to live up to the social expectations of others that, in turn may impact their ability to maintain relationships.

> "Sometimes someone makes a mistake and you get into a fight or argue. I don't like when people get angry. People get so angry for little things." (Jules)

> "We can't always be to another person what they want. There are times when we find out that we are not compatible with someone. Then there is the separation and the anxiety that follows and the depression that follows. I have had friends and I've lost friends." (Jimmie)

Leisure In My Community

Most participants were aware that leisure activities were available through their community. They identified a link between community leisure and socialization and also provided strategies about how to join into community groups. However, many participants chose not to engage in community leisure activities for a variety of reasons. For example, they spoke about how community leisure activities could positively impact socialization.

> "Well, community leisure activities are activities that make you forget about your personal problems. It helps you to make new friends and it relaxes you." (Paul)

> "Community leisure activities are good. They are activities where you meet people and you do an activity. It occupies your time and it keeps you out of trouble." (Mia)

Participants also provided strategies about how to successfully engage with community groups. For example, Vincent suggested how he would join a group:

> "I would talk to one of the people in the group and ask questions. How could I join? Do I have to pay membership? I would ask that."

Similarly, Roger spoke about appealing to different members of the group to gain access.

> "If I had to join a group, I would try to find people in the group that I would be more capable and more comfortable to go forward with. I would like to be introduced first to the person because you can't just go and skip into a group like you want. You got to be accepted by the group. You see usually groups are formed with certain kinds of people and, usually in a group, there is always a person that is the head."

Mia discussed potentially signing up for different groups through various organizations in her community.

> "You join a group when you sign up. When you sign up with somebody, you join a group. In the community there's councilors, there's community workers, there's resource centers or centers for Club Ami, and there are centers for activities that I can sign up for."

Jimmie also spoke about joining a community group with the help of an organization.

> "How do I join into a group? Well, I would say if it wasn't through a friend, it would have to be through an organization. Lets say it's the YMCA. You can call them and you

> arrange a time to speak to them or to meet with them to converse and exchange ideas and plan an activity. Plan an activity through the support of others."

However, many participants chose not to become involved with these groups. For example, Vincent was not interested in joining a community group:

> "No because I am a shy person. I am not socializing as much as I use to. I guess I do solo things like going on the Internet, going to the movies by myself or going to the library by myself."

Similarly, when asked if she would like to meet new people through one of these groups, Mia said:

> "Not at the moment, Quentin, I am fine with my swimming and gym. I have enough with that. There is no other leisure activity that I want to get involved in."

Marsellus and Paul also found it challenging to join groups since they were not working or enrolled in school:

> "That's what's hard now. Before it was easy to make friends at school or when I worked. But when you don't work, it seems like you can no longer join into a group...its tough." (Marsellus)

> "Well, most people find their friends if you are studying at school or if you are working at work. That's the law of society. You can't be waiting for a bus and say 'hey I want to be your friend'. It doesn't work that way." (Paul)

Yet, one participant provided an example of how he recently joined into a community group:

> "Well, I expressed my interest in hockey lately and I decided to play at the age of 35. I was very outgoing and I opened my heart and introduced myself. What I'm all about and why I am at the hockey rink. I also made a small party after and invited everybody to my place. It was a good experience. So what I usually say. I communicate my needs that I need to exercise and wants that I like to play hockey as part of exercise and many people welcomed that. They were very open after because I was very open at first." (Winston)

I Really Believe You Helped Me

Feedback from participants about their experiences in the LE program was predominantly positive. Participants enjoyed engaging in the community activities and learning about leisure.

For example, when we asked participants to provide feedback about the community outings, they seemed to enjoy their experiences and sharing in those experiences with the PI.

> “You know we decided to play billiards for an hour and the hour was good enough for me. I felt ok. It was not a stressful environment. I was able to concentrate on the game. I liked it. It was ok.” (Vincent)
>
> “The food and the company was good. I feel secure with you so it’s a plus. I am opening up much more to you than I have even to my case manager. She has experience as a psychologist. Dr. Strange has experience as a psychiatrist but I have never truly opened up like this in a longtime. So it takes someone to me special like you.” (Jimmie)
>
> “I really appreciate what you are doing for me. It’s helping my morale. Stop thinking that everything is over. You know, even if its’ difficult there can be a light at the end of the tunnel.” (Marsellus)

Participants also spoke about how they enjoyed learning about leisure or about leisure opportunities in the community:

> “I just have a small comment in that it is very good to learn about leisure. Since I met you, I have identified the sources where I can exercise leisure. I know how to go about it and I know what it is like to experience leisure thanks to you.” (Winston)
>
> “I learned that you can rent bicycles from the borough or from the city. I don’t think it’s just the borough. It’s everywhere and go and drop it at any of the stations or whatever so yeah.” (Paul)
>
> “I enjoyed talking about exercise and movements of exercise. I love talking about that.” (Lance)

However, participants were not so forth-coming with their concerns about participation in the LE program. When participants were asked what they did not enjoy about the sessions or the community outings, most of them said “nothing”. Furthermore, when asked if they would change anything about the sessions or outings, most participants also responded with “nothing”. However, a few of the participants did share some of their concerns. For example, when Vincent was asked what he did not like about the outings, he responded:

> “Transportation. Metro and bus. It’s not so bad but I don't’ like waiting to get to the destination.”

Vincent also expressed that he did not enjoy having to wait to engage in one of the activities once we arrived at the destination. “I did not like the timing because we had to wait until 5:00 pm.” Brett expressed how he found it difficult to make conversation once we were alone.

> “Sometimes I don’t know what to say so, sometimes, its like ok! But I don’t know what to say sometimes I don't know.”

Brett’s initial comments were interesting because, when asked what he did not like about the final outing, he expressed that he would have liked the chance to talk more.

> “We watched a film. The film was good but I was waiting for more. We are next to each other but we did not talk because it’s a movie so it’s ok. That’s what I felt. There was not a lot of talking. It’s a movie.”

Finally, Jimmie spoke about the hard time that he initially had being out in the community with other people.

> “I don’t know. It wasn’t because we were outside that I minded. I just felt it was a bit too open. But when I am in a closed or more closed in a situation, I find it is just as bad if not worse. I don’t like people around me much. I can’t concentrate because when they are talking I am listening to what they are saying. I am going to try and talk at the same time but about something else to a different person. It’s like...it's a bit of a queasy...it feels a bit strange to me.”

Discussion

This research study explored the community experiences of persons with SCZ or SAD in LE and associated program adherence. Study findings suggested that participants possessed a fundamental understanding of leisure, felt positive towards leisure and the role it played in their recovery, and identified leisure as an opportunity to engage in self-awareness and decision-making. Many participants also mentioned significant challenges associated with forming personal relationships in their lives. Despite being aware of community leisure opportunities, many participants seemed unmotivated to engage in community leisure activities. Finally, participants spoke about the factors involved in adhering to the L.E.A.P.S. program. These six research findings and their implications are discussed below.

First, participants shared their understandings of leisure and spoke about leisure engagement. Similar to past research, many participants discussed leisure according to the specific types of activities that they engaged in (Craik & Pieris, 2006). Given the wide age range of the study participants (e.g., 20-50 years), a number of various leisure activities were mentioned. This finding was expected because leisure participation and knowledge may vary due to age differences and past experiences (Shaw, Liang, Krause, Gallant, & McGeever, 2010). We were sensitive to these age-related differences when interpreting the interview data. Additionally, a majority of the leisure activities were passive (McCormick, Snethen, Smith, & Lysaker, 2012). The participants further spoke about factors that may have prevented engagement in a new activity. Similar to past research, they identified a lack of knowledge, insufficient finances, time and health as constraints to leisure participation (Pieris & Craik, 2004). However, the majority of participants suggested they were open to learning about new leisure activities. Therefore, our participants may benefit from regularly scheduled drop-in LE sessions that identify new leisure activities, address potential leisure constraints and reinforce adherence to LE programs.

Next, similar to past research, the participants felt positive about leisure and the role it played in mental health recovery (Iwasaki et al., 2015). More specifically, they talked about (a) positive relationships between leisure and health, (b) leisure as an opportunity for self-awareness, and (c) the role of decision-making in leisure. They also spoke candidly about the negative effects of SCZ or SAD on mental health. Leisure engagement was viewed as a way of potentially relieving some of their complex mental health symptoms (Ponde, Pereira, Leal, & Oliveira, 2009). For example, similar to a qualitative study about leisure and people with SCZ (Wilkinson et al., 2016), the participants discussed how leisure provided a distraction from being ill and helped to reduce stress. Moreover, many participants spoke about enjoying current leisure pursuits and how enjoyment enhanced personal health (Corring, Lundberg, & Rudnick, 2013; Pieris & Craik, 2004). The experience of enjoyment may be of great significance for persons with SCZ or SAD, given the relationship between these disorders and negative symptomatology (e.g., anhedonia; Corring et al., 2010; 2013). Thus, persons with SCZ or SAD may greatly benefit from LE services that provide opportunities to experience pleasure every day.

Participants also felt that leisure provided an opportunity to engage in self-awareness. Many participants spoke about how leisure allowed them to reflect on their personal preferences in order to better understand themselves and build confidence through decision-making. Similar to past research, this finding may link to the idea of individuality and its relationship to well-being for persons with SCZ or SAD (Ponde et al., 2009). Participants further talked about added opportunities to make decisions in daily life through leisure. They spoke about choosing where, when, and with whom they engaged in leisure. Opportunities for decision-making in leisure may also help to positively impact self-efficacy and perceived control (Pegg & Patterson, 2002). Greater levels of self-efficacy and perceived control may also influence participants' motivation to engage in leisure. For example, previous research suggested that a positive relationship existed between leisure motivation and recovery (Lloyd, King, McCarthy, & Scanlan, 2007). Thus, persons with SCZ or SAD may benefit from opportunities to engage in leisure-related decision-making.

Fourth, similar to a qualitative study about leisure and people with SCZ (Wilkinson et al., 2016), the participants spoke about perceived challenges associated with developing personal relationships. They were aware of the importance of relationships, provided strategies about how to develop and maintain relationships and shared concerns around building healthy relationships. Participants viewed relationships as a way of finding happiness, increasing knowledge, building confidence, and avoiding solitude. They also suggested that trust, communication, and identifying the needs of others were foundational to the development and maintenance of relationships. However, many participants' expressed significant challenges associated with social functioning (Yanos, Roe, Markus, & Lysaker, 2008). For instance, they talked about concerns with divulging mental health information to friends and not being able to live up to the social expectations of others that, in turn, may be directly related to self-stigmatizing behavior (Corring et al., 2013). For example, persons with SCZ or SAD, who experienced stigma, developed negative views towards themselves and their abilities if they internalized the perceived prejudices of others (Watson, Corrigan, Larson, & Sells, 2006). Previous failure in social situations, coupled with the internalization of perceived stigma, may negatively impact self-esteem and the confidence to socialize for persons with these disorders (Yanos et al., 2008). Therefore, persons with SCZ or SAD who wish to learn more about social skills may benefit from a group-based social LE intervention. Group-based LE intervention may provide opportunities to develop relationships with others who have identified similar leisure interests in the community (Heasman & Atwal, 2004). Positive interactions and experiences, developed through a group-based social leisure intervention, may help to improve the self-esteem and social confidence of persons with SCZ or SAD (Voruganti et al., 2006).

Fifth participants were aware of opportunities to take part in community leisure activities. They identified links between community leisure and socialization. The participants also provided strategies for engaging in community groups. However, similar to past research, participants appear to have engaged infrequently with community leisure activities (Snethen et al., 2012). People with serious MHP, who try and reach out to community groups, may experience challenges due to a negative view of the individual's social skills, apprehension towards interacting with new people, concern over not sharing interests with others, and concerns about community leisure professionals and other service users (Heasman & Atwal, 2004). However, the idea of forming an autonomy supportive user-led community group may outweigh the potential risks of encountering stigma (Heasman & Atwal, 2004).

Sixth, participants discussed the factors involved in adhering to the L.E.A.P.S. program. Prior to the start of the program, eleven individuals from the outpatient clinic were recruited by the PI and consented to take part in the LE program and subsequent research study. Ten participants completed the program, resulting in a 90% retention rate that was substantially higher than similar recreation and leisure programs (47%: Heasman & Atwal, 2004; 50%: Roder et al., 1998) but resembled the retention rate in a more recent study (80%: Snethen et al., 2012). They identified the community outings, community support from the PI and leisure learning as key to enjoyment and involvement in the program. Most participants spoke about enjoying the time that was engaged in the community outings. The ability to experience enjoyment is often challenging for persons with SCZ or SAD given the nature of negative symptoms (e.g., anhedonia: Corring et al., 2010; 2013). Thus, this is a key finding that had a positive impact on our participants.

Participants also spoke about feeling more comfortable when engaging in leisure with the PI, a finding that is similar to past research (Snethen et al., 2012). More specifically, they spoke about feeling secure and enjoying companionship. The PI conducted an autoethnography as part of his doctoral dissertation. Reflections from this narrative afforded him an opportunity to focus on the importance of developing compassionate and caring relationships with each participant (Ziguras & Stuart, 2000). He knew it was important for each participant to feel comfortable and safe when participating in leisure out in the community. Thus, the PI wanted to engage the participant in a peer relationship where professional boundaries were more relaxed. It seemed this type of dynamic was well received based on the feedback that participants provided. They spoke positively about the relationships formed with the PI and openly shared their feelings when co-participating in leisure. Opportunities to engage in this type of co-participation may be beneficial to improving the social health of persons with SCZ or SAD and it may lead to involvement in mainstream leisure opportunities (Heasman & Atwal, 2004). The participants also identified a few concerns about participation in the LE program. These issues centered on the use of public transportation and wait times associated with activities. These challenges may potentially be addressed through the implementation of better scheduling and the use of private or subsidized transportation. However, one individual did express his concerns with being outside in an open public environment. Social anxiety is not an uncommon feeling for persons with SAD or SCZ (Pallanti, Quercioli, & Hollander, 2004). Perhaps issues associated with social anxiety or community engagement could be addressed through LE modules and/or the support of a leisure companion. Overall, participants seemed to enjoy their experiences in the L.E.A.P.S. program. Most individuals suggested they would participate in a similar program in the future.

Limitations

The current study was exploratory in nature and a number of limitations need to be addressed. First, the qualitative nature of the study limits the generalizability of the research findings. Thus, this study’s findings may not be representative of the leisure experiences of all individuals with SCZ or SAD. However, it is important to note that the leisure stories shared by our participants echoed the stories of other persons with these disorders (Ponde et al., 2009; Snethen et al., 2012). Second, the relatively short duration of the program may have lent to the significant retention rate of study participants. Previous research suggested that similar recreation and leisure programs experienced an approximate 50% drop out rate (Heasman & Atwal, 2004; Roder et al., 1998). However, future research conducted on a leisure program of longer duration (e.g., 10 weeks) may further our preliminary understanding of the issue of retention. Third, thematic analysis of the interview data was completed only after all three leisure modules and community outings were finished. Individual analysis after each module and outing may have provided an understanding of experience at each time period as opposed to an understanding of the intervention as a whole. Fourth, the study included only one female participant. The inclusion of a greater number of female participants may have also helped to better understand the leisure experiences of females with SCZ or SAD. Finally, the study did not include an additional follow-up to determine if the participants utilized the resources provided to them or if they had accessed any of the identified community leisure activities. An extended follow-up may have also added insight into the benefits of providing a leisure resource file or LE information sessions as well as understanding personal motivation related to community leisure opportunities.

Future Research

Future research recommendations are related to participant recruitment and retention, marginalization, addressing anhedonia through leisure, and the development of a formal clinical LE manual and social LE program for persons with SCZ or SAD. First, similar to research conducted in adapted physical activity, small sample size may pose substantial research challenges (Watkinson & Wasson, 1984). Future research needs to continue to develop strategies to recruit larger sample sizes (Sherrill & O’Conner, 1999). For example, a longer recruitment phase, a larger participation incentive, or a wider participant age range may help to address this issue. Next, additional research needs to be conducted on the LE program adherence of people with SCZ or SAD. This research study focused on the factors involved in the initial retention of program participants. Thus, future longitudinal research should explore the factors associated with program adherence over longer periods of time. For example, it would be important to investigate the role caseworkers may play in facilitating leisure for people with SCZ or SAD.

Third, similar to past research (Wilkinson et al., 2016), marginalization of persons with SCZ or SAD in leisure was found to be a key part of the story. Persons with these disorders often face additional challenges associated with community access and leisure participation (Nagle et al., 2002; Snethen et al., 2012). Future research should explore how different issues of diversity (e.g., poverty, stigma, access) intersect to impact community access and leisure engagement through a social justice lens (Harvey, Varriano & Wilkinson, 2016). Fourth, future research should continue to explore the role of leisure in ameliorating anhedonia. Similar to past research, our participants reported having fun and enjoying their experiences in the LE program (Bizub, Joy, & Davidson, 2003; Corring et al., 2010; 2013; Gimmestad, 1995). Hence, leisure opportunities that help persons with SCZ or SAD to experience pleasure and reduce anhedonia may help to promote community living through a recovery model approach.

Finally, future studies should explore the development of clinical LE manuals and social LE programs for persons with SCZ or SAD. For example, this study's findings will be transferable by informing the creation of an introductory LE manual to serve the outpatient clinic. To the best of our knowledge, leisure does not seem to be an area that is directly addressed in the outpatient clinic. A manual that provides information about leisure, affordances and barriers, community leisure opportunities and resources may be beneficial to people with SCZ or SAD and their caseworkers alike. For example, caseworkers would be able to inform people with these disorders about leisure affordances and potentially address perceived leisure barriers earlier in the recovery process. Hence, a manualized LE approach is recommended to guide people with

SCZ or SAD about community leisure opportunities where they may engage in different leisure activities. Research on the implementation of this type of approach may help to gain a deeper understanding of complexities surrounding leisure, community engagement, autonomy support, and persons with SCZ or SAD. For example, the development of autonomy supportive networks may establish an additional layer of community assistance and provide knowledge about and access to community leisure opportunities. Furthermore, persons with SCZ or SAD may be assisted to identify and make community leisure choices as well as engage in self-determined leisure behaviour.

The research findings may also assist in the development of a social LE program for persons with SCZ or SAD. Stigma, deficits in social cognition, and social anxiety can all have a negative impact on the social health of persons with SCZ or SAD. Recent research suggests that impairments in social cognition may be central features of these disorders and not merely a co-morbid issue (Martinez-Dominguez, Penades, Segura, Gonzalez-Rodriguez, & Catalan, 2015). Moreover, the relationship between social cognition and daily functioning appears to be more complex than originally perceived (Martinez-Dominguez et al., 2015). Therefore, persons with SCZ or SAD may significantly benefit from group-based leisure interventions to improve social skills, networks, and related support (Heasman & Atwal, 2004; Snethen et al., 2012). The development of these types of interventions may include both an in-person and web-based component to help program participants to connect socially in different ways. Research findings suggest that most of our study participants enjoyed spending free time on the web. A program that would allow participants to maintain contact through virtual check-ins or other forms of electronic platforms may help to encourage and strengthen social bonds. Perhaps this type of virtual intervention may help persons with SCZ or SAD to learn from and relate to the similar social experiences of other people with SCZ or SAD. More importantly, LE interventions may provide important opportunities for persons with SCZ or SAD to be a part of autonomy supportive networks to recover in their home communities.

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Chapter Six

Conclusion

This doctoral dissertation was comprised of six chapters. The first chapter presented an overview of the main research constructs and theoretical grounding for leisure as a research framework. Research suggests that leisure may play an important role in the health and community recovery of all persons with MHP (Caldwell, 2005; Iwasaki et al., 2010). Leisure may enable people with MHP to experience interest, enjoyment, and excitement. It may also help to promote meaning making and reduce boredom for people with MHP (Iwasaki et al., 2014). However, leisure interventions may not be included as part of the treatment process in community mental health clinics (Snethen et al., 2012). In fact, leisure is often understudied and underutilized in the community recovery of people with MHP, including people with SCZ or SAD (Iwasaki et al., 2010; Rudnick, 2005). Symptomatology, comorbidity, and socio-cultural issues (e.g. stigma, poverty, unemployment) may also intersect to create complex relationships between leisure and people with SCZ or SAD. Therefore, the purpose of this dissertation was to better understand these complex relationships, and utilize the knowledge attained in the three research studies, to develop and implement a LE program for people with these disorders. The specific objectives of this dissertation were to (a) explore the experiences of a doctoral candidate with MHP who was interested in learning more about these complex relationships, (b) explore the research design characteristics and outcome effects of leisure interventions for people with SCZ or SAD, (c) explore the community leisure experiences of persons with SCZ, and (d) develop and implement a LE program for persons with SCZ or SAD living in the community. These research objectives were achieved through a cohesive series of four original manuscripts that are presented as part of this doctoral dissertation.

Chapter two was an autoethnography that used a novel visual research method to explore the experiences of a doctoral candidate with MHP who was interested in learning more about complex relationships between leisure and persons with MHP. A narrative video journal helped the candidate to uncover some of his own feelings and assumptions about mental health research, and explore key relationships between leisure and MHP. Reflecting on these relationships helped to uncover some deeply rooted societal issues that may impact the lives of persons with MHP and associated implications for leisure participation. Moreover, the creative method led to the development of a novel research program to help understand and address these complex relationships.

Chapter three included a scoping review that identified leisure interventions for persons with SCZ or SAD. The review uncovered 16 leisure interventions that were designed for persons with these disorders. The focus of the review was to explore the research design characteristics and outcome effects of the leisure interventions. The 16 studies fell into either behaviour modification or leisure outcome categories. Results suggested leisure interventions may help people with SCZ or SAD to increase appropriate behaviours, decrease inappropriate behaviours, increase self-esteem and self-confidence, develop coping and planning skills, improve daily functioning, increase socialization, ameliorate anhedonia, experience enjoyment, increase community participation, and decrease body weight. (Barak et al., 2001; Bizub et al., 2003; Card, 1989; Corring et al., 2010; 2013; Finnell et al., 1997; Gimmestad, 1995; Morris et al., 1999; Nathans-Barel et al., 2005; Pestle et al., 1998; Roder et al.,1998; Snethen et al., 2012; Voruganti et al., 2006; Wolfe & Riddick, 1984; Wong et al., 1987; 1988). However, relatively small sample sizes, variations in study design, different outcome measures, and the use of varying treatment approaches made it challenging to draw any definitive conclusions about the effects of leisure interventions for people with SCZ or SAD. Thus, much more research needs to be conducted to provide additional support for the use of leisure and TR interventions in psychiatric rehabilitation.

Chapter four describes a mixed-methods case study design that explored complex relationships between leisure and persons with SCZ from the perspective of individuals with the disorder. Participants were moderately satisfied with their leisure and motivated to participate in individual leisure pursuits. They were much less motivated to engage in leisure for social reasons but were concerned about limited social interaction. Participants mentioned how health problems impacted their ability to lead active daily lives. They also spoke about how they may engage in leisure to work towards improving individual health and well-being. This investigation led to a better understanding of complex relationships between leisure and health of persons with SCZ which, hopefully, will lead to engagement in healthy and active community leisure opportunities.

Chapter five investigated the implementation of a LE program for persons with SCZ or SAD living in the community. Results from chapters two, three, and four helped to inform the development and implementation of the LE program that consisted of LE and recreation participation in the community. A qualitative case study design explored the community leisure experiences and factors that impacted the participation in a LE program for persons with SCZ or SAD. Program adherence was 90%. This finding is substantial as approximately 50% of persons with SCZ or SAD dropped out of leisure programs (Heasman & Atwal, 2004; Roder et al., 1998). Results from the LE program suggested an understanding of leisure, relationship development, community engagement, and autonomy support were key to participation. Future research should continue to explore how LE programs may help persons with SCZ or SAD engage in leisure and become a part of autonomy supportive networks in their home communities.

Chapter six provided a brief summary of the relevant research findings and future recommendations follow. The doctoral dissertation represents the start of a novel research program. For example, the initial study provided unique insight into the doctoral candidate's experiences with MHP and how those experiences have shaped his personal life and professional research. The review paper provided a comprehensive understanding of the types of leisure programs that have been conducted for persons with SCZ or SAD. To the best of our knowledge this scoping review paper is one of the first of its kind in the area of leisure and SCZ or SAD. The two subsequent studies were built on the information, retrieved from the literature review, and contributed to the knowledge base on the relationships between leisure and persons with SCZ or SAD in the community. The two papers provided substantial insights and links for the community leisure experiences and leisure program adherence of persons with SCZ or SAD.

Future Research

Future research is necessary to further understand complex relationships between leisure and all persons with MHP. This much needed work will develop as my research program continues to grow. Thus, a substantial amount of research is still needed to address several key issues that surround leisure and persons with SCZ or SAD. For example, the first manuscript helped to uncover some deeply rooted societal issues that may impact the lives of persons with MHP and associated implications for leisure participation. Intersectional social issues like poverty, joblessness, homelessness, substance abuse, stress, and stigma and their relationship to leisure participation need to be explored. Research in these areas may help construct a deeper and richer understanding of the intersectional social issues that impact people with SCZ or SAD (Harvey et al., 2016). This type of research may also enhance the daily lives of persons with SCZ or SAD. Researchers and practitioners may implement leisure to address the concomitant effects of these issues (e.g., stress) or provide levels of support (e.g. finances) that can help offset some of these issues directly. For example, the implementation of autonomy supportive networks may help people with SCZ or SAD to come together and form relationships that, in turn, may lead to the sharing of ideas about how to address joblessness, homelessness, or stigma. Moreover, it may provide support for people directly living with substance use and substance abuse issues. Future research should also continue to explore relationships between community recovery for persons with MHP and leisure. Research in this area may promote leisure as a viable intervention strategy to address some of the community transition and community recovery needs of persons with MHP.

Findings from the second manuscript (e.g., scoping review paper) also identified additional research areas to explore. Leisure interventions for persons with SCZ or SAD have demonstrated positive results. However, small sample sizes, variations in study design, different outcome measures, and the use of varying treatment approaches make it challenging to draw any definitive conclusions about the effects of these interventions. Future researchers should try to recruit larger sample sizes and compare different treatment approaches to help address some of these issues. Future research in this area should further investigate the role of leisure interventions for both long-term care residents and community mental health consumers. This line of intervention research may identify similar treatment intervention effects across settings or uncover differences in treatment outcomes that need to be studied from varying contextual perspectives. Furthermore, leisure research should specifically focus on the role that leisure may play in addressing specific symptoms (e.g. anhedonia) and functional deficits (e.g. planning). This area of research may help to provide clinical teams with information and strategies to implement non-traditional ways of treating people. In turn, this type of treatment could help people with SCZ or SAD to learn about and participate in novel activities of their own choosing. These types of activities may help people with these disorders to engage in planning, experience flow, optimize arousal, and socialize with others. Furthermore, physical activities may help people to address comorbid health issues like weight gain and lethargy.

Findings from the third manuscript highlighted the need for a better understanding of the role of family members, friends and caseworkers in the lives of people with SCZ. Research on family members and friends may help to develop insight into their attitudes and beliefs about leisure. Moreover, it may help us to better understand how those attitudes and beliefs impact the leisure lives and daily functioning of people with SCZ. The relationship between a participant's caseworker and leisure is also an important area to research because these professionals play an important role in the lives of persons with SCZ during their recovery. While leisure is often undervalued and underutilized in the recovery of persons with MHP, including people with SCZ (Iwasaki et al., 2010; Rudnick, 2005); it does not seem to be an area that caseworkers and participants always explore together. Therefore, leisure interventions in psychiatric rehabilitation constitute a key research area to further develop, implement, and study.

The fourth and final manuscript identified the need to develop clinical LE manuals and social LE programs for people with SCZ or SAD. Despite the positive results from our program, much more work is needed to further develop this important research area. For example, the creation of a standard practice manual may help to provide information to clinical staff about the use of leisure in the recovery of persons with MHP. This manual could potentially be provided to other clinics and researchers could study the feasibility and usefulness of this manual across settings. Research on the implementation of this type of manual may also help to gain a better understanding of complexities surrounding leisure, community engagement, autonomy support, and persons with SCZ or SAD. Future research should further investigate the development of social LE programs for persons with SCZ or SAD. The inclusion of social LE programs in community mental health clinics may help to address issues around stigma, social anxiety, and deficits in social cognition. This line of research may potentially explore, how these groups are created, what types of technology are used to facilitate the groups, and what role would these groups play in the larger treatment process. For example, research can compare LE groups in both inpatient and community settings to better understand effects on leisure involvement and socialization. Research may also track the development of these groups to understand how they develop over time and what role the leisure interventionist plays in their development. The use of technology to help develop these groups may be another area of research interest. Groups may meet in person or through the use of virtual meeting spaces. The development of on-line or social media tools may facilitate the cohesiveness, communication, and connectivity of groups in the community. Finally, it would be important to determine the outcomes produced for people with SCZ or SAD. Research to track the importance of these groups, effects on socialization, participation, health and community involvement may be key areas to explore. More importantly, the groups may provide key opportunities for people with SCZ or SAD to explore leisure, develop autonomy support, become part of a resource network, and play a valuable role in their community recovery.

In summary, this dissertation is comprised of a cohesive series of four original research papers to gain an in-depth understanding of complex relationships between leisure and persons with MHP. This dissertation will also serve as the foundation for my future research program. There remains a substantial amount of research to perform in order to promote greater amounts of leisure opportunities for people with MHP.

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Appendices

Appendix A - Research Process Illustration

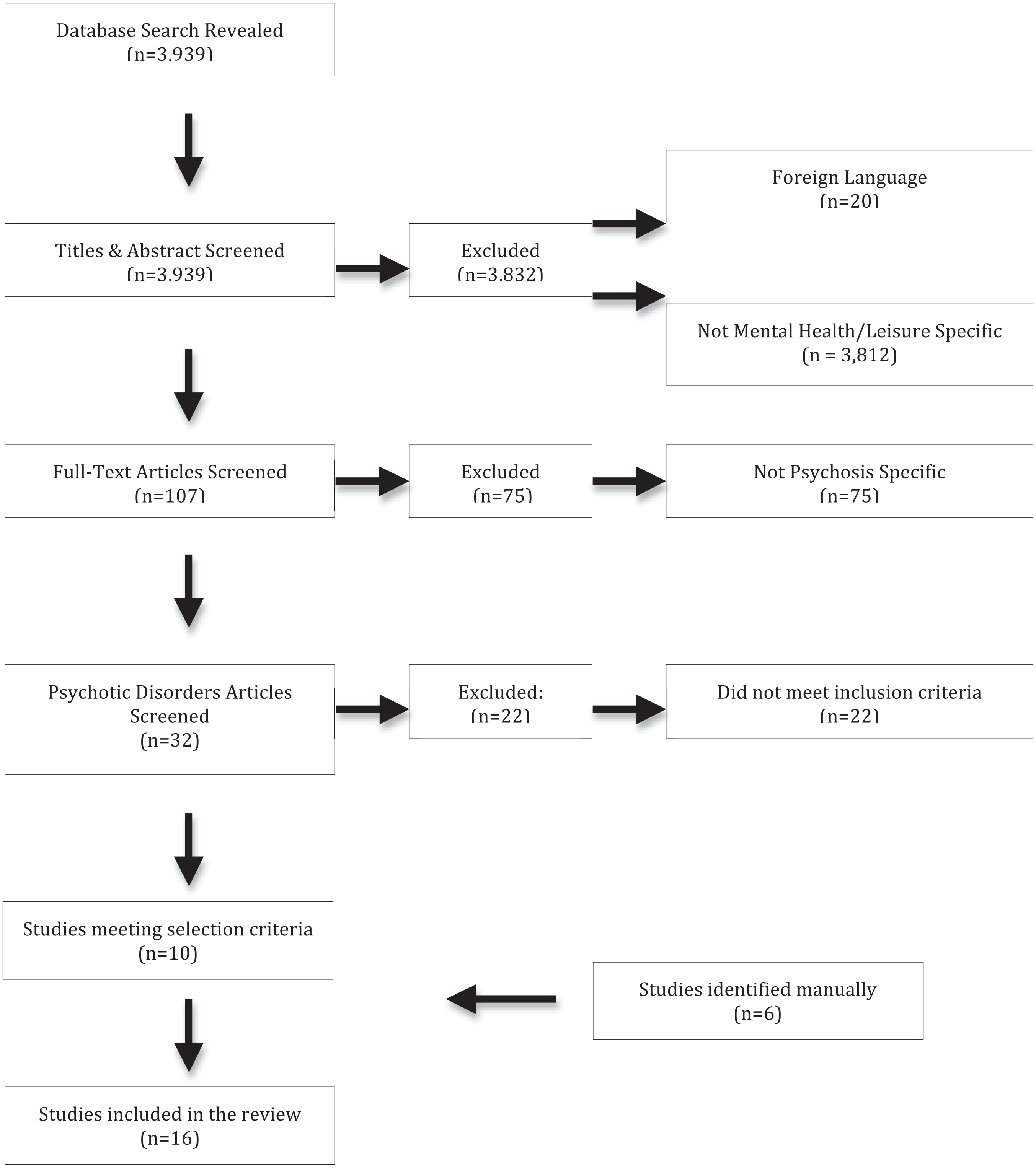

Figure 1. – Figure of the research article database search process. Articles included and excluded at each stage of the review process are included.

Appendix B

Table 1 **Research Design Characteristics**

Study	Sample	Research Design	Diagnosis	Treatment History
Wolf & Riddick (1984)	*N* = 16 M = 7, F = 9 Intervention Group (*N* = 8) (M = 3) Mean Age 45 Years (F = 5) Mean Age 54 Years Control Group (*N* = 8) (M = 4) Mean Age 31 Years (F = 4) Mean Age 58 Years	Non-randomized pre-post design	Schizophrenia	Previous Admissions (Y) Current Admission Length (NR) Medication (NR) Outpatient
Wong et al., (1987)	*N* = 2 M = 2 Age: P1 31 Years P2 37 Years	P1- A-B-A-B Design P2- Alternating treatment 3 Phases/ 2 Treatments	Schizophrenia	Previous Admissions (Y) P1 – 14 admissions in 12 years P2 – 4 admissions in 12 years Medication: Neuroleptics P1-Proxlin 10 mg P2-Navane 30 mg Inpatient
Wong et al., (1988)	*N* = 10 M = 10 Age Range 27-42 Years Mean Age 29.2 Years	Non-randomized alternating treatment design	Schizophrenia	Previous Admission (Y) Current Admission Length: (*M* = 5.3 Years) Medication: Neuroleptics Inpatient

Table 1 **Research Design Characteristics**

Study	Sample	Research Design	Diagnosis	Treatment History
Card (1989)	*N* = 6 M = 3, F = 3 Age Range 68-82 Years Mean Age 74.3 Years	Non-randomized time-series design	Schizophrenia	Previous Admission (NR) Current Admission Length: (*M* = 26.3 Years) Medication: Psychotropic Inpatient
Gimmestad (1995)	*N* = 1 F Age 36 Years	Case Study	Schizophrenia	Previous Admission (Y) Current Admission Length: (15 Months) Medication: Neuroleptic (Proxlin 25mg) (Cogentic 2mg) Inpatient
Finnell et al., (1997)	*N* = 6 M = 4, F = 2 Age Range 37-58 Years Mean Age 44 Years	Non-randomized post-only design	Schizophrenia Schizoaffective	Previous Admission (Y) Current Admission Length: (*M* = 6 Years) Medication: Psychotropic Inpatient
Roder et al., (1998)	*N* = 6 M = 3, F = 3 Mean Age 33.5 Years	Non-randomized intra-group design A-B-A- time sequence	Schizophrenia	Previous Admission (Y) Current Admission Length: (*M* = 12.5 Months) Medication: Neuroleptic Inpatient = 5, Outpatient = 1

Table 1 **Research Design Characteristics**

Study	Sample	Research Design	Diagnosis	Treatment History
Pestle et al., (1998)	*N* = 6 M = 3, F =3 Age Range 37-57 Years Mean Age 45.5 Years	Non-randomized time-series design repeated measures	Schizophrenia Schizoaffective	Previous Admission (Y) Current Admission Length: (*M* = 6 Years 4 Months) Medication: Psychotropic Inpatient
Morris et al., (1999)	*N* = 9 M = 5, F =4 Age Range 39-61 Years Mean Age 48.1 Years	Non-randomized post-only design	Schizophrenia	Previous Admission (Y) Current Admission Length: (3-14 Years; *M* = 7) Medication (NR) Inpatient
Barak et al., (2001)	*N* = 20 M = 6, F = 14 Mean Age 79.1 Years Intervention Group *N* = 10 M = 3, F = 7 Control Group *N* = 10 M = 3, F = 7	Randomized pre-post design	Schizophrenia	Previous Admission (NR) Current Admission Length (20-35 Years; *M* = 27 Years) Medication (NR) Inpatient
Bizub et al., (2003)	*N* = 5 M = 3, F = 2 Age Range (26-46)	Qualitative	Schizophrenia	Previous Admission (NR) Medication (NR) Outpatient

Table 1 Research Design Characteristics

Study	Sample	Research Design	Diagnosis	Treatment History
Nathans-Barel et al., (2005)	N = 20 M = 12, F = 8 Age Range (19-62) Mean Age 39.9 Years Intervention Group N = 10 M = 6, F = 4 Control Group N =10 M =6, F =4	Non-randomized pre-post design	Schizophrenia	Previous Admission (Y) Current Admission Length: (Minimum 2 Years) Medication: Antipsychotic Inpatient
Voruganti et al., (2006)	*N* = 54 M = 42, F =12 Intervention Group *N* = 23 M = 19, F = 4 Mean Age 32.04 Years Control Group *N* = 31 M = 23, F = 8 Mean Age 40.83 Years	Randomized prospective case-control pre-post design	Schizophrenia Schizoaffective	Previous Admission (NR) Medication (NR) Outpatient
Corring et al., (2010)	*N* = 6 M = 3, F =3 Age Range (25-49) Years Staff *N* = 6 M = NR, F = NR Age Range (NR)	Qualitative	Schizophrenia Schizoaffective	Previous Admission (NR) Current Admission Length: (2-81 Months; *M* =22.2) Medication (NR) Inpatient

Table 1 **Research Design Characteristics**

Study	Sample	Research Design	Diagnosis	Treatment History
Snethen et al., (2012)	*N* = 8 M = 5, F = 3 Age Range (24-57) Years	Non-randomized mixed-methods design	Schizophrenia Spectrum Disorders	Previous Admission (NR) Medication (NR) Outpatient
Corring et al., (2013)	*N* = 6 M = 4, F = 2 Age Range (36-59) ACT Staff *N* = 6 M = NR, F = NR Age Range (NR)	Qualitative	Schizophrenia Schizoaffective	Previous Admission (Y) Medication (NR) Outpatient

Note: F = Female, M = Male, *M* = Mean, MG = Milligram, *N* = Sample Size, NR = Not Reported, P = Participant, Y = Yes.

Appendix C

Table 2 **Leisure Intervention Characteristics**

Study	Study Purpose	Duration/Frequency	Selected Delivery Format
Wolfe & Riddick (1984)	Evaluate the impact of a leisure counseling program on the leisure attitude and self-esteem of adults with schizophrenia	10-weeks 1x per week	Recreation Therapist Group
Wong et al., (1987)	Determine the effects of minimally supervised independent recreational activities on stereotypic vocal behavior in persons with chronic schizophrenia	9-weeks 1x per day	Therapist Individual
Wong, et al., (1988)	Determine the impact of structured recreation activities on appropriate and psychotic behaviors of persons with schizophrenia.	9-weeks 5x per week	Psychologist Mental Health Professionals (3) Group
Card (1989)	Determine the effect of an organized recreation program on the perceived leisure functioning of elderly persons with schizophrenia.	3-months 2x per week	Licensed Practical Nurse, Graduate Students (3) Group
Gimmestad (1995)	Summarize the comprehensive therapeutic recreation treatment of a woman with schizophrenia.	15-months 1x per day	Recreation Therapist Group

Table 2 **Leisure Intervention Characteristics**

Study	Study Purpose	Duration/Frequency	Selected Delivery Format
Finnell, et al., (1997)	Compare the appropriate behavior scores of persons with schizophrenia and schizoaffective disorder participating in therapeutic recreation (TR) services and vocational rehabilitation (VR) services.	2-months TR- 3x per week VR- 1x per week	TR- Certified Therapeutic Recreation Specialist Activity Aid VR- Vocational Psychologist Activity Aids Group
Roder et al., (1998)	Examine the results of a structured behavior therapy aimed at teaching persons with schizophrenia recreational, residential, and vocational skills	4-months No Report	Psychologist Physician Psychiatric Nurse Group
Pestle et al., (1998)	Examine the effectiveness of a therapeutic recreation program overtime on the appropriate behavior of persons with schizophrenia and schizoaffective disorder.	15-months 3x per week	Certified Therapeutic Recreation Specialist Activity Aid Group
Morris et al., (1999)	Compare the amount of appropriate behaviors displayed by persons with schizophrenia in active and passive therapeutic recreation activities.	1-year 3x per week	Certified Therapeutic Recreation Specialist Group

Table 2 **Leisure Intervention Characteristics**

Study	Study Purpose	Duration/Frequency	Selected Delivery Format
Barak et al., (2001)	Evaluate the effects of animal assisted therapy on long-stay geriatric residents with schizophrenia in a controlled 1-year study.	1-year 1x per week	Three Animal Assisted Therapists Psychiatric Nurse Group
Bizub et al., (2003)	Demonstrate the benefits of therapeutic horseback riding for persons with psychiatric disabilities.	10-weeks 1x per week	Certified Therapeutic Riding Instructor Clinical Staff Member Group
Nathans-Barel et al., (2005)	Examine the effectiveness of animal assisted therapy ameliorating anhedonia in persons with schizophrenia.	10-weeks 1x per week	Qualified Animal Trainer Group
Voruganti et al., (2006)	Evaluate the effectiveness of an adventure and recreation based group intervention in the rehab of people with schizophrenia & schizoaffective disorder	8-months 1x per week	Recreation Therapist Occupational Therapist Social Worker Registered Nurse Individual Activities Closed-Group Format

Table 2 **Leisure Intervention Characteristics**

Study	Study Purpose	Duration/Frequency	Selected Delivery Format
Corring et al., (2010)	Explore the effectiveness of therapeutic horseback riding for persons with schizophrenia and schizoaffective disorder	10-weeks 1x per week	Recreation Therapists Riding Instructor Group
Snethen et al., (2012)	Explore the effectiveness of a community access recreation intervention on the community participation of adults with schizophrenia spectrum disorders.	9-weeks 3x per week	Recreation Therapist Individual/Co-participation
Corring et al., (2013)	Explore and explain the effectiveness of therapeutic horseback riding for assertive community treatment clients with schizophrenia and schizoaffective disorder	10-weeks 1x per week	Assertive Community Treatment Clinical Staff Riding Instructor Group

Appendix D
Intervention Activities
Scoping Review

Table 3 Intervention Activities

Study	Activity(s)
Wolf & Riddick (1984)	Leisure Counseling
Wong et al., (1987)	Reading, Model Building, Coloring, Crafts
Wong et al., (1988)	Basketball, Volleyball, Art
Card, (1989)	Exercise, Reality Orientation, Passive Activities (unspecified)
Gimmestad, (1995)	Recreation Therapy (unspecified), Community Outings
Finnell et al., (1997)	Active Recreation (i.e. Kickball, Volleyball, Softball)
Roder et al., (1998)	Leisure therapy (i.e. Leisure Planning, Leisure Identification)
Pestle et al., (1998)	Active Recreation (i.e. Volleyball, Frisbee Softball, Koosh Ball) Passive Recreation (i.e. Trivia, Arts & Crafts, Group Murals)
Morris et al., (1999)	Active Recreation (i.e. Aerobics, Kickball, Volleyball) Passive Recreation (i.e. Board Games, Card Games)
Barak et al., (2001)	Animal Assisted Therapy – Dog/Cat
Bizub et al., (2003)	Therapeutic Horseback Riding
Nathans-Barel et al., (2005)	Animal Assisted Therapy - Dog
Voruganti et al., (2006)	Adventure Recreation (i.e. Camping, Canoeing, Rock Climbing)
Corring et al., (2010)	Therapeutic Horseback Riding
Snethen et al., (2012)	Community Leisure Identification Community Leisure Participation (unspecified)
Corring et al., (2013)	Therapeutic Horseback Riding

Appendix E

Table 4 **Behavioural Outcome Interventions**

Study	Instrument	Measures	Findings
Wong et al., (1987)	Behavioural Observation Audio-Recordings	Stereotypical Vocalizations Self-Talk	Recreational activity was effective in reducing stereotypic vocalizations in both people with schizophrenia. Medium-rate self-talk for one person and high rate mumbling for the second person were reduced by 60-70%.
Wong et al., (1988)	TSBC	Appropriate Behaviour Inappropriate Behaviour	Results suggested that structured recreational activities led to an approximate 70% decrease in inappropriate behaviours (i.e. screaming, self-talk) and a five-fold increase in appropriate behaviours (i.e. appropriate facial expressions, physical position, listening to others, responding to conversation).
Finnell et al., (1997)	TSBC	Appropriate Behaviour	Findings suggested that people with schizophrenia demonstrated higher appropriate behaviour scores (i.e. appropriate facial expressions, psychical position, listening to others, responding to conversation) when participating in therapeutic recreation sessions rather than vocational rehabilitation sessions.
Pestle et al., (1998)	TSBC	Appropriate Behaviour	Appropriate behaviour scores increased significantly between time one and time four and time three and time four. Overall therapeutic recreation participation within a social learning program increased the amount of appropriate behaviours (i.e. appropriate facial expressions, physical position, listening to others, responding to conversation) displayed and observed.
Morris et al., (1999)	TSBC	Appropriate Behaviour	Total appropriate behaviour scores were not significantly different when comparing engagement in active and passive recreation activities. Total appropriate behaviour scores were in the 10th decile when compared to national norms which may suggest the participants displayed high levels of appropriate behaviour (i.e. appropriate facial expressions, physical position, listening to others, responding to conversation) during the recreation activities.

Note: TSBC = Time Sample Behaviour Checklist

Appendix F

Table 5 **Leisure Outcome Interventions**

Study	Instruments*	Measures	Findings
Wolfe & Riddick (1984)	LAS SES	Leisure Attitude Self-Esteem	Analysis of covariance compared people with SCZ to normative data. People with SCZ had less positive attitudes towards leisure. Mean self-esteem scores appeared to parallel normative data. While the experimental group did undergo positive shifts in leisure attitudes no significant differences between the experimental group and the control group were found with regards to post-test leisure attitude or self-esteem scores.
Card (1989)	CLEIRS 4-Scales (1) RLBD (2) BLRS (3) STILAPB (4) STILAP - B - D	Perceived Leisure Functioning	1 person with SCZ improved in (CLEIRS) scores, 1 person with SCZ declined in (CLEIRS) scores, 1 person with SCZ showed mixed results and 3 persons with SCZ demonstrated no change in (CLEIRS) scores.
Gimmestad (1995)	Case notes, Observations	Social and Independent Functioning	The person with SCZ initially acted withdrawn, non-verbal, and isolated when she first arrived to the group. The individual showed a range of emotions, responded to questions and actively took part in TR sessions. She participated in weekly trips out to a restaurant and participated in several outings with other participants. She was eventually discharged to a long-term rehabilitation center with a strong psycho-social component.

Table 5 **Leisure Outcome Interventions**

Study	Instruments*	Measures	Findings
Roder, et al., (1998)	LI LQ	Leisure Time	Post-test scores on the LI indicated that 5 participants significantly increased the amount of time spent in actively pursuing recreational activities (p=0.04). Two participants also indicated that they developed active strategies for coping with boredom and stress. Post-test scores on the LQ indicted significant changes were found in the expectancy and appraisal of competence (p=0.04) and in the appraised relevance of the issues targeted (p=0.04) for five participants. One participant showed no change. The intervention stimulated participants to pursue active leisure and equipped them with the skills needed to do so. Participant also indicated that it became a priority to spend their free time with others. Three participants engaged in a new activity post therapy.
Barak et al., (2001)	SAFE	Social-Adaptive Functioning	Significant improvements in SAFE total scores were found for the intervention group at 6 months (p = 0.003) and at end of study (p = 0.001). Significant improvement was found only for the intervention group in social-functioning (p = 0.001) for the within- group analysis.
Bizub et al., (2003)	Semi-Structured Qualitative Interviews	Participant experiences of therapeutic horseback riding	Participants bonded with the volunteers, enjoyed their experience, put coping skills to the test, bonded with the horse, and gained insight about themselves and their abilities.

Table 5 **Leisure Outcome Interventions**

Study	Instruments*	Measures	Findings
Nathans-Barel et al., (2005)	SHAPS QLESQ SQLS PANSS SANS	Hedonic Tone Quality of Life Quality of Life Symptom Severity Negative Symptoms	Significant results were found for the intervention group on SHAPS scores (p = 0.02) and the leisure factor of the QLESQ (p = 0.01). The motivation factor of the SQLS neared significance (p = 0.07). No other significant differences were found on the QLESQ, SQLS. SANS, or PANSS.
Voruganti, et al., (2006)	(PANSS) (GAF) (ASIS) (SSTICS) (SIP) Weight Scale	Symptom Severity Global Functioning Self-Esteem Perceived Cognitive Dysfunction Health Related Psychosocial Adjustment Weight (lbs)	Results found for the intervention group were improvements in self-appraised cognitive dysfunction (SSTICS) and health related psychosocial adjustment (SIP). Significant improvements were found for self-esteem and (ASIS) and global functioning (GAF) (p<.05). These scores were retained during the 1-year follow up. A significant weight loss (x=12lbs) was found for the intervention group compared to a weight gain (x=9lbs) in the control group. Treatment adherence was also reported as significant (97%).
Corring et al., (2010)	Semi-Structured Qualitative Interviews	Participant experiences of therapeutic horseback riding	Participants had fun and enjoyed participating in the intervention. The recreation staff said they felt the intervention helped participants to bond with the horse, focus, increase attention to riding, increase confidence and enjoy themselves.

Table 5 **Leisure Outcome Interventions**

Study	Instruments*	Measures	Findings
Snethen et al., (2012)	Semi-Structured Qualitative Interviews	Participant experiences of the I-CAN intervention.	Participants spoke about increased community involvement and how the intervention helped them to develop planning skills to engage in community events and coping skills to effectively deal with stress and anxiety. The relationships with the therapist and co-participation were found to be major contributing factors to community participation.
	(DRM)	Daily Community Participation	The DRM recorded an overall low number of activity episodes for all participants (*M* = 3.8) when compared to those in typical DRM studies. The greatest improvement occurred when the recreation specialist was present.
Corring et al., (2013)	Semi-Structured Qualitative Interviews	Participant experiences of therapeutic horseback riding	Participants enjoyed participating in the intervention, bonded with the horse, increased their self-esteem and confidence, and developed relationships with other members of the group and staff.

Note: ASIS = Adult Self-Image Scale, BLRS – Brief Leisure Rating Scale, CLEIRS = Comprehensive Leisure Rating Scale, DRM = Modified Day Reconstruction Method, GAF = Global Assessment of Functioning, LAS = Leisure Attitude Scale, LBS = Pounds, LI = Leisure Time Interview, LQ = Leisure Time Questionnaire, *M* = Mean, PANSS = Positive and Negative Syndrome Scale, QLESQ = Quality of Life Enjoyment and Satisfaction Questionnaire, RLDB = Revised Leisure Diagnostic Battery, SAFE = Social Adaptive Functioning Evaluation, SANS = Schedule for the Assessment of Negative Symptoms, SCID = Structured Clinical Interview for DSM-5, SCZ = schizophrenia, SHAPS = Snaith-Hamilton Pleasure Scale, SIP = Sickness Impact Profile, SQLS = Subjective Quality of Life Scales, SSTICS = Subjective Scale to Investigate Cognition in Schizophrenia, STILAP (B) (D) = State Technical Institute's Leisure Assessment Process – Breadth – Depth, SES = Self-Esteem Scale.

Appendix G
Participant Demographic Information
Schizophrenia & Leisure

Table 1

Participant Demographic Information

Participant	Francis	Peter	Brain	Meg	Chris	Joe	Stewart	Carter	Bonnie
Sex	M	M	M	F	M	M	M	M	F
Age	27	22	34	28	23	25	33	21	26

Appendix H
Information and Consent Form
Schizophrenia & Leisure

INSTITUT UNIVERSITAIRE EN SANTÉ MENTALE
MENTAL HEALTH UNIVERSITY INSTITUTE

INFORMATION and CONSENT

Schizophrenia and Leisure: Time is of the essence!

Shawn Wilkinson, M.A., William J. Harvey, Ph.D., Gordon bloom, Ph.D.
Ridha Joober, M.D., Ph.D., & Karim Tabbane, M.D.

(McGill University and Douglas Hospital Research Centre)

Dear Sir or Madam,

We are kindly asking for your participation in a research project. Please take all the time that you need to carefully read and understand the following information before signing the information/consent form to accept your participation in the project. This form may have words that you do not understand. Please ask the researcher any questions or to explain any words or information that is unclear to you.

Who is conducting the study?

I, Shawn Wilkinson, am conducting research at the Department of Kinesiology and Physical Education of McGill University under the supervision of Dr. William J. Harvey.

What is the goal of the study?

The purpose of this research project is to explore the feelings, attitudes, and beliefs that persons with schizophrenia hold about leisure. Research suggests that people experiencing schizophrenia often have more than one health problem. This means that many people with schizophrenia live with both physical and psychological symptoms that may have a negative impact on their health. There is also research showing that many people with schizophrenia may find it challenging to socialize with others. Taking part in recreation and leisure activities may potentially provide physical, psychological, and social health-related benefits for persons with schizophrenia. However, we are not sure how people with schizophrenia understand and take part in their own leisure activities in their neighbourhoods.

There are three goals of the research project. First, the researchers would like to further understand the feelings and attitudes that people with schizophrenia hold about leisure. Second, the researchers would like to explore how people with schizophrenia get involved in different recreation activities. Third, the researchers would like to understand how people with schizophrenia learn about leisure opportunities in their own neighbourhoods and communities.

The study will increase the understanding of the complex relationships between persons with schizophrenia, leisure and health.

What will be your role in the study?

You will be asked to complete a one and a half hour leisure assessment that will include an interview and two leisure questionnaires. You will also be asked to return for a one-half hour follow up meeting to discuss the results of the interview and the results of the leisure questionnaires. The assessment and follow up will take place in a private office at Pavilion-T of the Douglas Mental Health University Institute.

Audiotape Interview
The interview will consist of 12 open-ended questions. These questions are designed to explore your feelings, attitudes, beliefs, and participation about your recreation and leisure activities. There are no right or wrong answers to these questions. The researcher will ask you to please answer the interview questions to the best of your ability. The researcher will also audiotape the interview because the researcher wants to make sure that all of your responses are accurately recorded.

Leisure Satisfaction Measure
The Leisure Satisfaction questionnaire will measure how satisfied you are with your leisure activities. It includes 24 statements. Each statement can be answered using a whole number from 1-5. A description of what each number represents is provided at the top of the questionnaire. You will be asked to tell the researcher the number that best fits your ideas about your leisure activities.

Leisure Motivation Scale
The Leisure Motivation questionnaire will measure how motivated you are to participate in different leisure activities. It includes 48 statements. Each statement may be answered by writing a number from 1-5 on the questionnaire. A description of what each number represents will be described at the top of the questionnaire so that you know what each number means. You will be asked to tell the researcher the number that best fits your ideas about your leisure motivation.

Withdrawal from the study:
Participation in this study is voluntary. You are free not to participate. You can also withdraw from the project at any time, without giving any reason. Your decision not to participate in the study will not change the quality of care or services that you receive. You will be compensated for the time you have committed to the research project.

Confidentiality:
All information collected from the interview and the leisure questionnaires will be private and only available to the research team involved in the study. Names will be removed from all information and be kept in locked files in the CHAMPS secure lab space, under Dr. Harvey's (Director) supervision, at the Douglas Mental Health University Institute. The information will be destroyed after 7 years of storage. All audio files and transcript interviews will be deleted from the hard drive on the research computer in the CHAMPS lab space. Dr. William Harvey (CHAMPS Director) will be responsible for deleting all files. Your name will not be revealed if any publication results from the study.

Benefits of participating in this study:
The advantage of your participation in this study is that you will gain a better understanding of your feelings and attitudes toward leisure. You will also be contributing your personal knowledge and experiences so that others can learn more about the relationship between leisure and schizophrenia. The results will also help to better inform people with schizophrenia about the potential affordances and barriers to leisure participation. The full interview, a summary of the interview, and your leisure measure results will be provided to you during the follow up. You will also receive a list of potential leisure activities and information about where you can participate in these activities based on an evaluation of the results.

Compensation
You will receive $25 after you have completed the interview and both leisure questionnaires (as indicated by the researcher). You will also receive an additional $25 after the follow up session has been completed. This compensation will be provided to you in order to make up for your time and costs. If you withdraw from the project or are withdrawn before it is completed, you will receive a prorated amount according to your participation. Compensation will be provided to you from the personal funds of Dr. William Harvey, the researcher overseeing this project.

Are there any risks to participating?
There are no foreseeable risks to participating in this study. The interview is designed to simulate an everyday conversation. it is meant to produce an open and friendly discussion between the researcher (me) and research participant (you). The leisure measures requires you only to listen to the questions and tell the researcher the response using a number scale from 1-5.

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MENTAL HEALTH UNIVERSITY INSTITUTE

CONSENT FORM

Schizophrenia and Leisure: Time is of the essence!

Shawn Wilkinson, M.A., William J. Harvey, Ph.D., Gordon bloom, Ph.D.
Ridha Joober, M.D., Ph.D., & Karim Tabbane, M.D.

I, ____, consent to participating in the Schizophrenia and Leisure study to be carried out by Shawn Wilkinson and researchers of the Douglas Hospital Research Centre and McGill University.

By signing this form:

1. I understand that the purpose of this study is to explore the feelings, attitudes, and beliefs that persons with schizophrenia hold about leisure.

2. I confirm that I have agreed to participate in this study.

3. I understand that all information collected during the study will be private and only be available to the research team. Names will be removed from all the information collected and kept in locked files in the CHAMPS (Dr. William J. Harvey; Director) secure lab space at the Douglas Institute. The information will be destroyed after 7 years of storage. My identity will not be revealed if any publication results from the study.

4. I have been informed that there are no foreseeable risks to participating in the study.

5. I have the option to stop participating at any time without it affecting any future care for me. If I choose to stop participating in the study, than any of the data that has been collected from the interview or the leisure questionnaires will be destroyed.

6. I have been informed that I will receive $25.00 dollars after the initial interview has been completed and an additional $25.00 once the follow up visit has been completed. This money will be provided to me to compensate for my time and costs. If I choose to withdraw I will be compensated for the time I committed. Dr. William Harvey will provide compensation from his private funds.

7. I am aware that if I have any questions about this research, I can contact Mr. Shawn Wilkinson at (514) 848-2424, ext. 2282 or his supervisor Dr. William J. Harvey at (514) 398-4184, ext. 0488 who will answer any of my questions. If I have any questions about

my rights as a patient, or as a research subject, I can phone the Douglas Hospital Ombudsman at (514) 761-6131, ext. 3287.

8. If you have a caregiver who plays a significant role in your life, then, within the limits set by normal standards of confidentiality in relation to each patient, your caregiver shall be present when the study is explained to you. Your caregiver shall have an opportunity to ask questions, and the caregiver shall get a copy of the consent form.

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MENTAL HEALTH UNIVERSITY INSTITUTE

RESEARCH PARTICIPANT CONSENT

Title: **Schizophrenia and Leisure: Time is of the essence!**

I have read the information/consent form. I recognize that the research project was explained to me, that my questions were answered, and that I was given enough time to make a decision.

I agree to participate in this research project according to the conditions stated above. A dated and signed copy of the present information/consent form was given to me.

____
Research Participant Name

____
Research Participant Signature

____
Date

USE OF AUDIOTAPED OR VIDEOTAPED INTERVIEWS

Do you accept to consent to be audio-taped during the interview?

YES ☐ NO ☐

____
SIGNATURE OF THE PARTICIPANT

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MENTAL HEALTH UNIVERSITY INSTITUTE

COMMITMENT AND SIGNATURE OF THE RESEARCHER

Title: **Schizophrenia and Leisure: Time is of the essence!**

I confirm that we have explained to the research subject the information/consent form, that we have answered the questions that the research participant had, and that we have clearly indicated that she/he can withdraw from the study at any point without compromising any future care.

I commit myself, as well as the research team, to respect what we agreed upon in the information/consent form and to give a signed copy of this form to the research participant.

____
Name of researcher in charge of the research project

____
Signature

____
Date

Appendix I
Leisure Satisfaction Measure

LEISURE SATISFACTION MEASURE (LSM)

Purpose: The purpose of the Leisure Satisfaction Measure is to determine the degree to which you are currently content with your leisure.

Directions: Listed below are 24 statements. To the left of each statement is a line to indicate how true that statement is. A "1" means that the statement is almost never true, "2" means that it is seldom true, "3" means that it is sometimes true, "4" means that it is often true, and "5" means that it is almost always true. Write down the number that best fits your situation.

Definition: "Leisure Activities" are those things that you do that are not part of your work and are not part of your basic grooming needs.

1	**2**	**3**	**4**	**5**
ALMOST NEVER TRUE	**SELDOM TRUE**	**SOMEWHAT TRUE**	**OFTEN TRUE**	**ALMOST ALWAYS TRUE**

___ 1. My leisure activities are very interesting to me.

___ 2. My leisure activities give me self-confidence.

___ 3. My leisure activities give me a sense of accomplishment.

___ 4. I use many different skills and abilities in my leisure activities.

___ 5. My leisure activities increase my knowledge about things around me.

___ 6. My leisure activities provide opportunities to try new things.

___ 7. My leisure activities help me to learn about myself.

___ 8. My leisure activities help me to learn about other people.

___ 9. I have social interaction with others through leisure activities.

___ 10. My leisure activities have helped me to develop close relationships with others.

___ 11. The people I meet in my leisure activities are friendly.

___ 12. I associate with people in my free time who enjoy doing leisure activities a great deal.

___ 13. My leisure activities help me to relax.

___ 14. My leisure activities help relieve stress.

___ 15. My leisure activities contribute to my emotional well-being.

___ 16. I engage in leisure activities simply because I like doing them.

___ 17. My leisure activities are physically challenging.

___ 18. I do leisure activities which develop my physical fitness.

___ 19. I do leisure activities which restore me physically.

___ 20. My leisure activities help me to stay healthy.

___ 21. The areas or places where I engage in my leisure activities are fresh and clean.

___ 22. The areas or places where I engage in my leisure activities are interesting.

___ 23. The areas or places where I engage in my leisure activities are beautiful.

___ 24. The areas or places where I engage in my leisure activities are well designed.

Patient's Name	**Physician**	**Admit #**	**Room/Bed**

Appendix J
Leisure Motivation Scale (LMS)

LEISURE MOTIVATION SCALE (LMS)

PURPOSE: The purpose of this scale is to help the patient and the therapist work together to find out, in part, why the patient chooses to engage in leisure activities.

DIRECTIONS: Listed below are 48 statements. Each one begins with the phrase: "One of my reasons for engaging in leisure activities is..." To the left of each statement is a line to indicate how true that statement is. A "1" means that the statement is never true, "2" means that it is seldom true, "3" means that it is sometimes true, "4" means that it is often true, and "5" means that it is always true. Write down the number that best fits your situation.

DEFINITION: "Leisure Activities" are those things that you do that are not part of your work and are not part of your basic grooming needs.

1	2	3	4	5
NEVER TRUE	SELDOM TRUE	SOMEWHAT TRUE	OFTEN TRUE	ALWAYS TRUE

One of my reasons for engaging in leisure activities is...

___ 1. to expand my interests
___ 2. to seek stimulation
___ 3. to make things more meaningful for me
___ 4. to learn about things around me
___ 5. to satisfy my curiosity
___ 6. to explore my knowledge

___ 7. to learn about myself
___ 8. to expand my knowledge
___ 9. to discover new things
___10.to be creative
___11.to be original
___12.to use my imagination

___13.to be with others
___14.to build friendships with others
___15.to interact with others
___16.to develop close friendships
___17.to meet new and different people
___18.to help others

___ 25. to get a feeling of achievement
___ 26. to see what my abilities are
___ 27. to challenge my abilities
___ 28. because I enjoy mastering things
___ 29. to be good in doing them
___ 30. to improve skill and ability in doing them

___ 31. to compete against others
___ 32. to be active
___ 33. to develop physical skills and abilities
___ 34. to keep in shape physically
___ 35. to use my physical abilities
___ 36. to develop my physical fitness

___ 37. to be in a calm atmosphere
___ 38. to avoid crowded areas
___ 39. to slow down
___ 40. because I sometimes like to be alone
___ 41. to relax physically
___ 42. to relax mentally

___19.so others will think well of me for doing it
___20.to reveal my thoughts, feeling, or physical skills to others
___21.to influence others
___22.to be socially competent and skilful
___23.to gain a feeling of belonging
___24.to gain other's respect

___43. to avoid the hustle and bustle of daily activities
___44. to rest
___45. to relieve stress and tension
___46. to do something simple and easy
___47.to unstructured my time
___48.to get away from the responsibilities of my everyday life

Patient's Name	**Physician**	**Admit #**	**Room/Bed**

Appendix K
Interview Guide
Schizophrenia and Leisure

Demographic Information

____
Name

____
Signature

______ ___________________________
Age Date

Interview Protocol

Interview – Start: Finished:

Location:

Interview Questions

1. How are you today?

2. Can you please describe what a typical day is like for you?

3. What do you do during your free time?
   (a) Can you please explain/describe these activities in more detail.
   (b) When do you do them?
   (c) Who do you do them with?
   (d) Where do you do them?

4. Why do you do these activities?

5. How do you plan these activities?

   If yes: (a) Please tell me more! How do you participate in these activities?

   If no: (a) How do you participate in these activities?

6. Why do you participate in these activities?

7. What types of new activities would you like to try? Why?

8. What would encourage you to try a new activity?

9. What, if anything, prevents you from trying a new activity?

10. Leisure may mean different things to different people. What does leisure mean to you?

11. What does leisure have to do with health?

12. Do you have any question or comments for me?

Appendix L
Leisure Satisfaction Measure (LSM) Results
Schizophrenia and Leisure

Table 2

Leisure Satisfaction Measure (LSM) Results

Measure	Psychological	Educational	Social	Relaxation	Physiological	Aesthetic
Francis	4	4.5	2.5	3.75	3.25	2.75
Peter	2.25	1.5	2.5	3.25	2.75	4
Brian	3.75	3.5	2.75	2.75	4	3.5
Meg	5	3.75	3.25	5	4.25	5
Chris	3	4	3.75	4.25	4.75	4.5
Joe	3.5	3.25	2.25	2.5	2	3.5
Stewart	4.5	3.5	3.75	4.75	5	4.75
Carter	3.5	4	4.5	5	3.5	5
Bonnie	3	3.5	2.5	2.25	3.25	4.25

Appendix M
Leisure Motivation Scale (LMS) Results
Schizophrenia and Leisure

Table 3

Leisure Motivation Scale (LMS) Results

Measure	Intellectual	Social	Competence Mastery	Stimulus Avoidance
Francis	53	46	43	45
Peter	25	36	43	34
Brian	39	31	40	42
Meg	56	48	58	41
Chris	53	54	60	41
Joe	38	26	30	51
Stewart	49	41	57	47
Carter	43	46	51	45
Bonnie	33	25	38	18

Appendix N
Leisure Education Program Breakdown
L.E.A.P.S.

Week 1 – Introduction (Total Time 1.5 Hours)

- Explain Study
- Obtain Ethical Consent
- Conduct Profile Interview (15 minutes)
- Session 1- Leisure Awareness (30 minutes)
- Create Healthy Recreation List

Week 2 – Interview 1 (Total Time 2 Hours)

- Leisure Awareness Interview (30 minutes)
- Session 2 – Social Interaction Skills (30 minutes)
- Recreation Outing – (1 hour)

Week 3 – Interview 2 (Total Time 2 Hours)

- Social Interaction Skills Interview (30 minutes)
- Session 3 – Leisure Resources (30 minutes)
- Recreation Outing - (1 hour)

Week 4 – Interview 3 (Total Time 1.5 Hours)

- Leisure Resources Interview (30 minutes)
- Recreation Outing – (1 hour)

Week 5 – Debrief (Total Time 30 Minutes – 1 Hour)

Appendix O
Leisure Education Content Model
L.E.A.P.S.

Leisure Awareness -Knowledge of Leisure -Self-Awareness -Leisure & Play Attitudes -Related Participatory & Decision Making Skills	**Social Interaction Skills** - Communication Skills - Relationship Building Skills - Self-Presentation Skills
Leisure Resources -Activity Opportunities -Personal Resources -Family & Home Resources -Community Resources -State/National Resources	**Leisure Activity Skills** - Traditional -Nontraditional

Leisure Education Content Model – (Stumbo & Peterson, 2009)

Appendix P
Session 1 - Leisure Awareness
L.E.A.P.S.

Session 1 – Leisure Awareness - 30m

The goal of today's session is to learn more about leisure, its potential advantages and about our own leisure habits.

(1) Knowledge of Leisure (Focus: Leisure and its potential advantages)

So let's start by talking a little about leisure in general.

-Leisure is very individual and it can be defined in different ways. For example, you just told me that leisure is (repeat their definition).

-I like to think of leisure as an activity someone chooses to take part in so that person can, maybe, make his or her life more fun and meaningful.

Is there anything else you can tell me about leisure?
-(If no response; then prompt discussion with talks about free time, activities, feelings)

What types of advantages do you think leisure can have in a person's life? Are there any disadvantages that leisure may cause in a person's life?

-Leisure can have physical, mental, and social benefits. (Prompts) (Focus on Social)*

Physical: lose weight, build muscle, improve breathing
Mental: learn new skills, learn new games, help improve concentration
Social: make new friends, enjoy new groups, spend more time talking with other

(2) Self-Awareness (Focus: Past and current leisure patterns)

-I think to better understand our leisure we need better understand ourselves. One way we can do that is by thinking about who we are. So please tell me a little bit about who you are and what you like to do!

Please tell me about your past leisure activities:

Please tell me about your current leisure activities:

Tell me what kind of leisure would you like to do? Why?

(3) Leisure and Play Attitudes (Focus: Personal beliefs and values about leisure).

So you told me that you define leisure as (repeat their definition). Is that correct?

When I say the word leisure how does that make you feel?

Where did you learn about leisure? Who taught you about leisure?

Why would leisure be important to you? (What is your attitude towards leisure?)

(4) Decision Making Skills (Focus: Choice and its relationship to leisure).

We have to make decisions everyday. Please tell me about some of the decisions you make everyday? (Very Good! or provide daily examples (ex. what to eat, how to dress).

-We need to make decisions about the types of leisure that we may take part in. Leisure does not just happen by chance.

-We have to plan our leisure and choose what activities we want to do. Choice is an important part of leisure.

-Choice helps us to get involved in activities that we want to take part in. It can help us to feel independent because we are the ones who decide which activities we want to do.

-When a person chooses a leisure activity to do, it can make him or her feel like he or she is in control of their life and continue to take part in those chosen activities, especially if we have a good experience.

-For example we can choose who we want to spend time with, where we want to hang out, or we can choose if we want to go bowling or watch a movie.

-Choice can also help us to say no to leisure activities that we may not want to participate in. For example, smoking or drinking.

-Just to review, choice is important because when we choose to do something we may enjoy the activity and we may feel more involved because we choose to do it.

<u>Is there anything else you can tell me about the leisure choices that you make?</u>

Ok so to practice making leisure choices I want you to choose five of the 10 activities we listed to get involved in.

Appendix Q
Session 2 - Social Skill
L.E.A.P.S.

Session 2 – Social Skills - 30m

The goal of today's session is to learn more about social skills and how these skills can be used in leisure.

(1) Communication Skills (Focus: Starting, maintaining and ending a conversation)

Today I want to start by talking about having a conversation with other people.

Leisure can be a social experience because we may spend our leisure time with other people. We can leisure with a friend, a group of friends, or on a team. We may also meet new people through leisure or have the chance to join a new group. A very important part of leisure is communicating with other people. If we want to talk to someone sometimes we may have to start the conversation.

What do you think is important when starting a conversation with other people?

☐ Eye Contact
☐ Clear Voice
☐ Shake Hands
☐ Greeting, How are you?

Please imagine that we just met and I wanted to start a conversation with you.

I might start the conversation by saying, ". Hello my name is Shawn. What is your name? (Pause) It's nice to meet you (Name). So (Name) tell me a little bit more about yourself?

So that's how I might start a conversation with you if we just met. How would you start a conversation with me? Let's practice!

(Prompts)
Where are you from?
Do you come here often?
How often do take part in this activity?

It is also important to be able to keep a conversation going after we introduce ourselves. For example, we may want to know more about the person's interests, what the person likes or dislikes, or how the person spends their time.

What are some things we can talk about with someone we just met?

What are some questions we can ask a person we just met?

Ok so let's imagine again that we just met. I will introduce myself, you will introduce yourself and I want you to ask me 3 questions so that you can learn more about me.

(Prompts)
Where are you from?
What do you do for a living?
What are you doing here?

What about a leisure question? Can you think of a leisure question to ask me?

Ending a conversation is also something we need to know how to do.

What do you think is important when ending a conversation with someone?

☐ Eye Contact
☐ Clear Voice
☐ Polite Tone
☐ Goodbye

For example if we were talking and I wanted to end the conversation I might say. Sorry to have to go (Name) but I have an appointment. It was nice to talk with you and I hope to see you again soon.

So that's how I might end a conversation when talking with you. How would you end a conversation with me?

(2) Relationship Building Skills (Focus: Developing and Maintaining Social Networks

Developing relationships with others can be a good thing. Leisure can help to develop relationships because we share experiences with others. If we meet someone and we share the same interests, we may want to develop a relationship with that person. It is important to know that relationships take work. Building a relationship can be hard work but it can also be very rewarding. It can be rewarding because we can share our thoughts and feelings with others and we can spend our time with others so that we do not always feel alone.

<u>What do you think is important to developing a relationship?</u>

☐ Share Experiences
☐ Stay In Touch
☐ Compromise With Others
☐ Feel Comfortable
☐ Express Your Opinions.

How do you think we develop relationships?

(3) Self-Presentation Skills (Focus: Hygiene, grooming, and appropriate dress)

So like we talked about leisure can be a social experience. When we spend time with others there are social expectations for all of us to follow.

What do you think those social expectations are?
☐ Take Care Of Our Bodies
☐ Dress Properly For The Occasion

Can you give me some examples of how we take care of our bodies everyday?
☐ Brush Our Teeth
☐ Clip Our Nails
☐ Shower After Sweating)

Can you give me some examples about how we dress differently for different occasions?
☐ Clean Clothes When Going Out With Friends
☐ Sneakers and Comfortable Clothes When Being Physically Active
☐ Warm Clothing When Going Out In The Winter.

What do these things have to do with leisure?

Appendix R
Session 3 - Community Leisure Resources
L.E.A.P.S.

Session 3 – Leisure Resources 30m

The goal of today's session is to learn more about community leisure activities and leisure resources.

(1) Leisure Activity Opportunities (Focus: Identifying community leisure activities)

-So first we are going to talk about what we mean by community.

What does community mean to you?

Community can mean different things to different people. We talk about social media communities, church communities, and neighbourhood communities. Community for me is a place where people meet and share similar ideas, interests, and attitudes.

What do you think a community leisure activity is?

Community leisure activities are different types of activities that happen in the community where we live that we can become involved in. So these are activities that may be happening here in Verdun within or close to the hospital as well as activities happening anywhere in Montreal.

Like we talked about a few weeks ago, these activities can be physical, social, or mental. They can be done alone, with friends, or with a group of people. They may cost money or they may be free.

So we discussed that leisure does not just happen by chance. You have to plan your leisure and choose what activities you want to do. One of the most important parts of planning is knowing what activities are available in your community. It is important to know how to find out about leisure activities so you can become involved in them.

-Can you tell me about any leisure opportunities you know of in your community?

Local Ideas

(Verdun): Cinema Under The Stars, Free Concert Series, Theatre and Dance in the City

(Montreal): Jazz Fest, Comedy Fest, Bike Paths, Public Pools, Public Sports Courts.

What resources can you use to find out more about leisure opportunities in your community?

☐ Phone Book
☐ Community Center Brochure
☐ Internet
☐ Television
☐ Radio
☐ Newspaper
☐ Word of Mouth

So to review our lesson today, it is important to know that we can learn about leisure opportunities in the community through these sources. You can also ask your case manager about the recreation center here at the hospital and what opportunities they may offer.

It is important to know that participating in these activities may help you to become more involved in your community. You can meet new people, discover new places, and learn new skills by becoming more involved.

Once you find out more about an activity you are interested in, you have to go and check the activity out. This can be hard because we are trying something new or meeting new people but it is very common to feel this way when we try something new.

How do you feel about trying a new activity in your community?

(2) Resources (Focus: Personal Resources)

The second point we are going to talk about today is leisure resources

Resources are the things that help us to know more about leisure so we may be able to become more involved in leisure activities.

What resources do you think you need to participate in leisure activities?

☐ Money
☐ Time
☐ Transportation
☐ Knowledge of Leisure
☐ Social Skills
☐ Activity Skills

What resources do you think you already have?

Lets' talk about the resources that you already do have. For example, you can walk so that can help you to visit different places, walk to different places, or you can run or jog to stay healthy.

<u>How would you use these resources to participate in leisure?</u>

Appendix S
Information and Consent Form
L.E.A.P.S.

INFORMATION and CONSENT FORM

L.E.A.P.S

Title: Leisure Education & Active Participation for Persons with Schizophrenia & Schizoaffective Disorder

Shawn Wilkinson, M.A., (PhD Candidate McGill University), William J. Harvey, Ph.D., (Associate Professor McGill University; Research Associate DMHUI), Gordon Bloom, Ph.D. (Associate Professor McGill University) Ridha Joober, M.D., Ph.D., (Professor McGill University; Senior Researcher DMHUI), Karim Tabbane, M.D. (Assistant Professor McGill University; Faculty of Medicine DMHUI)

REB Protocol Number: 14/36

Dear Sir or Madam,

We are kindly asking for your participation in a research project. Please take all the time that you need to carefully read and understand the following information before signing the information/consent form to accept your participation in the project. This form may have words that you do not understand. Please ask the researcher any questions or to explain any words or information that is unclear to you.

Nature and objectives of the research project.

Who is conducting the study?

I, Shawn Wilkinson, am conducting research at the Department of Kinesiology and Physical Education of McGill University under the supervision of Dr. William J. Harvey.

What is the goal of this study?

The purpose of this research project is to explore the factors involved in participating in a leisure education program for persons with schizophrenia and schizoaffective disorder. Research suggests that people with schizophrenia and schizoaffective disorder often experience physical and psychological symptoms that may have a negative impact on their health. Taking part in recreation and leisure activities may help to provide physical, psychological, and social health-related benefits for persons with schizophrenia and schizoaffective disorder. Participating in leisure may be dependent on learning and developing leisure knowledge and leisure skills. It is important to learn the knowledge and skills to take part in activities that are good for your health. Persons with schizophrenia and schizoaffective disorder may need to relearn these skills. Moreover, persons with schizophrenia and schizoaffective disorder often have difficulty adhering to similar physical activity and exercise programs. Therefore, it is important to explore what factors may impact participation in a leisure education program for persons with schizophrenia and schizoaffective disorder.

There are three goals of the research project. First, the researchers would like to better understand what factors help people with schizophrenia and schizoaffective disorder to remain involved in a leisure education program. Second, the researchers would like to explore how a leisure education program may affect how a person with schizophrenia or schizoaffective disorder understands leisure. Third, the researchers would like to understand how a leisure education program may affect the leisure lifestyles of people with schizophrenia or schizoaffective disorder.

The study will increase the understanding of the complex relationships between persons with schizophrenia, schizoaffective disorder, leisure and health.

Procedures of the research project.

What will be your role in the study?
You will be asked to participate in a 5-week leisure education program. The program will include 1 profile interview, 3 audiotaped interviews, 3 sessions where we talk about leisure, 3 community outings, and 1 final session where we will provide you with interview results. The program will occur over a 5-week period and it will involve about 7.5 hours of your time.

The interviews, sessions where we talk about leisure, and the final session will take place in a private office at L'Etape of the Douglas Mental Health University Institute. The outings will occur in the community.

Profile Interview
The profile interview will consist of 10 questions. These questions are designed to learn more about your personal situation and to explore your feelings, attitudes, and beliefs about leisure.

Audio Interviews
The audio interviews will consist of 10-11 open-ended questions. These questions are designed to explore your understanding, feelings, attitudes, and beliefs about the leisure sessions and community outings. There are no right or wrong answers to these questions. The researcher will ask you to please answer the interview questions to the best of your ability. The researcher will also audiotape the interview because the researcher wants to make sure that all of your responses are accurately recorded.

Leisure Sessions
The leisure sessions will help us to explore your understanding of leisure. We are going to talk about how you define leisure, what your attitudes about leisure are, where you can become involved in leisure, and what skills you may need to take part in community recreation programs.

Community Outings
The community outings will give you a chance to take part in recreation activities in your community. We will work together to find 3 healthy recreation activities that you want to take part in. We will then go out and take part in these recreation activities together. There will be no cost involved for you.

Withdrawal from the study:
Participation in this study is voluntary. You are free not to participate. You can also withdraw from the project at any time, without giving any reason, by informing the researcher in charge of the project or one of the other members of the research team. Your decision not to participate in the study or to withdraw from the study will not change the quality of care or services that you receive. If you withdraw from the study, the information that was already collected in the course of the project will be stored as long as necessary, to ensure your safety as well as the safety of the other research participants and to meet the regulatory requirements. The information will be destroyed after seven years conforming to regulatory requirements.

Confidentiality:
During your participation in this project, the project researcher and his team will collect and record the information concerning you in a study file. Only the data required to meet the scientific goals of the project would be collected. We are going to collect qualitative interview data only. This data will be collected from the initial profile interview and the 3 audiotaped interviews.

All this information collected during the research project will remain strictly confidential to the extent prescribed by the law. In order to protect your identity and the confidentiality of this information, only a code number will identify you. The key to the code linking your name to your study file will be kept by the project researcher.

All information collected from the interviews will be private and only available to the research team involved in the study. Names will be removed from all information and be kept in locked files in the CHAMPS secure lab space, under Dr. Harvey's (Director) supervision, at the Douglas Mental Health University Institute. The information will be destroyed after 7 years of storage. All audio files and transcript interviews will be deleted from the hard drive on the research computer in the CHAMPS secure lab space. Dr. William Harvey (CHAMPS Director) will be responsible for deleting all files. Your name will not be revealed if any publication results from the study.

You have the right to consult your study file in order to verify the information gathered and to rectify it if necessary, as long as the project researcher or the institution holds this information.

Benefits of participating in this study:
The advantage of your participation in this study is that you will gain a better understanding of leisure and community recreation resources. You will also be contributing your personal knowledge and experiences so that others can learn more about the relationship between leisure, schizophrenia and schizoaffective disorder. The results will also help to better inform people with schizophrenia or schizoaffective disorder about the potential facilitators and obstacles to participating in a community recreation program. The full interviews and a summary of the interviews will be provided to you during the final session. You will also receive a list of potential leisure activities and information about where you can participate in these activities based on an evaluation of the results.

Are there any risks to participating?
There are no foreseeable risks to participating in this study. The interviews are designed to simulate an everyday conversation. It is meant to produce an open and friendly discussion between the researcher and research participant.

Disadvantages associated with the research project.
Disadvantages associated with this research project are minimal. However, you will be asked to travel to the clinic on five separate occasions. You will also be required to spend approximately 7.5 hours of your time involved in the project.

Non-waiver of legal rights
By accepting to participate in this study, you are not waiving any of your legal rights nor discharging the researchers, the sponsor or the institution, of their civil and professional responsibility.

Compensation
You will receive 50$ after you have completed all interviews. You will also be provided with 2 public transportation tickets during each visit if you are required to take public transportation. If you withdraw from the project or are withdrawn before it is completed, you will receive a prorated amount according to your participation. The transportation tickets will be purchased using the private funds of Dr. William Harvey. Compensation will be provided to you from the personal funds of Dr. William Harvey, the researcher overseeing this project.

Compensation in case of Injury and Rights of the Research Subjects
If you should suffer any injury following any procedure related to the research project, you will receive the appropriate care and services for your medical condition without any charge to you.

Control of Ethical Aspects of the Research Project
The Ethics Research Board of the Douglas Mental Health University Institute approved this research project and guarantees the follow-up. In addition, it will first approve any review and amendment made to the information/consent form and to the study protocol.

Identification of Contact Persons
I am aware that if I have any questions about this research, I can contact Mr.
Shawn Wilkinson at (514) 848-2424, ext. 2282 or his supervisor Dr. William J. Harvey at (514) 398-4184, ext. 0488 who will answer any of my questions. If I have any questions about my rights as a patient, or as a research subject, I can phone the Douglas Hospital Ombudsman at (514) 761-6131, ext. 3287.

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CONSENT FORM

L.E.A.P.S
Leisure Education & Active Participation for Persons with Schizophrenia & Schizoaffective Disorder

Shawn Wilkinson, M.A., William J. Harvey, Ph.D., Gordon Bloom, Ph.D.,
Ridha Joober, M.D., Ph.D., & Karim Tabbane, M.D.

I, ______________________________________, consent to participating in the L.E.A.P.S. study to be carried out by Shawn Wilkinson and researchers of the Douglas Hospital Research Centre and McGill University.

By signing this form:

1. I understand that the purpose of this study is to explore the factors involved in adhering to a leisure education program for persons with schizophrenia or schizoaffective disorder.

2. I understand that all information collected during the study will be private and only be available to the research team. Names will be removed from all the information collected and kept in locked files in the CHAMPS (Dr. William J. Harvey; Director) secure lab space at the Douglas Institute. The information will be destroyed after 7 years of storage. My identity will not be revealed if any publication results from the study.

3. I have the option to stop participating at any time without it affecting any future care for me. If I choose to stop participating in the study, then any of the data that has been collected from the interviews will be destroyed.

4. I am aware that if I have any questions about this research, I can contact Mr. Shawn Wilkinson at (514) 848-2424, ext. 2282 or his supervisor Dr. William J. Harvey at (514) 398-4184, ext. 0488 who will answer any of my questions. If I have any questions about my rights as a patient, or as a research subject, I can phone the Douglas Hospital Ombudsman at (514) 761-6131, ext. 3287.

5. If I have a caregiver who plays a significant role in my life, then, within the limits set by normal standards of confidentiality in relation to each patient, my caregiver shall be present when the study is explained to me. My caregiver shall have an opportunity to ask

questions, and the caregiver shall get a copy of the consent form. This is optional and only needs to be done if you choose to include your caregiver.

RESEARCH PARTICIPANT CONSENT

Title: **L.E.A.P.S: Leisure Education & Active Participation for Persons with Schizophrenia & Schizoaffective Disorder**

I have read the information/consent form. I recognize that the research project was explained to me, that my questions were answered, and that I was given enough time to make a decision.

I agree to participate in this research project according to the conditions stated above. A dated and signed copy of the present information/consent form was given to me.

____
Research Participant Name

____
Research Participant Signature

____
Date

USE OF AUDIOTAPED INTERVIEWS

I accept to be audio-taped during the interview.

YES ☐

____
SIGNATURE OF THE PARTICIPANT

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COMMITMENT AND SIGNATURE OF THE RESEARCHER

Title: **L.E.A.P.S: Leisure Education & Active Participation for Persons with Schizophrenia & Schizoaffective Disorder**

I confirm that we have explained to the research subject the information/consent form, that we have answered the questions that the research participant had, and that we have clearly indicated that she/he can withdraw from the study at any point without compromising any future care.

I commit myself, as well as the research team, to respect what we agreed upon in the information/consent form and to give a signed copy of this form to the research participant.

____
Name of researcher in charge of research project

____
Signature

____
Date

Signature of the person who obtained the consent if different from the researcher in charge of the research project.

I have explained to the research subject the terms of the present information/consent form and I answered all his questions.

____
Name and signature of the person who obtains the consent Date

Appendix T
Participant Demographic Information
L.E.A.P.S.

Table 1 *Participant Demographic Information*

Participants:	Vincent	Jules	Winston	Mia	Jimmie	Lance	Paul	Brett	Roger	Marsellus
Sex	M	M	M	F	M	M	M	M	M	M
Age	35	22	35	36	49	47	23	21	49	48
Diagnosis	SCZ	SCZ	SAD	SCZ	SAD	SCZ	SCZ	SCZ	SCZ	SCZ

Appendix U
Profile Interview
L.E.A.P.S.

Profile Interview Guide

Time of Interview:

Date:	Place:
Interviewer:	Interviewee:

---

1. How old are you?

2. What is your level of education?

3. Are you employed?
    a. What kind of work do you do?
    b. How many hours do you work a day?
    c. How many hours do you work a week?

4. What is you income level?

5. What is your marital status?
    a. Are you currently dating someone?
    b. Do you have any children?
    c. If yes, how many?
    d. If yes, how old?

6. Where are you currently living?
    a. Who do you live with?

7. What does the word leisure mean to you?

8. What do you do during your free time?

9. What types of new leisure activities would you like to try?

10. What may prevent you from trying a new leisure activity?

Please list 5-10 healthy recreation activities you would like to try.

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

Appendix V
Leisure Awareness Interview
L.E.A.P.S.

Interview Guide 1 (Week 2 – Leisure Awareness)

Name: ____ Date:_________________

Interview Protocol

Interview – Start: Finished: Location:

Interview Questions

1. How are you today?

2. Can you tell me how you feel about leisure?
   (a) What do you enjoy about leisure?
   (b) What do you not enjoy about leisure?

3. Last week we talked about self-awareness. Can you please tell me what self-awareness means to you?
   (a) How is self-awareness important? Why?

4. Last week we talked about leisure awareness. Can you please tell me what leisure awareness means to you?
   (a) How is leisure awareness important? Why?

5. Can you please describe how you get involved in leisure?
   (a) What do you need to do to participate in leisure? Why?
   (b) Who do you leisure with? Why?
   (c) Where do you leisure? Why?
   (d) Why do you participate in leisure? Why?

6. Last week we spoke about decision-making. Can you please tell what does decision-making have to do with leisure?
   (a) Can you give me an example of a leisure decision?

7. What does leisure have to do with choice?

8. What did you enjoy about last weeks session?

9. What did you not enjoy about last weeks session?

10. Do you have any questions or comments for me?

Appendix W
Social Skills Interview
L.E.A.P.S.

Interview Guide 2 (Week 3 – Social Interaction Skills)

Name : ____ Date : ________________

Interview Protocol
Interview – Start: Finished: Location:

Interview Questions

1. How are you today?

2. Can you tell me how you feel about social situations?
   (a) What do you like about social situations?
   (b) What do you not like about social situations?

3. Last week we talked about effective communication. Can you please tell me what effective communication means to you?
   (a) How is communication important?
   (b) How do you introduce yourself?
   (c) How do you describe yourself to others?
   (d) What type of questions can you ask someone you meet for the first time?
   (e) How do you join a group?

4. Last week we talked about relationships. How are relationships important?
   (a) How do you develop a relationship?
   (b) How do you maintain a relationship?
   (c) What are some positive benefits of relationships?
   (d) What are some negative aspects of relationships?

5. Last week we talked about self-presentation skills. Can you please tell me what do self-presentation skills have to do with leisure?
   (a) Can you give me an example of a self-presentation skill?

6. Last week we went on an outing. Can you please describe your experience during this outing?
   (a) What were you feelings during this outing?

7. What did you like about last weeks outing?

8. What did you not like about last weeks outing?

9. What if anything would you change about last weeks outing? Why?

10. Would you participate in this outing again?
    (a) Would you go alone? Why?
    (b) Would you go with others? If yes, who? If no, why not?

11. Do you have any questions or comments for me?

Appendix X
Community Leisure Resource Interview
L.E.A.P.S.

Interview Guide 3 (Week 4 – Leisure Resources)

Name : ____ Date : ________________

Interview Protocol

Interview – Start: Finished: Location:

Interview Questions

1. How are you today?

2. Last week we talked about community leisure activities. Can you please tell me how you feel about these community leisure activities?

3. How can you identify a community leisure activity you are interested in?
   (a) Where can you look for potential leisure activities?
   (b) How do you get involved in leisure activities?
   (c) How would you get to those leisure activities?
   (d) Why would you get involved in leisure activities?

4. Last week we talked about leisure resources. Can you please tell me what leisure resources means to you?
   (a) Can you give me an example of a leisure resource?

5. What types of resources do you need to get involved in leisure?
   (a) How do finances (e.g., money) influence your participation in leisure activities?

6. Last week we went on an outing. Can you please describe your experience during this outing?
   (a) What were you feelings during this outing?

7. What did you like about last weeks outing?

8. What did you not like about last weeks outing?

9. What if anything would you change about last weeks outing? Why?

10. Would you participate in this outing again?
    (a) Would you go alone? Why?
    (b) Would you go with others? If yes, who? If no, why not?

11. Do you have any questions or comments for me?