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Balancing Everyday Life

Exploring change following an activity-based lifestyle intervention for mental health service users

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UNIVERSITY

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Abstract

There is limited research that evaluates occupational therapy and lifestyle interventions, especially for mental health service users. This thesis provides increased knowledge and understanding of the processes and factors that led to better quality of everyday life, engagement in meaningful activities, and balance for participants who took part in the Balancing Everyday Life (BEL) intervention. BEL was implemented in 2012-2015 as part of a larger research project, of which this dissertation is part. BEL is a group-based occupational therapy intervention that aims to support overall well-being and recovery through finding a personalized balance of meaningful activities and relationships.

Study I investigated whether socio-demographic, care context, clinical and self-related factors could predict clinically important improvements in the outcomes mentioned above. Data collection took place with 133 participants at baseline, and then again at BEL end and six months following. Bi-variate analyses and then multi-variate regression analyses were performed. Though many associations were found, few factors were identified as predictors in the regression analyses. The strongest predictors of belonging to the improved groups for occupational balance included having a friend for the leisure domain of occupational balance and female gender for the self-care domain. Having children was found to be a predictor for improved occupational engagement.

Studies II-IV used a qualitative Grounded Theory approach. Nineteen participants were interviewed after BEL, and some were interviewed mid-intervention and 1.5-2 years after BEL. Study II focused on the meaning of the group for the BEL participants, and a process of meaning-making through group participation was constructed of three categories: Joining with others, Sense of belonging, and Re-valuing Self. Those who experienced the most meaning reported feeling less lonely, more connected, as well as respected and worthy.

Study III focused on the processes at work that supported making lifestyle changes. A process of making changes was constructed, consisting of five categories: Going at it gently: change is an on-going process; Support for progress, permission to fail; Prioritizing and setting boundaries; Adjusting for a sustainable balance; and Caring for a valued Self. Each category included a strategy for change as well as a related inner change. A more self-compassionate approach seemed to be a key for caring for Self and making sustainable changes.

Study IV focused on perceptions of the BEL format and content and included focus group and/or individual interviews with 12 group leaders and 19 participants. Both parties felt that they had benefited from BEL's structure and manual, yet flexibility was desired. BEL appeared to create bridges - to other people, to society at large, and to a future version of everyday life. BEL's occupation- and person-focused approach was appreciated. Group leaders experienced BEL as easy to implement and some felt it strengthened their professional role. Participants appreciated feeling respected and listened to by the group leaders, and appreciated them maintaining structure in the group. Regarding hindering factors, group leaders mentioned mainly material obstacles, such as the lack of suitable group rooms or projector. Participants felt that too different functional levels between the group participants could be an obstacle.

As similar research and interventions are lacking, this dissertation provides an important contribution to the knowledge base for occupational therapeutic interventions in the psychiatric field.

Key words: Lifestyle, lifestyle intervention, mental health, mental illness, occupational therapy, quality of life, change process, meaning, grounded theory, recovery

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MADE IN SWEDEN

For Ulla, and to Mats, Lucas, and Henrik

*We need **Joy** as we need air.*
*We need **Love** as we need water.*
*We need **each other** as we need*
*the **earth we share.***

Maya Angelou

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I. Jenny Hultqvist, Kristine Lund, Elisabeth Argentzell, Mona Eklund. Predictors of clinically important improvements in occupational and quality of life outcomes among mental health service users after completion and follow-up of a lifestyle intervention: Multiple regression modelling based on longitudinal data. Submitted to Health Services Research.

II. Lund, K., Argentzell, E., Leufstadius, C., Tjörnstrand, C., & Eklund, M. (2017). Joining, Belonging, and Re-valuing: A process of meaning-making through group participation in a mental health lifestyle intervention. Published online: November 20, 2017. Scandinavian Journal of Occupational Therapy.

III. Lund, K., Argentzell, E., Bejerholm, U. & Eklund, M. Breaking a Cycle of Perceived Failure: The Process of Making Changes towards a More Balanced Lifestyle. Under review for the Australian Occupational Therapy Journal.

IV. Lund, K., Hultqvist, J., Bejerholm, U., Argentzell, E., & Eklund, M. (2019). Group leader and participant perceptions of Balancing Everyday Life, a group-based lifestyle intervention for mental health service users. Published online: February 1, 2019. Scandinavian Journal of Occupational Therapy.

Studies II and IV have been published in this thesis with kind permission from the publisher.

Abbreviations and definitions of main concepts

BEL	Balancing Everyday Life (BEL) is an occupational therapy lifestyle intervention which aims to support personal recovery and well-being through a group-based course in which participants can learn and work towards finding a personalized and healthy balance of meaningful activities and relationships (Argentzell & Eklund, 2012; Eklund, Tjörnstrand, Sandlund, & Argentzell, 2017).
CHIME	A recovery framework proposed to promote recovery-oriented approaches in clinical work. CHIME is an acronym for Connectedness, Hope and optimism about the future, Identity, Meaning in life, and Empowerment (Leamy, Bird, Le Boutillier, Williams, & Slade, 2011).
Life balance	Life balance incorporates occupational balance as well as balance in body and mind, balance in relation to others, as well as time balance (Wagman, 2012).
Lifestyle	The way one lives one's life ("lifestyle," 2017).
Meaning-making	Meaning is related to feeling that one's life has value. Meaning-making is a process of routes or experiences that enhance meaning in one's life, such as connecting with others, having a bigger purpose, experiences of efficacy or competency, and having a sense of identity (Ikiugu & Pollard, 2015; King, 2004).
Mental health	"A state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community" (World-Health-Organization, 2018).
Mental health service users	People with experience of mental and emotional distress who are accessing psychiatric services (Mental Health Foundation, 2018). "Service users" is also used, for short.
Occupations	Although the term occupation is commonly associated with work, it is used in occupational therapy to denote activities that make up our lives. Occupation can be defined as the activities and things we need to and/or want to do, and which occupy our time. They can vary greatly on a daily, weekly, or yearly basis, or be rather similar or routine depending on a multitude of personal and life factors (World Federation of Occupational Therapists, 2016).
Occupational balance	The subjective perception of having the right amount and variation of occupations (Wagman, Hakansson, & Bjorklund, 2012).
Occupational engagement	"The occupying of place and time in a rich tapestry of experience, purpose, and attached meaning" (Christiansen & Townsend, 2010, p. 2).
Personal recovery	Refers to the recovery journey toward mental health: "A deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life… Recovery from mental illness involves much more than recovery from the illness itself. (Anthony, 1993, p. 15).
Process	"A process consists of unfolding temporal sequences that may have identifiable markers with clear beginnings and endings and benchmarks in between. The temporal sequences are linked in a process and lead to change" (Charmaz, 2014, p. 17).
Quality of life	Feeling satisfied with one's life, including life domains such as work, relationships, health, and living situation (Lehman, 1996; Priebe et al., 2010). Quality of life also includes perceptions of one's position in life and where one is in relation to their goals, expectations, standards and concerns" (World Health Organization, 1995, p. 1405).
RCT	Randomized controlled trial
Severe mental illness	Having a psychosis or other mental disorder, receiving treatment for more than two years, and having a dysfunction as defined by the Global Assessment of Functioning instrument (Ruggeri, Leese, Thornicroft, Bisoffi, & Tansella, 2000).
Well-being	"An umbrella term for the different valuations people make regarding their lives, the events happening to them, their bodies and minds, and the circumstances in which they live" (Diener, 2006, p. 400). In this thesis, well-being incorporates quality of life.

Background

Our lives are constructed by our daily occupations – which can be described as the everyday activities that we need or want to do, and that bring meaning and purpose to our lives (World Federation of Occupational Therapists, 2018). Occupations that a person performs can vary greatly on a daily, weekly, or yearly basis, or be rather similar or routine depending on a multitude of personal and life factors. The subjective perception of having the right amount and variation of occupations can be defined as occupational balance (Wagman, Hakansson, & Bjorklund, 2012), and is affected by our patterns of daily occupations which can be viewed as a more objective construct (Eklund, Orban, et al., 2017).

Mental illness is considered to be one of the world's leading public health concerns, and is expected to grow in the coming years (Keyes, 2013). Research shows a relationship between the quality of life of mental health service users and the extent to which they are engaged in meaningful occupations (Bejerholm & Eklund, 2007; Goldberg, Britnell, & Goldberg, 2002). Furthermore, activities associated with meaningfulness include creativity, seeking knowledge, socializing, and productive activities such as working, volunteering, taking care of home, or taking part in health care/community services (Argentzell, Håkansson, & Eklund, 2012; Goldberg et al., 2002). Research shows that long-term mental health service users can struggle with daily structure and routines, imbalance in one's daily occupations, and/or a lack of meaningful social interaction and work activities (Argentzell et al., 2012; Bejerholm & Eklund, 2006, 2007; Eklund, Erlandsson, & Leufstadius, 2010; Eklund, Leufstadius, & Bejerholm, 2009; Haertl & Minato, 2006; Leufstadius & Eklund, 2008; Minato & Zemke, 2004).

Research is needed on health-promoting interventions as evidence is still scarce in the mental health area. This was evidenced in recent Swedish and international mental health guidelines (Moll et al., 2015; National Board of Health and Welfare, 2011, 2013; World Health Organization, 2013, 2018), which call for health care measures to support and improve overall health and longevity, quality of life, and well-being of people living with mental illness. Aware of the risks of under-engagement, social isolation, and imbalance in one's daily life, as well as the need for manualized, occupation-based lifestyle interventions for mental health service users, researchers Argentzell and Eklund created the Balancing Everyday Life (BEL) intervention which

was launched as part of a research study (ClinicalTrial.gov registration number NCT02619318) in 2012.

BEL is an occupational therapy lifestyle intervention which aims to support personal recovery and well-being through a group-based course in which participants can learn and work towards finding a personalized and healthy balance of meaningful activities and relationships (Argentzell & Eklund, 2012). BEL is not prescriptive, but rather aims to offer participants information that can help them identify what goals for change would be helpful and meaningful for them. The research project's main part was an RCT study evaluating the effectiveness of BEL. The study showed that the BEL intervention group improved more from baseline to the end of the 16-week intervention in regards to occupational engagement, level, and balance, as compared with a care as usual group receiving mental health and occupational therapy services (Eklund, Tjörnstrand, Sandlund, & Argentzell, 2017). In addition, the intervention group also had improved on symptom severity and level of functioning. At a follow-up six months after completing BEL, this group had a significant improvement in quality of life, and differences remained for occupational engagement and level. The difference in gain in occupational balance was not significant at the follow-up, as both groups had improved (Eklund, Tjörnstrand, et al., 2017).

The author was enrolled to join the project as a doctoral student in 2014, and this thesis contains four studies examining different aspects of the BEL intervention in regards to the BEL participants and group leaders.

Introduction

Mental health and well-being

Mental health and mental illness/disorders

The World Health Organization describes mental health as "a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community" (2018). Having mental health or a mental illness/disorder can be viewed as two opposing states, but it has been suggested that the two concepts interact with one another, and instead of being a continuum of health and illness, it can instead be seen as two continuums that interact with one another (Keyes, 2013; Provencher & Keyes, 2011). For example, it is possible for a person to experience mental health while still experiencing mental illness symptoms, or the opposite, experience decreased mental health without having mental illness.

Experiencing a mental illness is quite common, affecting approximately one in three people in their lifetime. Many mental health issues begin early in life and most people with long-term disorders do not receive treatment (World Health Organization, 2013). World-wide there is great discrepancy in the mental health services available (Thornicroft & Tansella, 2004). According to the World Health Atlas, Sweden is one of the European countries that has the highest resources in regards to mental health services (World Health Organization, 2015). However, Sweden has a focus on improving mental health services further as, similar to most other countries, mental health problems are rising. In a report by the Public Health Agency of Sweden (2017), 19% of women and 13% of men polled reported that they were currently experiencing decreased mental well-being. Of those, depression and anxiety were the most often-reported disorders. Mental illness can take a toll on people's lives, including their relationships and ability to experience meaning and purpose in their daily life. Symptoms related to mental illness can also affect one's engagement in work or related activities, and every year mental illness (including substance abuse disorders) accounts for the most hours of lost work due to disability (World Health Organization, 2018).

Severe mental illness affects approximately 2-3% of the population and tends to be a longer-term period (more than 2 years) in which one's mental illness, which can include

psychosis, bipolar, or other disorders, affects the ability to perform important life activities (Ruggeri, Leese, Thornicroft, Bisoffi, & Tansella, 2000). People with severe mental illness can have a limited social network to turn to for support (Hitch, Pepin, & Stagnitti, 2013; Macdonald, Hayes, & Baglioni, 2000), and feeling alone with one's problems and experiencing stigma can lead to further isolating oneself. The Swedish government, the World Health Organization, and many countries have called for improved care and programs aimed to support an improved situation, as well as personal recovery, for people living with mental illness (Socialdepartementet, 2012; World Health Organization, 2018). For this dissertation, the term "mental health service users," or "service users" (Mental Health Foundation, 2018) for short, is used to describe people with experience of mental and emotional distress who are accessing psychiatric services.

Personal Recovery

The recovery movement within mental health suggests that *personal recovery* can be viewed as a unique, personal journey of finding meaning and purpose through "living a satisfying, hopeful and contributing life even with limitations..." (Anthony, 1993, p. 15). The recovery movement developed from people sharing their first-hand experiences of recovery from severe mental illness (Deegan, 1997) and focuses on empowering people to overcome challenges related to their mental illness in order to live a meaningful life despite the illness (Anthony, 1993; Davidson, O'Connell, Tondora, Lawless, & Evans, 2005; Le Boutillier et al., 2011). Anthony suggests that it is not only aspects of the illness people need to recover from, but also the losses in life due to the illness as well as the effects of stigma that one has internalized. He concludes:

> Recovery is a truly unifying human experience. Because all people (helpers included) experience the catastrophes of life… Successful recovery from a catastrophe does not change the fact that the experience has occurred, that the effects are still present… [Instead], they are no longer the primary focus of one's life. The person moves on to other interests and activities. (p.15)

Social isolation and feeling alone is common among people with long-lasting mental illness (Davidson et al., 2004; Nyström, Dahlberg, & Segesten, 2002). Research suggests that important aspects of personal recovery are finding opportunities for positive social interaction with others, engaging in activities, gaining new perspectives and enhancing a sense of meaning in life (Davidson et al., 2004; Onken, Dumont, Ridgway, Dornan, & Ralph, 2002; Shepherd, Boardman, & Slade, 2008b). Connecting with others and engaging in hope-promoting relationships are particularly important aspects of mental health and personal recovery. In a report that reviewed numerous articles across different disciplines, Leamy et al. (2011) proposed five processes that were important to personal recovery, forming the CHIME acronym:

- Connectedness
- Hope and optimism about the future
- Identity
- Meaning in life
- Empowerment

The CHIME framework is proposed to promote recovery-oriented approaches in clinical work (Leamy et al., 2011). The themes that make up CHIME were also evident in a comprehensive report (Onken et al., 2002) based on focus group interviews with more than 100 mental health service users regarding what helped and hindered the recovery process. In this report, positive staff attitudes (versus negative condescending attitudes) and housing and financial stability were also mentioned as important for supporting people in healing and growing along the recovery journey.

Quality of life

Subjective quality of life generally refers to feeling satisfied with one's life, including life domains such as work, relationships, health, and living situation (Lehman, 1996; Priebe et al., 2010). Quality of life also includes perceptions of one's position in life and where one is in relation to their goals, expectations, standards and concerns" (World Health Organization, 1995, p. 1405). It has been often studied together with well-being, especially as it pertains to people living with mental illness (Lehman, 1983; Norman et al., 2000), and is a common benchmark studied in regards to mental health and illness (Connell, Brazier, O'Cathain, Lloyd-Jones, & Paisley, 2012; Connell, O'Cathain, & Brazier, 2014). Having symptoms related to depression and anxiety has been shown to be associated with decreased quality of life (Chan, Krupa, Lawson, & Eastabrook, 2005; Priebe et al., 2010); so is having schizophrenia, but that relationship to quality of life tends to be weaker (Priebe et al., 2010). Regarding mental health service users' experiences of what is important regarding quality of life, a qualitative study found that mental health service users stressed the importance of absence of "ill-being" which referred to having depression, more than experiencing well-being, i.e., having good feelings (Connell et al., 2012). Furthermore, relationships and belonging were important for feeling connected and part of society.

Occupation and well-being

Subjective well-being is included in the World Health Organization's definition of mental health (2018) and has often been studied together with quality of life, especially as it pertains to people living with mental illness (Lehman, 1983; Norman et al., 2000). Well-being can be defined as "an umbrella term for the different valuations people make regarding their lives, the events happening to them, their bodies and minds, and the circumstances in which they live" (Diener, 2006, p. 400). Well-being, and the related concepts of happiness and flourishing, have been a focus of personal recovery (Slade, 2010).

Occupational therapy was founded on the premise that engaging in occupations is important to well-being, adds meaning and purpose to life, and can heal illness (Christiansen, 2007; Meyer, 1977). Long-evident in occupational therapy literature and history are a focus on empowerment, client-centeredness, self-determination, hope, and quality of life through meaningful engagement in occupations, which aligns well with the recovery movement (Krupa, Fossey, Anthony, Brown, & Pitts, 2009; Rebeiro, 2005). Studies show that having opportunities for connection with others, as well as the meaning of engaging in daily occupations, is important for mental health service users, especially when one is not engaged in paid work (Argentzell et al., 2012; Eklund, Hermansson, & Håkansson, 2012; Leufstadius, Eklund, & Erlandsson, 2009). Furthermore, engagement in meaningful occupation, as well as social inclusion, are outlined among important characteristics in a proposed recovery-oriented practice guideline based on a qualitative analysis of international literature (Le Boutillier et al., 2011).

Occupational engagement

Occupation and occupational engagement are often described as linked concepts. Occupations can be viewed as having many layers including meaning, purpose, cultural influences, as well as social and economic factors (Christiansen, Clark, Kielhofner, & Rogers, 1995; Christiansen & Townsend, 2010; Nelson, 1988). Occupational engagement can be defined as "the occupying of place and time in a rich tapestry of experience, purpose, and attached meaning" (Christiansen & Townsend, 2010, p. 2). Commonly-cited aspects of occupation and engagement include doing, being, and becoming (Wilcock, 1998), to which K. Rebeiro, Day, Semeniuk, O'Brien, and Wilson (2001) suggested a fourth aspect, belonging, as well as a renewed focus on meaning. Wilcock and Hocking connect the World Health Organization's definitions of mental health and well-being with these four aspects of occupational engagement and conclude that "becoming" relates to people identifying their capacities and strengths in order to "achieve their potential and the good of others." (2015, p. 138) People with severe

mental illness can lack opportunities for a range of meaningful, active, and restful occupations. In addition, not having paid work or other activities that provide structure and routines, as well as lacking social contacts, can contribute to being under-engaged, as was found in studies of daily life of people with schizophrenia (Bejerholm & Eklund, 2004, 2006; Haertl & Minato, 2006; Hayes & Halford, 1996; Minato & Zemke, 2004). Furthermore, being under-occupied has been found to be associated with lower levels of well-being and recovery (Eklund & Argentzell, 2016). Although higher occupational engagement has generally been found to be positive (Eklund & Argentzell, 2016), a qualitative study with mental health service users who were in the recovery process identified different stages of engagement in occupations (Sutton, Hocking, & Smythe, 2012), and that even disengagement could be valuable in early stages of recovery.

Occupational engagement has been generally found to be positive for quality of life among mental health service users, especially when it was meaningful, purposeful and constructive. Finding the right balance was important though, as some activities such as work tasks or pressures that were not within the person's capabilities, could create more negative symptoms and decrease quality of life (Connell et al., 2014). This is consistent with studies that found an association between occupational engagement and quality of life (Bejerholm & Eklund, 2007; Goldberg et al., 2002), though higher levels of psychiatric symptoms were an important factor to explain the variance.

Research suggests that self-related factors such as self-esteem and self-mastery, as well as clinical and sociodemographic factors, may affect occupational aspects and quality of life of people with mental illness (Bejerholm, 2010; Bejerholm & Eklund, 2007). Clinical factors such as less psychiatric symptoms and better psychosocial functioning have been found to be associated with higher self-rated quality of life (Bejerholm & Eklund, 2007; Björkman & Hansson, 2002; Hansson, 2006; Johanson & Bejerholm, 2017; Lam & Rosenheck, 2000). Self-related factors such as better self-esteem and self-mastery have been found to be associated with quality of life (Chapman, Duberstein, Sorensen, & Lyness, 2007; Eklund, Bäckström, & Hansson, 2003) as well as occupational engagement (Bejerholm & Eklund, 2007; Eklund & Bejerholm, 2007), occupational balance (Eklund & Argentzell, 2016; Leufstadius & Eklund, 2008), and activity level (Eklund & Bejerholm, 2007). Sociodemographic factors also show associations with quality of life such as a higher educational level (Eklund & Bäckström, 2005). Furthermore, gender seems to play a role in occupational balance as more women report being over-occupied in the home domain and with less time for leisure or self-care (Eek & Axmon, 2015; Eklund & Argentzell, 2016; Håkansson & Ahlborg, 2010).

Meaning and Purpose

The importance of meaning and purpose are often mentioned in literature relating to mental health and well-being, including personal recovery (Anthony, 1993; Leamy et al., 2011; Slade, 2010) and occupational engagement (Hasselkus, 2011; Ikiugu & Pollard, 2015). Viktor Frankl authored the seminal book *A Man's Search for Meaning* (2004), which was originally published in 1945. He writes that finding purpose in one's life and having hope, regardless of circumstances, attributes to experiencing meaning in life. He stressed the importance of meaningful activity when he wrote about his clients who were struggling to find meaning despite unemployment:

> [There was a] twofold erroneous identification: being jobless was equated with being useless, and being useless was equated with having a meaningless life. Consequently, whenever I succeeded in persuading the patients to volunteer in youth organizations, adult education, public libraries and the like—in other words, as soon as they could fulfil their abundant free time with some sort of unpaid but meaningful activity—their depression disappeared although their economic situation had not changed. (p. 142)

Many years later, Frankl's work continues to impact literature on helping people find meaning in life. In occupational therapy literature there are many discussions and models that link one's occupations and the meaning or value they offer to life. Ikiugu and Pollard (2015) use the work of Frankl and others as a starting point, and explore routes to meaning-making through daily occupations and experiences. They suggest experiences that lead to meaning-making include connection to others and a purpose greater than oneself, experiences of efficacy or competence, a sense of identity and dignity, and of belonging within one's culture or context.

Other occupational therapy models and theories have connected meaning with purpose, value, and occupational engagement (Wilcock & Hocking, 2015). In addition to the doing, being, becoming, and belonging aspects described above (K. Rebeiro et al., 2001; Wilcock, 1998), Hammell (2004, p. 302) added that meaning in occupation should be the focus, and that "these concepts, grounded in research evidence derived from clients' perspectives, might provide a useful vision for occupational therapy theory, enabling us to address issues of fundamental importance (meaning, purpose, values, self-worth)." Similarly, King (2004) proposed a meta-model, based on research and literature from different health professions, with three universal routes to experiencing meaning in life: belonging, doing, and understanding self and the world. The Value and Meaning in Occupations (ValMO) model suggests that experiences of occupational value in daily activities affect one's sense of meaning, which then affects sense of health and future choices for occupational engagement (Erlandsson, Eklund, & Persson, 2011). In summary, meaning, purpose, occupational engagement, and a sense of belonging are often linked.

Life and occupational balance concepts

Balance is a core theme in the BEL intervention, which aims to support participants in finding a personalized balance in regards to occupational engagement, relationships, and their personal needs (Argentzell & Eklund, 2012). Perceptions of health and occupational balance have been found to be correlated (Wilcock et al., 1997). Experiencing balance or imbalance is considered an individual, subjective, and dynamic process that can be an outcome of one's lifestyle, health, occupations and relationships (Matuska, 2012; Matuska & Christiansen, 2009; Wagman, 2012; Wagman, Håkansson & Björklund, 2012). As mentioned earlier, experiencing the amount and variety of occupations as satisfactory refers to occupational balance (Wagman et al., 2012). Wagman (2012) proposes that life balance may a broader concept, and that life balance incorporates occupational balance as well as balance in body and mind, balance in relation to others, as well as time balance. In a study focusing on occupational engagement and occupational balance, Eklund and Argentzell (2016) found that mental health service users tended to identify in different life domains as "in balance" or "under-occupied," while few felt that they were "over-occupied." The group that identified as "in balance" generally had better scores in well-being and recovery than the "over- or under-occupied" groups.

Activity level is a related concept to occupational engagement and balance but focuses more on the amount of activities that a person performs on a daily basis (Wilcock & Hocking, 2015). One study found higher activity level to be related to better self-mastery, less severe psychiatric symptoms, and better psychosocial functioning (Eklund & Leufstadius, 2007).

Lifestyle

Lifestyle has been addressed in occupational therapy in regards to balance (Christiansen & Matuska, 2006; Matuska, 2012; Matuska & Christiansen, 2008). Lifestyle can be generally described as the way one lives one's life ("lifestyle," 2017), but it is a term that is often used in media and advertising as well. Lifestyle can be hard to define as it takes on different connotations depending on context (Jensen, 2007), though it is often referred to when there is a problem or when something needs to change. The term emerged from the sociology and psychology fields in the early 20th century, and encompassed the choices one makes, the socio-economic environment, as well as style in which one interacts with others which may be constructive or destructive. Furthermore, lifestyle can be viewed from an individual level, as well as sub-cultural, national, and global levels (Jensen, 2009).

Another usage of the term is "lifestyle diseases" which, although not a specific diagnosis, refers to illnesses associated with obesity, inactivity, poor nutrition, or smoking. Lifestyle has been a focus for health care interventions for mental health service users as

they are more likely than the general population to be afflicted by lifestyle-related diseases and early mortality, and those with severe mental illness are especially affected (Cabassa, Ezell, & Lewis-Fernández, 2010; National Board of Health and Welfare, 2013; Parks, Svendsen, Singer, Foti, & Mauer, 2006). However, although this is known, one study found that service users desired support in making weight-related lifestyle changes, but that it was not clear which health professionals could address this issue, and resources seemed to be lacking for both service users and health professionals in this area (Marterella, 2010).

The BEL intervention and this thesis take an approach to lifestyle which is similar to the occupational science and occupational approach used in the Lifestyle Redesign interventions (Clark et al., 1997; Clark et al., 2012; Mandel, Jackson, Zemke., Nelson, & Clark, 1999). This approach views occupational engagement as the primary focus as it relates to over-all health and well-being. But this also includes occupations that can contribute to physical and mental health such as preparing meals, exercising, and resting. As social isolation can be a problem for people with mental illness, BEL also includes a focus on personal and social relationships.

Occupational Therapy Interventions

Group-based occupational therapy

Goals of occupational therapy groups can vary, but a common theme is to offer a structured, occupation-based experience in which members can acquire skills and support each other in trouble-shooting daily-life problems. Further goals can be to socialize and engage with others in finding better routines and activity balance, and to connect with others in the community and engage in activities (Eklund, 1999; Fazio, 2008; Lloyd, King, & Bassett, 2002; Schwartzberg, 2008; Tjörnstrand, 2010). Occupational therapy literature on group therapy and interventions (Cole, 2012; Mandel et al., 1999; Schwartzberg, 2008) often refers to psychotherapy literature regarding therapeutic factors of making personal changes through group therapy. These include group cohesion, universality, altruism, and personal learning (Yalom & Leszcz, 2005). Limited research suggests that these factors apply to occupational therapy groups, with the most important being group cohesiveness, interpersonal learning-output, installation of hope (Falk-Kessler, Momich, & Perel, 1991; Webster & Schwartzberg, 1992), altruism, and catharsis (Webster & Schwartzberg, 1992). However, research on occupational therapy groups suggests that additional therapeutic factors may be present in occupational therapy groups such as engaging in occupations with the group, or receiving support from group leaders and members to begin to engage in more personally-meaningful occupations (Eklund, 1997; Horghagen,

Fostvedt, & Alsaker, 2014; Rebeiro & Cook, 1999; Sundsteigen, Eklund, & Dahlin-Ivanoff, 2009; Webster & Schwartzberg, 1992).

Occupational Therapy Lifestyle Interventions

The development of the occupational science discipline in the past 25 years has inspired international research and discussion about the interplay between health and occupation (Wilcock, 2000; Yerxa, 2000; Yerxa et al., 1990). Lifestyle Redesign®, based on the tenets of occupational science and occupational therapy, is one of the few manualized and evidence-based occupational therapy interventions. This program is a weekly group-based preventative intervention (also including monthly individual sessions) focused on promoting health and well-being in independent-living older people (Clark et al., 1997; Jackson, Carlson, Mandel, Zemke, & Clark, 1998). What was especially interesting about the Well-Elderly study was that it was a randomized controlled trial that included three groups: an occupational therapy group, a traditional social group which engaged in activities, and a control group which received no intervention. The occupational therapy Lifestyle Redesign® group experienced significantly better physical and mental improvements compared with the other two groups. This included increased vitality, less physical declines, pain, and emotion-based limitations (Clark et al., 1997). These findings were later repeated with a more culturally-diverse population, and with a shorter intervention time (six months versus the original nine), which showed significant improvement in social function, mental health and life satisfaction, and decreased depressive symptoms and bodily pain (Clark et al., 2012). Research on programs similar to, or inspired by, Lifestyle Redesign® have had varied results (Johansson & Björklund, 2016; Mountain et al., 2017). The Re-designing Daily Occupations (ReDO™) program was developed for women with stress-related disorders (Erlandsson, 2013) and was found to increase return to work rates when compared with a matched group receiving care as usual from the Social Insurance Agency (Eklund & Erlandsson, 2011). ReDO™ participants found value in the course and group format and felt that they had made personal changes including improved self-image and perceived health, awareness of how they perform occupations, and finding new ways to engage in daily occupations including setting limits for themselves (Wästberg, Erlandsson, & Eklund, 2013).

The BEL intervention builds on the structure and knowledge of these occupation-based interventions, while incorporating research and knowledge on daily life among people with mental illness and occupational engagement (Argentzell et al., 2012; Bejerholm, 2010; Bejerholm & Eklund, 2004; Leufstadius, Erlandsson, & Eklund, 2006). BEL's focus is to contribute to a more engaged and meaningful life and lifestyle. Incorporating personal recovery and occupational therapy tenets, BEL encourages a person-focused approach to the topics presented during the intervention, with the aim to empower participants to set their own goals. Topics covered in BEL sessions include finding a

personalized balance in daily life, engaging in meaningful occupations, personal relationships, nutrition, as well as active and restful occupations (Argentzell & Eklund, 2012). These subjects are meant to offer information and, together with the group format, to support participants to reflect on and discuss their interests, talents, resources, needs, and opportunities, as they pertain to their daily life and life goals.

Thesis rationale

As BEL is a new intervention, and because research-based mental health occupational therapy interventions are scarce, it was felt warranted to study the experiences of BEL participants and group leaders, as well as factors affecting outcomes of the intervention. A mixed-methods design was chosen to gain a range of perspectives. A grounded theory qualitative approach could explore experiences and perceptions, as well as focus on emerging aspects of processes and meaning related to the intervention (Charmaz, 2014), while a quantitative approach could help add to the understanding of factors relating to intervention outcomes.

Thesis aim

The overall aim of this thesis was in-depth exploration of components of the BEL intervention, specifically from the participants' and occupational therapists' perspectives. Also to gain insight into predicting factors of improved occupational and quality of life factors after completing BEL and then at a six-month follow-up.

Study I

The aim of this study was to investigate whether socio-demographic, care context, clinical and self-related factors could predict the outcomes of the BEL intervention, in terms of occupational factors and quality of life.

Study II

The aim of this qualitative study was to explore participants' perceptions of the group in the BEL lifestyle intervention; specifically, the personal experiences of what brings meaning when participating in a group intervention.

Study III

This grounded theory study aimed for an in-depth exploration of the processes by which BEL participants made lifestyle changes, if any.

Study IV

The aim of this qualitative study was to gain BEL participants' and group leaders' perspectives of the BEL intervention content and format, including factors that helped, hindered, and that could be improved.

Methods

Overview of the studies

A mixed-methods design of qualitative and quantitative methods was used for this thesis, and a summary of methods employed can be seen in Table 1. Four studies compose this thesis, which were part of a larger mixed-methods research project to evaluate the effects of the BEL intervention (Eklund, Tjörnstrand, et al., 2017). Study I was a quantitative longitudinal study with 133 BEL participants who were interviewed and completed self-report measures at baseline, at the end of the BEL intervention, as well as 6 months after. This study used logistic regression analysis to explore predictors of clinically important changes among BEL participants with respect to occupational aspects and quality of life. Studies II-IV were qualitative and were conducted using a constructivist grounded theory approach as described by Charmaz (2006, 2014). Developing from social interactionism, constructivist grounded theory encourages theory-building with a focus on the interactive process that emerges in the interface between the researchers' and participants' perspectives. Grounded theory can be an asset to a mixed-methods study (Charmaz, 2015; Johnson, McGowan, & Turner, 2010), and Charmaz states that "the flexibility of grounded theory makes it amenable to shaping quantitative instruments, to following up on quantitative findings, and to offering an in-depth view of the studied experience" (2015, p. 57). According to Creswell (2013), grounded theory is a suitable method for a study of participants who have gone through a certain process, which in this study was taking part in the BEL intervention.

Table 1.
Overview of study designs and research methods

Study	Design	Participants	Data collection	Method
I	Longitudinal quantitative	BEL participants from 14 settings n=133	Self-report and interview rating measures (see description under Study IV below)	Logistic regression analysis. Statistical analyses with SPSS version 25
II	Qualitative	Sub-sample of 19 BEL participants from 10 groups in 8 settings	26 interviews	Constructive Grounded Theory (Charmaz, 2014)
III	Qualitative	Sub-sample of 19 BEL participants from 10 groups in 8 settings	29 interviews	Constructive Grounded Theory (Charmaz, 2014)
IV	Qualitative	Sub-sample of 19 BEL participants from 10 groups in 8 settings Sample of 12 BEL group leaders from 10 settings	29 interviews 3 focus group interviews plus 4 individual/pair interviews	Constructive Grounded Theory (Charmaz, 2014)

BEL intervention

BEL was structured as a 16-week course to be administered in a group. BEL was designed with the intent of being implemented in out-patient or community-based mental health settings. In this dissertation, BEL will be referred to interchangeably as an intervention and a course. BEL was organized to have weekly meetings the first 12 weeks that would last one and one half to two hours. After 12 weeks, two booster sessions took place, two weeks apart. BEL's content structure was organized into three phases, which can be seen in Figure 1. Part A lasted three weeks and served as a general introduction and a time for the participants and leaders in the group to get acquainted. It included exploring one's past and present occupational engagement, learning about occupational balance and imbalance, as well as meaning and purpose in life. Part B was the main section of the course which lasted seven weeks and focused on working toward better balance in one's life. Weekly topics included the art of rest and relaxation, mindfulness, nutrition, physical exercise, leisure activities, social life and relationships, and productivity. Part C focused on transitioning to working on one's own, or with others, and was organized as two sessions plus two boosters that were spaced 2 weeks apart. This was an opportunity for participants to reflect on progress made during the course, and to prioritize what they wanted to work on after the course end.

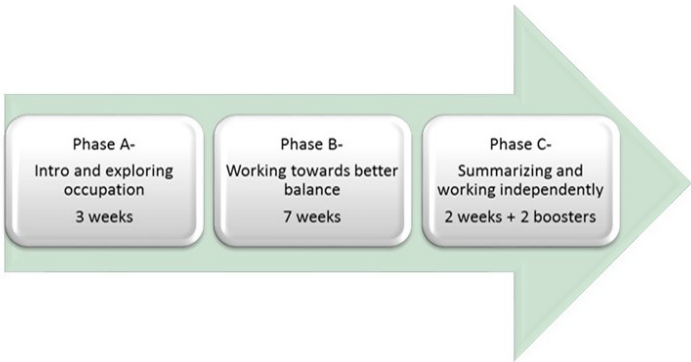


Figure 1.
Phases of the original BEL intervention

Study context

Like many other countries, Sweden has a national health care system, but Sweden is also known to have an especially strong welfare state (Institute, 2014). In general, mental health services are divided into two areas: health care clinic/hospital settings run by the county councils, and community-based settings run by the local municipalities (Institute, 2014). Both areas may include services run by private and/or non-profit organizations and procured by the county councils and municipalities.

The opportunity to participate in the BEL research project was offered to psychiatric outpatient clinics and community settings that had an occupational therapist on staff in three regions in western and southern Sweden. The BEL intervention was eventually implemented in fourteen of these settings which included eleven outpatient clinics and three community day centers. Reasons for settings not participating in the study included ongoing/expected re-organizations, already engaged in other projects, or not wishing to participate. Clinic settings included outpatient general psychiatry as well as specialized departments for specific diagnoses such as psychosis-related or bipolar disorders. Community-based settings included activity day centers which aim at offering occupational engagement and socialization opportunities for people living with long-term conditions and documented disabilities (Institute, 2014; Tjörnstrand, 2012). People living with psychiatric disabilities in Sweden are entitled to the opportunity for engaging in meaningful activities and to participate in the community according to the Social Services Act (SFS, 2001:453). Community services are meant to supplement psychiatric care for those who are no longer in need of regular specialized psychiatric care.

Participants and inclusion criteria

Study I

Participants in Study I were the 133 mental health service users who entered the BEL intervention and agreed to be part of the research study. Participants were recruited to take part in the BEL intervention by occupational therapists who were employed in the respective settings and worked as gatekeepers for the BEL project. Participants were verbally informed and interviewed by the gatekeeper to assess if BEL would be a suitable fit. Inclusion criteria for BEL included being of working age, receiving services from an out-patient psychiatry clinic or community day center, having sufficient Swedish for group participation, and identifying with having trouble with balance in daily life. Exclusion criteria included working more than half-time, having substance abuse as a primary diagnosis, or having co-morbidity of dementia or a developmental disorder. Participants were invited to take part of the larger research study evaluating the outcomes of BEL in a randomized controlled trial (RCT) (Eklund & Argentzell, 2016; Eklund, Tjörnstrand, et al., 2017). Of the 133 participants who joined the study, 106 participants attended BEL through services offered in out-patient psychiatry clinics, and 27 participants attended BEL at a community-based day center. Informed consent was collected for all participants by a researcher involved in the BEL project, or a research assistant. At each data collection point, participants were offered a gift certificate to a movie or florist in appreciation for their time and contribution. A sub-sample of BEL participants was selected for the qualitative studies that make up Studies II - IV.

The sociodemographic information of the BEL participants can be seen in Table 2. Self-reported diagnoses included a broad range, typical of what is seen in mental health services, including anxiety, depression, attention-deficit hyperactivity (ADHD), bipolar, Asperger's, schizophrenia, borderline and eating disorders. Most participants reported multiple diagnoses.

Table 2.
Sociodemographic and clinical characteristics of participants collected at baseline

CHARACTERISTICS	STUDY I n=133	STUDIES II - IV 19 participants
Women, n (%)	102 (77%)	14 (74%)
Age mean (standard deviation)	40 (11)	45 (11)
Living with a partner or spouse, n (%)	40 (30%)	5 (26%)
Have children, n (%)	63 (47%)	12 (63%)
Have children living at home, n (%)	30 (23%)	8 (42%)
Have a close friend, n (%)	110 (83%)	18 (95%)
Education level completed		
Elementary school, n (%)	24 (18%)	5 (26%)
High school / secondary school, n (%)	78 (59%)	9 (47%)
University or college, n (%)	31 (23%)	5 (26%)
Attended BEL in out-patient psychiatry, n (%) (vs. community-based activity center)	106 (80%)	11 (58%)
Diagnosis		
Depression / Anxiety / Bipolar, n (%)	69 (52%)	10 (53%)
Psychosis, n (%)	25 (19%)	3 (16%)
ADD/ADHD, n (%)	31 (23%)	3 (16%)
Other, n (%)	8 (6%)	1 (5%)

Studies II-IV

Nineteen BEL participants were interviewed, using the "intensive interviewing" approach as described by Charmaz (2014). Occupational therapy group leaders from eight settings were approached by the researchers, who asked if they could contact participants to be interviewed about their experiences with BEL. Setting selection was based on gaining a range of small towns to large city locations, as well as if they had recently concluded a BEL group, or had one running at the time of recruitment. When recruiting participants to interview, occupational therapists were asked to seek variation and identify participants who may have differing views, in order to avoid, for example, only positive accounts. A sub-sample of 22 BEL participants were selected this way and scheduled for interviews. Three of them cancelled due to illness, forgetting the interview, or needing to work. Thus, a total of 19 service users participated. Maximum variation sampling (Patton, 2015) was used as part of the initial sampling (Charmaz, 2014), in order to have a mix of participant diagnosis, age, sex, opinion of BEL, and time passed since completing BEL. Additional participants were then recruited later in the selection process to include participants who were mid-way in the BEL intervention, as well as to recruit male participants as the initial sub-sample lacked men. Approximately three quarters of the participants were female, which reflects a similar percentage in the larger project (Eklund & Argentzell, 2016; Eklund, Tjörnstrand, et al., 2017) and in Study I. Sociodemographic and clinical information of the participants are included in Table 2.

In addition to the BEL participants interviewed in studies II and III, study IV also included group and individual interviews with twelve BEL group leaders from ten mental health settings. Of the twelve group leaders interviewed, ten were occupational

therapists and two were co-leaders with other professional backgrounds. All group leaders were female. Occupational therapy group leaders who were part of the research study and had led at least one BEL group were invited via e-mail by a researcher in the BEL project to attend a half-day focus group discussion (FGD) about their perceptions of the BEL intervention. Co-leaders were invited via the occupational therapy group leader with whom they had co-led the BEL group.

Methods and procedures for data collection

Study I

Data collection took place between 2012 and 2015. Participants met with a research assistant in a private room at their care center where they filled out questionnaires, which included some structured interviews. Research assistants were trained on the instruments and had prior experience working with mental health service users. Participants could take breaks as needed.

BEL group leaders arranged the times with the participants and research assistants, and booked the room if necessary. Data was collected at three points: at baseline before starting the BEL intervention (133 participants), shortly after completing the BEL intervention (100 participants, attrition of 33), and again six months following BEL completion (87 participants, further attrition of 13). Reasons for attrition included not finishing the intervention, illness, work or family commitments, and declining data collection.

Socio-demographic and clinical factors

A questionnaire was created for this study to gather socio-demographic and clinical information. This included age, gender, if they were single or in a relationship, if they lived together or alone, their educational level, and self-reported diagnosis and/or mental health problems. Using a previously-validated procedure (Eklund & Sandlund, 2012), diagnoses were classified according to the ICD-10 system by a specialized psychiatrist.

Psychosocial functioning

The Global Assessment of Functioning, GAF (Endicott, Spitzer, Fleiss, & Cohen, 1976), was used to measure psychosocial functioning. GAF has two rating scales, one which focuses on symptoms, and the other which focuses on functioning. The scale is from 1 to 100, with a lower number indicating more psychiatric symptoms and lower psychosocial functioning, and a higher number indicating less symptoms and better functioning. GAF has been shown to have good inter-rater reliability

(Startup, Jackson, & Bendix, 2002). Before administering the GAF, research assistants in the BEL project received training and were then calibrated with an experienced occupational therapist working in psychiatry.

Self-factors

Two self-factors were addressed in this study, self-esteem and self-mastery, which are psychological resources that have shown to be associated with positive mental health and well-being outcomes (Eklund & Bäckstrom, 2006; Mann, Hosman, Schaalma, & de Vries, 2004). Two instruments were used; the Rosenberg self-esteem scale (Rosenberg, 1965) and the Pearlin Mastery Scale (Pearlin, Menaghan, Lieberman, & Mullan, 1981). The Rosenberg self-esteem scale covers ten different aspects of self-esteem. The yes/no response format (Oliver, Huxley, Bridges, & Mohamad, 1996) was used in Study I. Psychometric properties of the Swedish version of the Rosenberg Self-esteem scale have been found to be good in terms of internal consistency, criterion, convergent and discriminant validity, and sensitivity to change (Eklund, Bäckström, & Hansson, 2018).

The Pearlin Mastery Scale consists of seven questions (rated 1 as lowest, 4 as highest) that reflect the individuals' perceptions of control over factors that affect their lives. The Swedish version, Mastery-S, has been reported to obtain valid and reliable data (Eklund, Erlandsson, & Hagell, 2012).

Occupational engagement

The Profiles of Occupational Engagement among people with Severe mental illness (POES) (Bejerholm, 2011; Bejerholm & Lundgren-Nilsson, 2015) was used to measure occupational engagement. This instrument utilizes a 24-hour "yesterday diary" in which participants describe the activity performed, if they were with others or alone, where they were and their reflections/feelings. Based on the diary, a rating is made by a professional on nine items expressing level of occupational engagement on a four-point rating scale. Psychometric tests has shown that POES has good psychometric properties regarding inter-rater agreement and internal construct validity (Bejerholm, Hansson, & Eklund, 2006; Bejerholm & Lundgren-Nilsson, 2015). The current study was based on a self-report version of POES.

Activity level and occupational balance

Activity level and occupational balance were measured by means of Satisfaction with Daily Occupations and Occupational Balance (SDO-OB) (Eklund & Argentzell, 2016). The SDO-OB includes four categories – work, leisure, home chores and self-care. Each category has 3–4 items where the person first answers whether he/she currently performs the activity or not. The sum of yes-answers forms a measure of the level of activity. After answering yes or no, the person rates his/her level of satisfaction with the activity, but the satisfaction scale was not used in this study. Occupational

balance questions for the four categories reflect whether the person feels they do way too little (-2), too little (-1), just enough (0), too much (1) or way too much (2). At the end of the instrument, one final question addresses general occupational balance with the same 5-point scale. Psychometric testing has shown satisfactory construct validity for these balance questions (Eklund & Argentzell, 2016).

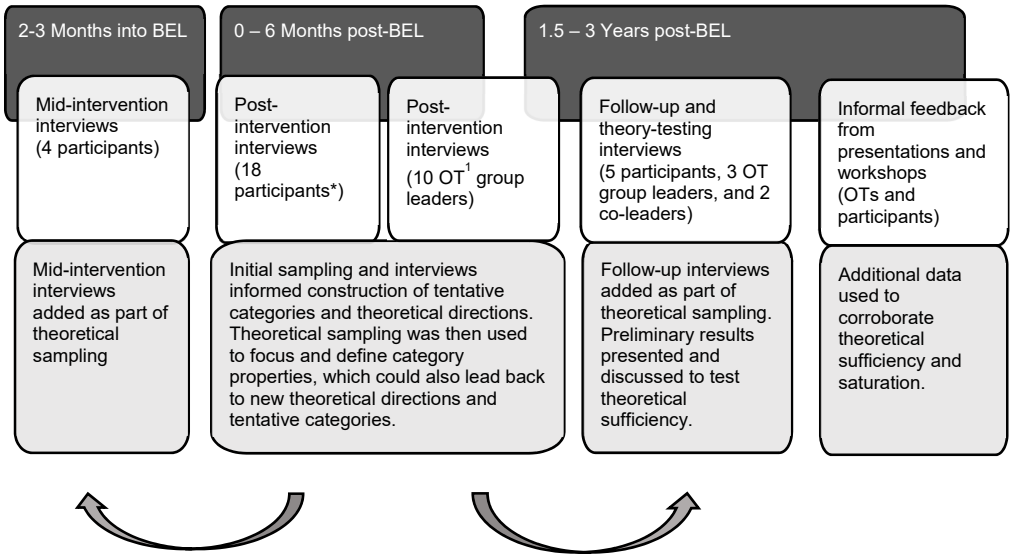
Quality of life

The Manchester Short Assessment of Quality of Life (MANSA) (Priebe, Huxley, Knight, & Evans, 1999) was used to measure quality of life. This instrument includes self-ratings of general life satisfaction and satisfaction regarding 11 domains of quality of life (work, financial situation, social relations, leisure, living situation, personal safety, family relations, sexual relations, and physical and mental health). The individual rates satisfaction on a scale from 1-7, with 1 indicating "could not be worse" and 7 indicating "could not be better". The mean ratings from the different domains form a general quality of life score. Bjorkman and Svensson (2005) found the Swedish version of MANSA to be psychometrically regarding internal consistency and construct reliability (Bjorkman & Svensson, 2005).

Studies II-IV

For the participant and group leader interviews, a semi-structured interview guide was used. As is suggested by Charmaz (2014), the interview questions started out more general and open-ended, with the intent of keeping the researcher's assumptions and theories in the background. As the interviews progressed and the research team began to see common themes or categories emerging, more pointed questions were also included to test emerging categories and theories through asking a sub-sample of BEL participants and group leaders. The NVivo software version 11 (2015) was used to store transcripts, code data, and record and organize memos which were written throughout the data collection and theory-building process.

A total of 29 interviews with BEL participants were performed between 2013 and 2017. Participants were interviewed one week to six months after they had completed BEL. Four participants were also interviewed mid-course as part of theoretical sampling (three of these four were also interviewed post-course, with attrition of one participant due to being ill). Study II included four follow-up interviews with three participants, and Studies III and IV included a total of seven follow-ups with five participants. Follow-up interviews took place one and one half to two years after completing BEL and were part of theoretical sampling and theory testing in order to fill out properties of categories and processes, and to gain participant feedback on emerging categories and theory. The thesis author performed 25 of the interviews, and four were performed by a researcher in the project. Figure 2 shows the process and progression of the data collected for Studies II-IV.



* One of the participants interviewed mid-intervention dropped out and was not interviewed on this occasion.
[1] OT = Occupational therapist

Figure 2.
Summary of interviewing process for Studies II-IV

The majority of the interviews were conducted at the clinic or activity center where the participant had attended BEL. A few interviews took place in the participant's home, at the author's research institution, or by phone, depending on what was convenient for the participant. All interviews were audiotaped with given permission of the participants, and were later transcribed to assist in the coding and analyzing phase. The exception was four theory testing interviews, two of which were over the phone, as the aim was for the interviewer and participant to review preliminary results together, as presented in text form beforehand. Notes were taken for these interviews and included in the analysis. Additional data collected included informal feedback sessions with occupational therapist group leaders regarding the BEL manual and content. In addition, preliminary results were presented to group leaders and participants involved in the project. Notes taken were used to validate, and if relevant, supplement emerging categories. As some BEL groups and group leaders had been involved from the beginning of the project, it could have been up to three or more years after their group completed BEL. This explains why the figure shows an extended time of three plus years.

Data collection with the group leaders for study IV were conducted as FGDs, and individual/duo interviews. Three FGDs were held at the author's research institution between 2014 and 2015. FGDs lasted between two and a half and three hours and were

organized so that there were planned pauses for coffee and lunch, which were provided. All three FGDs were led by the same moderator who is an experienced occupational therapist and who was a doctoral student at the time. As suggested by Krueger and Casey (2009), an assistant was also present in the FGDs to observe and support the moderator with observation and follow-up questions. The author of this thesis observed one FGD as well. A total of nine occupational therapists took part in three FGDs. Each of the FGDs had more occupational therapists scheduled to participate, but cancellations occurred due to issues with health, weather, transportation, or work demands. Thus, the numbers of occupational therapists for the FGDs were two, four, and three. As part of theoretical sampling, additional interviews took place in 2018. These included one individual interview with an occupational therapist who was not able to attend an earlier FGD, and three individual follow-up interviews with occupational therapists who had been part of the FGDs previously. These three were selected as they had led four or more groups and had gathered more experience since the original FDGs, which could help to confirm or challenge the emerging categories and theory presented by the first author during these individual interviews. Two of the follow-up interviews also included the occupational therapist's colleague (with other professional background) who co-led the BEL group with them, as the importance and experience of leading together with another professional had been discussed in the FGDs. Based on convenience for the interviewees, the individual/duo interviews took place in a public library conference room, the author's research institution, or the care center where the therapists worked.

Notes taken from feedback given during meetings with group leaders and participants were also used as additional data to validate or add to the emerging categories and theory. This data included informal feedback meetings that BEL researchers had with occupational therapists regarding the BEL course content and manual. In addition, the thesis author also gave some presentations on the preliminary findings to participants and group leaders, and notes from these meetings were also used for validation.

Data analyses

Study I

The statistical analyses were done in two parts: bivariate analyses, and then multivariate regression analyses. The first part investigated potential associations between the selected baselines factors (care setting context, socio-demographic, clinical and self-related factors) and the dependent factors (occupational engagement, activity level occupational balance, and quality of life). Change variables, which were continuous, were calculated from the baseline scores to BEL end, as well as baseline to the six-month

follow-up. Associations were analyzed between the change variables and possible predictors. The analyses performed were Spearman correlations, the Mann-Whitney U-test, and the Kruskal-Wallis test.

In the second part of the analysis, a cut value (C) was used to dichotomize the change variables according to a medium effect size (ES), (C = ES * SD0, where SD0 = standard deviation at baseline, with an effect size of 0.5 as suggested by Cohen (1988). In this study, the terms "improvement" and "clinically important improvement" are used to denote a positive change with a medium ES or higher.

Logistic regression analyses were then performed for each dependent variable, using the Enter method of entering one independent variable at a time. Potential predictors identified from the bivariate analyses were regressed against the dichotomized change variables indicating clinically important improvements in the occupational and quality of life aspects.

The p-value used to indicate significance was $p < 0.05$, though variables with an association at $p < 0.10$ for potential predictor variables (part one) were included in the multivariate analyses (part two). IBM SPSS version 25 was used for the analyses. An expert statistician was advised when designing this study.

Studies II - IV

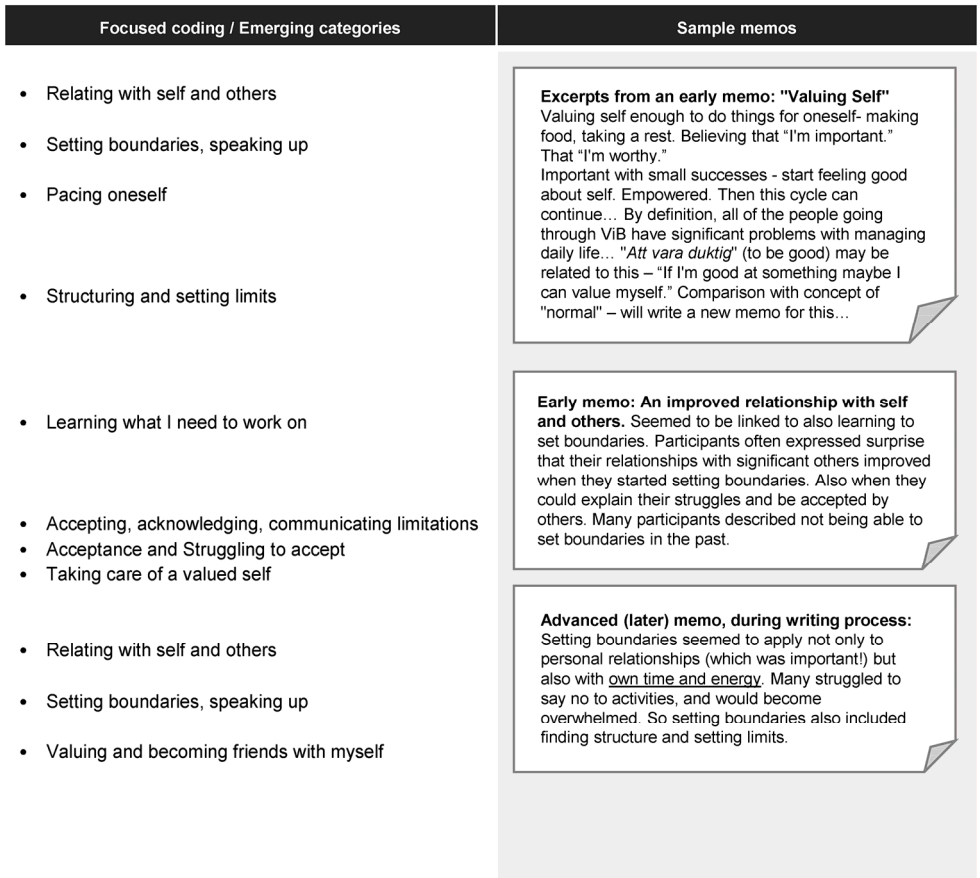
Grounded theory (Charmaz, 2015) was used to guide the iterative data collection and analysis. Interviewing and analysis was an on-going process as suggested by grounded theory methods (Charmaz, 2015). Initial coding is described as part of the early process in which the researcher starts to create links between the data and emerging theories about what is happening as told by the participants (Charmaz, 2014). Line-by-line coding was used as part of initial coding (see Figure 3) for the first 12 participant interviews and the three group leader FGDs. Focused coding (Charmaz, 2014) then followed for these interviews, and continued for the remaining participant interviews and the individual/duo interviews with the group leaders. Focused coding meant focusing on frequent or significant codes and starting to form categories in aims of describing the "analytic story" of the gathered codes. Memo-writing took place throughout the data collection and analysis process, moving from early memos to more analytical memos. Writing memos, which included written notes as well as creating visual illustrations known as clustering (Charmaz, 2014) or mapping (Dey, 2013), served to document and brain-storm the relationship of categories, the development of new categories, as well as emerging theory.

Charmaz (2014) suggests taking frequent stops along the way to ask "what is happening?" After the initial and focused coding, we then moved into theoretical

Text from interview	Initial coding
Anita I know an important thing that I have learned is that I need to learn to say "no." So that I could be able to get a good balance in my daily life. So it like doesn't work to have 20 meetings in a day. That was an important thing I have learned. And this with getting a structure for everyday life so that I can have an equal balance. ALL days.	• Learning that I need to learn to say no • Setting boundaries for better balance • Learning it doesn't work with too many daily commitments • Bringing down the tempo • Getting a structure • Finding an equal balance for all days
Erika I had a hard time with the balance between free time, I mean rest, work and leisure, that, yeah, I can work with one thing and then I forget to rest. I need to think about it more and accept that I can't, like everyone…like many others, that I need to rest. And if I don't get the, if I don't get sufficient sleep, then it just gets, I can't function. /…/	• Hard finding balance between different life areas • Forgetting to rest • Comparing self to concept of normal • Needing to accept need to rest, pace • Realizing importance of sleep on functioning
Yeah, you learned how you could balance between, yeah, those friends who have taken energy from you, or that you should dare to say no… To realize that, yeah, help to understand that you are not a worthless person just because you have a disability.	• Balancing relationships - givers and takers • Learning/daring to say no • Gaining new view of self with disability - not worthless

Figure 3.
Coding and memo samples

sampling (Charmaz, 2014), which is a time to seek more information, define the properties of the categories and processes taking place, and to challenge emerging theories. Initially, Studies II - IV developed somewhat parallel, as the data collection and analysis process took place. The importance of the group was an early category to emerge and therefore more detailed questions about the participants' experiences of the group were added. This would then form data for Study II, used to describe the process of meaning-making through group participation. Participants making life and lifestyle changes was also a category to emerge, so further exploration was focused on this, including what participants felt helped them to make changes, as well as the process of making changes. This then informed Study III on the process of making changes. Participant and group leader's perceptions of the BEL intervention was a natural and early focus in the interviews. As the analysis continued, it was felt important to present



factors of the BEL intervention that helped and hindered the processes described in Studies II and III, as well as those that related to participating in and leading the intervention. Thus, Study IV evolved to focus on these factors from the group leader and participants' perspectives. Theoretical sampling included adding additional interviews, as described in earlier sections, such as four participants in the same group who were mid-way in the BEL intervention, longitudinal follow-ups with participants, as well as follow-up interviews with occupational therapists. Co-leaders were also added as part of theoretical sampling. As tentative theories of the proposed processes and factors emerged, these were presented to participants in the latter phases of interviewing, including follow-up interviews. Participants (Studies II-IV) and group leaders (Study IV) could give feedback and additional information they felt was important. This was the process of co-constructing the theories and processes presented in the results. Theoretical sufficiency (Charmaz, 2014; Dey, 1999) was felt to be

reached when no new information was obtained that would affect the category properties. Supervisors and co-authors, who were more senior researchers, also gave feedback on the emerging categories, theory, structure, and writing process of the studies.

Ethical considerations

The studies that make up this thesis were approved by the Regional Ethical Vetting Board in Lund, registration number No. 2012/70. All participants (BEL participants and group leaders) were given written and verbal information about the study aims and methods. It was explained that taking part in the study was voluntary, that data would be kept confidential, and that they could withdraw without explanation. Written consent was obtained from all participating. Data collection with BEL participants and group leaders took place in private rooms. Arrangements were made so that participants had access to a health professional at their care center in case they felt they needed support after being interviewed and filling out the questionnaires. Participants were also informed that they could take a break at any time during data collection. Participants were offered coffee and a snack during data collection, and the group leaders who participated in the half-day FGDs were offered lunch. BEL participants were offered a florist- or movie-ticket gift card for each data collection meeting. In order to maintain confidentiality, pseudonyms have been used in the attached articles when names of the BEL participants are referred to, and the abbreviation 'GL' has been used when the name of the group leader was mentioned in participant quotes. To avoid identification, some minor changes or omissions have been made to participant quotes such as when the name of their care center, town or other specific personal information was mentioned.

Results

Determinants of change in occupational and quality of life outcomes

Study I explored whether care context or socio-demographic, clinical and self-factors could predict clinically important improvements in the outcomes of occupational engagement, activity level, occupational balance, and quality of life among BEL participants. Improvements at completed BEL and at a follow-up six months later were in focus. Overall, numerous potential predictors were found to be associated with clinically important improvements according to bivariate analyses, but as described below, the multivariate analyses identified few predicting factors of improvement in the targeted outcomes. Table 3 shows the associations found from the bivariate analysis, and Table 4 presents predictors identified from the multivariate analyses.

After BEL completion

The change variable based on occupational engagement after BEL end was associated with diagnosis other than depression and/or anxiety, having children, and being a woman. Of these three, having children was the only one found in the multivariate analysis to be a statistically significant indicator. Having children increased chances almost four-fold of belonging to the group with clinically important improvements (OR 3.94, p=0.020, CI 1.240-12.548). For activity level, having children and being of younger age (less than 40) were found to be associated with change measured after BEL completion, but neither of these showed to be significant predictors in the multivariate analysis. For occupational balance in the work domain, no associations were found. In the occupational balance leisure domain, the variables having a close friend, having seen a friend the last week, and self-mastery were found to be associated with the change variable. In the regression analysis, the only significant indicator found was having a close friend, which increased chances of being in the clinically important improvement group four-fold (OR 4.3, p=0.023, CI 1.218-15.091). In the occupational balance home chores domain, self-esteem was found to be associated with the change variable, and was also found to be a predictor. For each increased step in the self-esteem score, the odds decreased by 40% for belonging to the clinically improved group (OR 0.412,

p=0.018, CI 0.197-0.858). Regarding occupational balance in the self-care domain, women had a six-fold increased chance of belonging to the group that made clinically important improvements, compared with men (OR 5.96, p=0.022, CI 1.298-27.357). For general occupational balance, psychosocial functioning was found to be associated with the change variable, but was not found to be a predictor. Regarding quality of life, several baseline factors showed an association with the change variable after completing BEL, including age, having a close friend, having seen a friend in the last week, psychosocial functioning, symptoms, diagnosis, and setting. However, none of these factors could explain clinically important change in quality of life at the BEL end, according to the regression analyses.

Six months after BEL completion

At six months after completed BEL, the occupational engagement change variable showed no associations with the selected predictor variables. Change in activity level was found to be associated with having children and younger age (less than 40 years), though only having children could explain clinically important change in the multivariate analysis (OR 0.268, p=0.018, CI 0.090-0.802). The OR indicates that the chances for the group with children of belonging to the group with improved activity level was 27% of the chances of those who did not have children. Change in occupational balance in the work domain was found to be associated with being single, though not in the multivariate analysis addressing clinically important improvement. In the occupational balance leisure domain, having a close friend was found to be a predictor, with more than a five times increased chance of belonging to the group with clinically important improvement (OR 5.29, p=0.005, CI 1.651-16.971). For change in the occupational balance home chores and self-care domains, no variables predicting clinically important change could be found, though having seen a friend was associated with change in the home chores domain based on the bivariate analysis. For change in general occupational balance, associations were found with education level, having a close friend, and psychosocial functioning. Significant predictors for clinically important change were psychosocial functioning (OR 0.95, p=0.027, CI 0.902-0.994) and educational level (OR 0.30, p=0.039, CI 0.093-0.939). Change in quality of life was associated with self-esteem, psychosocial functioning and symptoms, though, similar to the earlier data collection point, none of the selected predictors became significant in the multivariate model analyzing clinically important change. In summary, only few of the targeted factors could explain any variance in change in occupational engagement, activity level, occupational balance, and quality of life.

Table 3.
Associations between sociodemographic, clinical, self-concept variables, and outcome variables (change) after completing BEL and at six-month follow-up.

Variables		Occ. eng.[1]	Occupational balance						QOL
			Activity level	Work	Leisure	Home	Self-care	General balance	
Age	BEL end	NS	p=.020 r_s=-.234	NS	NS	NS	NS	NS	p=.031 r_s=.217
	Follow-up	NS	p=.013 r_s=-.257	NS	NS	NS	NS	NS	NS
Sex	BEL end	p=.069	NS	NS	NS	NS	p=.082	NS	NS
	Follow-up	NS	NS	NS	NS	NS	NS	NS	NS
Marital status	BEL end	NS	NS	NS	NS	NS	NS	NS	NS
	Follow-up	NS	NS	p=.026	NS	NS	NS	NS	NS
Living situation	BEL end	NS	NS	NS	NS	NS	NS	NS	NS
	Follow-up	NS	NS	NS	NS	NS	NS	NS	NS
Education	BEL end	NS	NS	NS	NS	NS	NS	NS	NS
	Follow-up	NS	NS	NS	NS	NS	NS	p=.089	NS
Having children	BEL end	p=.010	p=.035	NS	NS	NS	NS	NS	NS
	Follow-up	NS	p=.005	NS	NS	NS	NS	NS	NS
Having friend	BEL end	NS	NS	NS	p=.001	NS	NS	NS	p=.012
	Follow-up	NS	NS	NS	p=.004	NS	NS	p=.007	NS
Having seen friend	BEL end	NS	NS	NS	p=.016	NS	NS	NS	p=.037
	Follow-up	NS	NS	NS	NS	p=.043	NS	NS	NS
Self-esteem	BEL end	NS	NS	NS	NS	p=.072 r_s=-.182	NS	NS	p=.074 r_s=.180
	Follow-up	NS	NS	NS	NS	NS	NS	NS	p=.012 r_s=.264
Self-mastery	BEL end	NS	NS	NS	p=.020 r_s=-.234	NS	NS	NS	NS
	Follow-up	NS	NS	NS	NS	NS	NS	NS	NS
GAF sym.[a]	BEL end	NS	NS	NS	NS	NS	NS	NS	p=.019 r_s=.235
	Follow-up	NS	NS	NS	NS	NS	NS	NS	p=.016 r_s=.253
GAF func.[b]	BEL end	NS	NS	NS	NS	NS	NS	p=.096 r_s=-.170	p=.009 r_s=.261
	Follow-up	NS	NS	NS	NS	NS	NS	p=.007 r_s=-.231	p=.029 r_s=.231
Depression, anxiety/other	BEL end	p=.059	NS	NS	NS	NS	NS	NS	p=.062
	Follow-up	NS	NS	NS	NS	NS	NS	NS	NS
Setting[c]	BEL end	NS	NS	NS	NS	NS	NS	NS	p=.081
	Follow-up	NS	NS	NS	NS	NS	NS	NS	NS

[1]Occupational engagement. [a]Symptom severity. [b]Level of functioning. [c]Out-patient psychiatry or community-based day centres. Internal attrition in a number of subjects occurred on the variables, between 3 and 52 and at Time=1 and between 40 and 42 at Time=2.

Table 4.
Predictors of clinically important change based on multi-variate analyses.

Predictors		**Occ. eng.**[1]	**Occupational balance**						**QOL**
			Activity level	Work	Leisure	Home	Self-care	General balance	
Female gender	BEL end						OR 5.96 p=.022 CI 1.298-27.357		
	Follow-up								
Having children	BEL end	OR 3.94 p=.020 CI 1.240-12.548							
	Follow-up		OR .268 *p*=.018, CI 0.090-0.802						
Having a close friend	BEL end				OR 4.3 p=.023 CI 1.218-15.091				
	Follow-up				OR 5.29 p=.005 CI 1.651-16.971				
Higher self-esteem	BEL end					OR 0.412 p=0.01 CI 0.197-0.858			
	Follow-up								
Higher psycho-social function-ing	BEL end								
	Follow-up							OR 0.95 p=.027 CI 0.902-0.994	
Higher education level	BEL end								
	Follow-up							OR 0.30 p=.039 CI 0.093-0.939	

[1] Occupational engagement.

A process of meaning-making through group participation

The importance and meaning of the group was a strong category to emerge from interviews with the BEL participants. Three main categories making up the stages of the process of meaning-making through group participation were constructed, along with related sub-categories. Below is a summary of the categories of meaning-making experiences and the related sub-categories. Categories built upon one another progressively, and the process of meaning-making could stop at any stage. Participants could also progress through all three stages in the process (see Figure 4), but not experience all sub-categories.

Process of meaning-making experienced through the BEL group participation.

- Joining with others: from feeling alone to connected
    - From fears and isolation to socialization
    - I'm not alone with daily life struggles
- A sense of belonging: mutual support and understanding
    - Sharing openly in a safe context
    - Good and bad days: group acceptance and understanding
    - Expanding one's social network
    - Bonding and healing through humor
- Re-valuing Self: respect and self-worth
    - Facing old views and prejudices
    - Feeling valued; respecting self and competencies
    - Purpose and self-worth through helping others

Joining with others was often reported as a personally significant step, especially if fears and previous negative experiences had kept participants from joining groups in the past. Participants often expressed surprise that after just a few sessions they could talk freely with the other group members. Experiencing *a sense of belonging* was the next stage, when the sense of togetherness deepened through sharing and bonding with others, as participants felt that the social environment was supportive and safe. Participants said that having good and bad days that affected their ability to engage in life made it difficult to sustain social relationships. Feeling understood by others, feeling 'held' by the group, and making friends or better social contacts were important parts of experiencing meaning. Mutual support allowed participants to cheer one another's accomplishments as well as support each other when struggles arose. This helped participant to want to make progress with their goals. Participants who still felt alone

after the intervention, or who did not identify or bond with their fellow group members, reported experiencing less meaning in the group. However, these participants often reported that they connected and identified with the group leaders, who were considered by participants to be part of the group. Being able to give advice and help others in the group was reported as an important part of *re-valuing self*. It was often mentioned that helping others gave a sense of purpose in relation to being able to use one's life experiences in a positive, useful way. It was also valuable for participants to receive positive feedback from their peers and to realize their competencies versus only focusing on their perceived limitations.

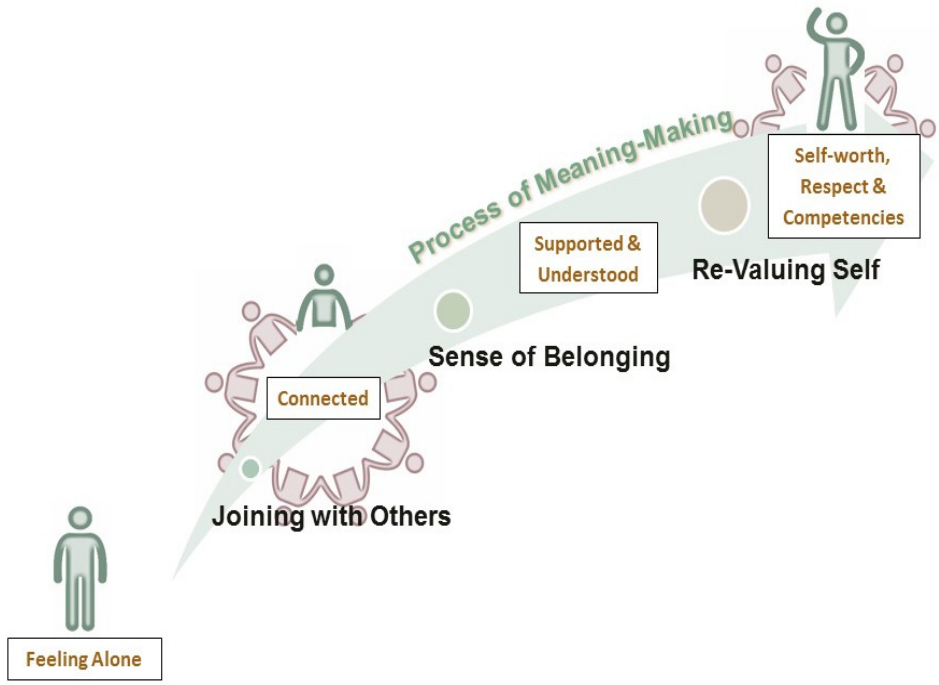


Figure 4.
Process of meaning-making with related personal changes. Based on the figure presented in Study II

Making changes toward a more balanced lifestyle and breaking a cycle of perceived failure

BEL participants described making changes in their life and lifestyle that enhanced a sense of balance. Most participants were pleased with the changes they had made, though a few reported not making changes. Participants described how they had often experienced a sense of failure when trying to make changes in their life previously, as they would set big goals which they would then abandon later as they felt they were not making progress. Being able to making changes to experience a more balanced lifestyle was described as a dynamic process.

A main category to describe this process was constructed, titled ***Breaking a cycle of perceived failure: the process of making changes toward a more balanced lifestyle.*** This process consisted of five categories, each of which had two sub-categories where one concerned a strategy for change and the other described the type of inner change made. Figure 5 illustrates this process. Participants described that learning to take a *gentle approach* to making changes was important as they realized that *change is an on-going process*. This formed the first category, and the strategy sub-category concerned *identifying and breaking down goals* into smaller sub-goals helped people begin to work towards personally-desired change and to feel as if they were making progress, even (or perhaps especially) as they were taking small steps. The inner-change sub-category related to this was about *being kind to self,* which was important as many participants described an antagonistic self-reproach when they would "fail" at something. Thus, by starting to take steps and being kind to self, the process towards personally-desired change could begin. Receiving *support for making progress, while having permission to fail* formed the second category, which was important to keep forward momentum. The strategy sub-category concerned having *support and accountability.* Whether in regard from the group, a health care worker, or a friend, support and accountability helped push oneself to take action on a stated goal. Participants described that a fear of failure could thwart initial or continued attempts to change, and therefore *daring to try* was an important inner-change sub-category, knowing that it was acceptable and they had support if the end result was not exactly as planned or desired. *Prioritizing and setting boundaries* was the next step in the process, forming the third category. The strategy of *structuring and setting limits* could entail finding structure through health-promoting occupations and routines. Learning to set limits was also important as many participants described having difficulty with saying now, which affected the daily activities they engaged in as well as in their relationships. One way of setting limits was learning to discern if a certain occupation or relationship supported their over-all well-being or not. As one participant described, it was about "more quality than quantity" when it came to occupations. The related inner-change sub-category was *prioritizing self and taking control* which focused on identifying personal needs and learning to set

boundaries. The fourth category was *adjusting for a sustainable balance*. The strategy of *pacing oneself* included being aware of one's own personal rhythms and needs, and incorporating rest and recuperation as needed. The inner change related to this was *coming to terms with oneself,* as participants could learn to accept certain life events, losses, and limitations. This was a process unique to each person, as they reflected upon the past and could come to terms with where they were in life. For some this was acceptance, for others it was not accepting certain life struggles or situations. The final category was *caring for a valued self.* The strategy for change was *utilizing inner and outer resources,* which could include their family, friends, or care professionals, but also identifying their own inner resources and strengths which could support them through difficult situations. The related inner change was *befriending self,* which meant learning to accept help from others, as well as care for themselves as they would a friend.

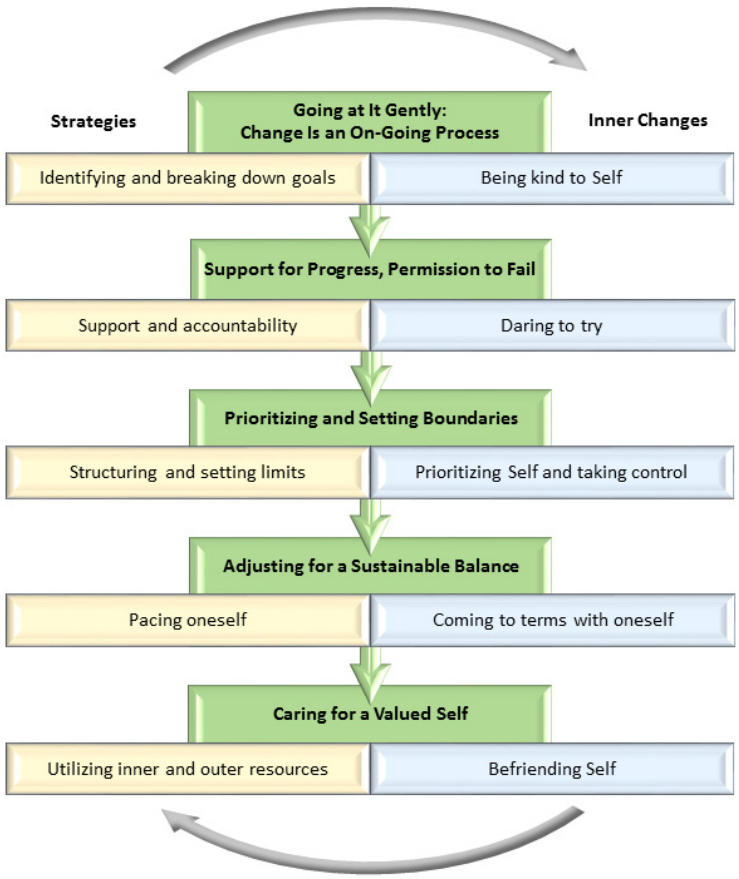


Figure 5.
Breaking a cycle of perceived failure: the process of making changes toward a more balanced lifestyle.

Group leader and participant perceptions of BEL

The results regarding the group leaders' and the participants' perspectives of BEL's content and format are presented in two sections (Parts 1 and 2 below) that are summarized in Figure 6. The term group leaders referred to the ten occupational therapist group leaders who were interviewed, as well as the 2 co-leaders who were health professionals, but not occupational therapists. Furthermore, group leaders and participants are together referred to as stakeholders in this study. Since the findings from the group leader and participant perspectives were generally similar, they are presented combined, unless otherwise noted, in Part 1. However, when it came to facilitating and hindering factors as it pertained to group leaders implementing and leading BEL, and participants attending and taking part in BEL, the perspectives differed and are thus presented separately in Part 2.

Part 1

Group leaders and participants experienced the BEL intervention as very positive in general. The first category was *Appreciating structure and content, desiring flexibility*. BEL's clear structure and format were appreciated. Both stakeholders felt that the manual was easy to follow and was a good reference for participants after the course, though some had difficulty organizing the weekly course papers into the binder. Group leaders and participants reported that the weekly topics addressed important aspects of life and built progressively upon each other. Having a manual-based intervention also made it easier for the occupational therapists' planning. The topics regarding productivity and social relationships could be sensitive or provoking for some participants, as the topics could surface feelings around lost relationships and one's role as a worker. Some participants shared that they experienced shame when hearing the word "productive" if they did not have paid work. Ultimately, however, these topics were experienced as very valuable to discuss and process together with the group. Occupational therapists felt that BEL filled a need for occupation-focused interventions in mental health outpatient or community settings, and both stakeholders appreciated the positive approach which focused on the person and their strengths and abilities instead of focusing on illness and symptoms. The "course" format was appreciated by participants, though some, before beginning BEL, had misgivings that it would be similar to a traditional education course and they might not perform satisfactorily. Thus, support from the occupational therapists was important to describe the goals and approach of BEL. BEL was referred to as a "valuable tool," and learning how to set manageable goals was stressed by both stakeholders as an important take-away from the course. The organization of the course in three phases (see Figure 1) was experienced as positive, and booster sessions in the third phase were appreciated for supporting the learning from the course, as well as easing the transition of ending.

As much as the structure and format of BEL was appreciated, most group leaders and participants also reported that they desired flexibility in order to meet different group and participants needs. For example, some experienced certain examples or exercises to be too simple or at the wrong level, such as an exercise on how to read facial expressions, while others felt the level as presented was informative and appropriate. Still, some group leaders and participants felt that certain exercises were too abstract or could be presented in a more straight-forward way for participants who needed a more concrete approach. Other participants appreciated support from their group leaders in explaining the material so they could understand. Both stakeholders felt that BEL would be better if the leaders could adapt as needed, based on the needs of their clients; however, as the project included an RCT study, the occupational therapists had been instructed to avoid changes to the material as presented for reasons of intervention fidelity and research validity. Another expression of flexibility desired was more time in regard to the amount of sessions in BEL. Many experienced the intervention as "intensive" and would have liked more time to process the material from the previous week. However, later in the interviewing process, when group leaders were more experienced, less people mentioned the course length as a problem.

The second main category of Part 1 was *Making connections - BEL as a bridge.* The value of making personal connections through BEL was often reported as a personally significant outcome of the intervention. Connecting participants was one of the ways that BEL could act as a bridge, and the closed group format supported the participants and group leaders to get to know one another. For some participants, it was the first time to attend a group and they enjoyed making deeper connections to the staff and fellow clients. Some group leaders realized that many of their long-term clients had not met each other more than in the waiting room before taking part in the BEL intervention. Getting to know the group leaders on a more personal level was appreciated by the participants as they then felt on a more equal level. Participants could also work toward goals to be more involved in activities outside the care center, which could lead to new personal and occupational connections. Many participants shared a desire to meet after the course end, and some did, though others said that it was hard to organize and they preferred a group leader to do this. Connecting to a future version of everyday life was another way that BEL could be a bridge for the participants. Participants reported breaking old patterns in order to become more active in setting goals and taking care of themselves. By working on goals, participants could start to bridge where they were in life with where they wanted to be. This could include engaging in more purposeful and meaningful occupations including leisure and social activities, work-like activities, or studies. Group leaders and participants sometimes reported that they were surprised with how much progress some participants had made through the intervention. Both stakeholders stressed that change takes time, and often the participants desired support after BEL completion to continue work towards balance and meaningful occupational engagement.

Part 2

Stakeholder-specific perceptions of facilitating and hindering factors was the focus of Part 2. In regards to implementing BEL, group leaders felt that facilitating factors included the BEL training they had received, the fact that BEL is occupation-focused and incorporates research on occupation and mental health, co-workers being open and positive to the intervention, positive reports (word of mouth) from previous participants, and having a co-leader to share the group responsibility with. Some occupational therapists felt that BEL helped to clarify their role with other professionals. Hindering factors to implementing BEL were mostly resource-related, as lack of group rooms or having a projector could limit possibilities or make it more difficult. Another hindering factor could be having difficulty to recruit participants who feared or disliked groups.

Participants felt that facilitating factors of taking part in BEL included a positive, supportive group, feeling safe in the group environment, having competent and engaged group leaders, and feeling on a similar functioning level as the other group members. Hindering factors as experienced by the participants included having different functioning levels in the group, or differing general life situations such as work or sick leave status. But these were hindrances only if they affected over-all communication or connection. Fears or previous negative experiences could also hinder participation, as could health issues.

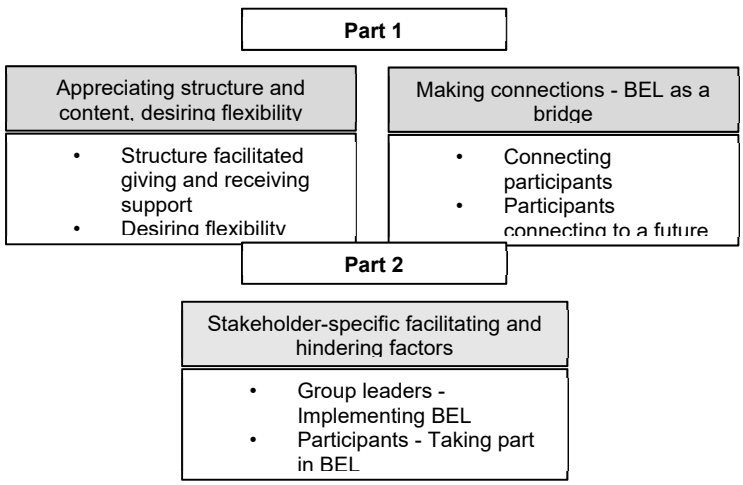


Figure 6.
Categories and sub-categories

Discussion

The four studies that made up this dissertation focused on the processes at work through the BEL intervention. Study I focused on sociodemographic, setting, clinical and self-factors as possible predictors of change in occupational aspects and quality of life. Study II proposed a process of meaning-making through group participation in BEL which included going from feeling alone to connected and supported, and re-valuing Self. Study III proposed a process of making changes toward a more balanced lifestyle as most participants interviewed reported making meaningful changes in their life. This process included strategies and inner changes that were related to different categories for making changes. Study IV focused on the BEL intervention from the group leader and participant perspectives. The structure and content of BEL was appreciated, though flexibility was desired. BEL could act as a bridge connecting participants to others and to a future version of a more balanced and engaged everyday life. Facilitating and hindering factors were identified, as perceived by the occupational therapists and participants. Figure 7 summarizes the findings of this dissertation, and how aspects of the BEL intervention worked in synergy with participants' experiences to act as a bridge toward a more balanced and meaningful daily life.

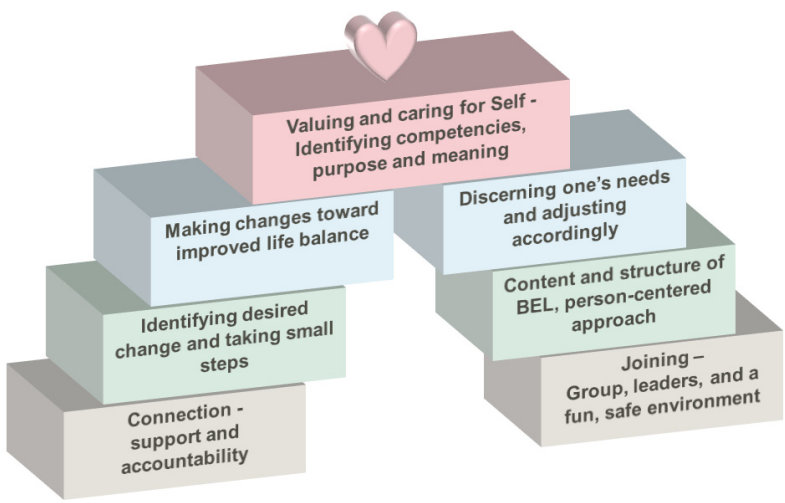


Figure 7
Components of BEL as a bridge toward a more balanced and meaningful daily life

Making life and lifestyle changes

In the BEL intervention, participants could set and work towards weekly goals, and receive feedback and support from the group. Setting personally-meaningful goals at an appropriate level was important, and most participants reported that they had dared to perform activities that fear, anxiety, or inexperience had prevented earlier. The studies in this thesis can give insight regarding what helped participants make changes in their lives. The results from the RCT study suggest that BEL participants did indeed make changes and they showed significant improvement in many areas, including occupational engagement, occupational balance, activity level, quality of life, decreased symptomology and improved functioning (Eklund, Tjörnstrand, et al., 2017).

Study I suggested that there were few of the measured factors at baseline that could predict belonging to the groups who made clinically important change, which suggests that making improvements were possible for participants with a range of sociodemographic and self-factors. Although few predictors were found, it is possible that other factors exist that were not measured. Studies II-IV proposed that the BEL intervention provided a supportive structure and social environment in which participants had the opportunity to recognize and value the actions they were taking toward a balanced lifestyle. Furthermore, these studies stressed the importance of the group format (Study IV), supportive group members and leaders (Studies II and IV), and how this could help participants in re-valuing Self as respected and worthy (Studies II and III). Study IV highlighted the importance of the content and structure of BEL, and that it was important for participants to have the opportunity to get an overview of their daily life and routines, and then to receive the tools and support to go about making changes. These findings corroborate research conducted on more traditional lifestyle interventions that showed on-going group support, socialization opportunities, structured education and accountability was appreciated by mental health service users and helped with motivation to make changes (Butterly, Adams, Brown, & Golby, 2006; Yarborough, Stumbo, Yarborough, Young, & Green, 2016).

The process of making changes proposed in Study III (see Figure 5) suggests that change involved participants realizing that working toward better balance is an on-going, gradual process of making small steps and adjustments. It contrasted what participants described as a cycle of failure, which included setting large, unspecific goals, working on goals alone, taking an all-or-none approach, and then failing to see progress. This negative cycle then confirmed a negative self-view and led to a lack of hope. The results suggested that perceived failures in the past were not a lack of action or initial motivation, but rather a lack of recognizing that one was making progress when small steps, or even attempts, had been made. The interaction of utilizing strategies for change, working toward goals, experiencing inner changes, and receiving support and encouragement could break this negative cycle. A commonly-used model in more

traditional lifestyle interventions targeting health behaviors change such as quitting smoking or dietary changes is the Transtheoretical Model of Health Behavior Change (Prochaska & Velicer, 1997). This model focuses on stages, as well as processes, of change. The authors describe five stages of change that focus on readiness for making and maintaining changes: pre-contemplation, contemplation, preparation, action, and maintenance. In relation to these changes, the participants interviewed for Studies II-IV seemed to move from preparation to action and maintenance. Furthermore, the model lists ten processes of change and, after reviewing other studies on health behavior change, Prochaska and Velicer suggested a "higher order" of two factors - experiential processes that are more internal, and behavioral processes that are more activity-related. Those behavioral processes could be viewed as similar to what in Study III are called strategies, and the experiential processes are similar to what we called inner changes. Some of their processes aligned with categories of the process outlined in Study III; for example, they described consciousness raising and self-reevaluation, which could be similar to what we described as *identifying and breaking down goals,* and what they called helping relationship was similar to the sub-category *support and accountability*. However, the Transtheoretical Model also focuses on factors to control negative behavior such as counterconditioning and stimulus control, whereas our process of change lacks such an emphasis.

The findings of this dissertation also support research done on occupation-based mental health groups that focused on supporting change. For example, Sundsteigen, Eklund, and Dahlin-Ivanoff (2009) found that participating in an occupational therapy group helped service users in making changes by managing daily occupations better through taking into account personal needs and capacities, and that they "accepted striving for balance as a constant challenge" (Sundsteigen et al., 2009, p. 177). Similarly, Rebeiro and Cook's occupational spin-off model describes the interaction of the supportive group environment, positive experience of engaging in occupations, feeling of accomplishment, and personal striving for improved well-being (1999). Studies II-IV seem to confirm these earlier findings. Study II's focus on the importance of the group support is also aligned with these studies and others (Eklund, 1997; Falk-Kessler et al., 1991) that have found the group to be a key component in participants' journey towards health.

Predictors of making clinically important change

Study I explored whether care context or socio-demographic, clinical and self-factors could predict clinically important improvements in the outcomes of occupational engagement, activity level, occupational balance, and quality of life among BEL participants. Of all factors studied, only a few factors were found to be predictors. One of the strongest predictors was having a close friend, which increased chances of belonging to the improved group in occupational balance in the leisure domain. This was the only factor found at both BEL end and follow-up for the same outcome variable. It could be theorized that those with a close friend at baseline could have more opportunities to engage in leisure activities, which supported the improvement during and after the intervention. However, those without a friend was a relatively small group, so this could be further explored in future research. Studies II-IV stressed the importance and meaning of connection and accountability, which supports this finding. Other studies have linked having a friend with quality of life (Eklund et al., 2003), through there are contrasting results regarding if having a friend is a predictor (Lam & Rosenheck, 2000), or not (Eklund & Bäckström, 2005).

Having children was found to be a predicting factor with what could be seen as contrasting influence. Those with children had increased chances of belonging to the group with increased occupational engagement (which includes the person's satisfaction with balance, variety of occupations, meaning, and routines) at BEL end. However, those with children had a decreased chance of belonging to the group with increased activity level six months later. It is possible that those without children may have had more time or need to increase their activity level. Those with children seemed to able to find better satisfaction with their occupational engagement without increasing their activity level which could have included the process described in Study III which includes prioritizing and setting boundaries which could help participants reduce the quantity of occupations engaged in, while increasing the perceived quality. This appears important as being over-occupied is more common among those with children (Eklund & Argentzell, 2016).

Female gender was found to be a predictor of belonging to the improved group in the occupational balance self-care domain at BEL end. However, this finding had a large confidence interval (OR 5.96, CI 1.298-27.357), and should thus be interpreted with caution. For both genders, setting boundaries, prioritizing self, and caring for a valued self were important parts of the process of making changes described in Study III, though women more often described the importance of learning to say no and set limits. These findings support research that shows that women tend to have less time for self-care and are often "on call" more for the needs of others (Eek & Axmon, 2015; Eklund & Argentzell, 2016; Håkansson & Ahlborg, 2010). The importance of re-valuing Self was also stressed in Study II, which could support time spent in self-care.

Clinical and self-factors were not found to be strong predictors. Better self-esteem decreased chances of belonging to the improved group regarding occupational balance in the home chores domain at BEL completion. The same was true for better psychosocial functioning and general occupational balance at the six-month follow-up. These results seem logical as lower self-esteem and psychosocial functioning may give more room for improvement in functioning, in turn entailing improved occupational balance.

Interestingly, no predicting factors were found for quality of life, including self-esteem and self-mastery. This contrasts earlier studies that found self-factors to be strong determinants (Argentzell, Tjörnstrand, & Eklund, 2017; Eklund et al., 2003). However, those studies were cross-sectional and did not focus on change or intervention outcomes, which could explain the divergence of findings. Another study found that increased self-esteem also improved health, quality of life, and social relationships (Ventegodt et al., 2007). Study I suggests that, according to bivariate analyses, self-factors at baseline were associated with change on occupational balance, activity level and quality of life following the BEL intervention, though not strong predictors of making clinically important improvements.

The meaning of connection

As mentioned above, receiving support and accountability from the group was an important factor for participants when attempting to make changes in their lives. , and that that those with a close friend had increased odds of belonging to the group with improved leisure. The importance of group support was the main focus of Study II, yet was also an important part of the results in Studies III and IV. Experiencing meaning was often mentioned in relation to feeling connected with others in the group, as well as improved relationships with others in their lives. A theory was proposed that meaning-making occurred through group participation as participants experienced positive personal contrasts related to feeling less alone, more connected, supported, respected, and worthy. However, Studies III and IV suggest that gaining the tools to make changes, feeling as if one is progressing, finding better balance in daily life and befriending Self also contribute to experiencing meaning.

Belonging is often identified as the base or first step of connecting with others on the path to creating meaning in life (King, 2004), and as an important part of the therapeutic process in occupational therapy group interventions (Horghagen et al., 2014; Rebeiro & Cook, 1999; Sundsteigen et al., 2009). Study II found that joining was an important, and perhaps over-looked, step for participants who felt alone or socially isolated. Just as a negative cycle of perceived failure was explained in Study III regarding participants previously not succeeding to make life changes, social isolation

is also described similarly when people feel poorly treated by others or have stigmatizing experiences (Link, Mirotznik, & Cullen, 1991). It seems that lack of connection to others, as well as lack of forward movement toward one's goals and dreams, can be obstacles to personal recovery toward mental health (Davidson et al., 2004; Onken et al., 2002). Alternatively, social connectedness or belonging has been associated with creating or enhancing meaning in life (Argentzell et al., 2012; Eklund, Hermansson, et al., 2012; Lambert et al., 2013; Stavrova & Luhmann, 2016). Stavrova and Luhmann (2016) suggest that the relationship between connection and meaning is bidirectional and found that higher levels of meaning were prospectively associated with three types of connectedness (intimate, relational, and collective), and that people experiencing higher levels of meaning were more likely to join volunteer organizations and have long-term relationships. Furthermore, lack of belonging, i.e. experiencing rejection or exclusion, has been found to decrease one's perception of meaning in life (Stillman et al., 2009). These results could shed light on why BEL participants found such meaning in overcoming fears and isolation to join with others in a positive group environment, which could further lead to a sense of belonging (Study II). The opposite was also true, participants in Study II who did not feel connected with the group, or felt that their main goals were not realized, seemed to experience much less meaning from the intervention. It can be theorized, if connection and meaning are bidirectional, that connection felt through the BEL group could create meaning, which could then lead to further connections in the participants' lives. This could then help in making progress toward meaningful change in their lives. This hypothesis is supported by Study IV which suggested that BEL could act as a bridge, which included connecting participants with others, and to a future version of daily life.

Being able to share experiences with others who understood was important for participants, but the group also helped participants to see their strengths and resources (Studies II-IV). Yalom and Leszcz (2005) write that the group can become a sort of family, creating a safe and nurturing social environment in which participants can heal wounds from earlier family and social situations and negative past events. Participants shared that the BEL environment quickly felt safe, and they could talk about certain life experiences that they had not dared to share with others before. However, an important result in Study II was that participants who felt that their life experiences could now help others reported feeling a sense of purpose and increased meaning. It is further theorized that through connecting with others in the process of participating in BEL, participants could identify with existential factors that challenged the notion of being alone in the universe, and having a lack of meaning, in line with Yalom and Leszcz (2005) description of existential healing factors. They suggest that life meaning emerges through transcending oneself and becoming absorbed in something or someone outside oneself. This dissertation suggests that through helping others and feeling useful, identifying others' self-competencies as well as their own, and making progress toward meaningful change, participants could identify with a purpose, which

added to experiences of meaning-making, as described by Ikiugu and Pollard (2015). These experiences are in agreement with Frankl (2004) who wrote that meaning in life can be achieved by having meaningful occupations (work or deeds), by experiencing something or encountering someone (love and connection), and by the attitude we take toward unavoidable suffering.

Caring for a valued Self

As mentioned above, being a woman was found to be a predictor of belonging to the group that made clinically important improvements in occupational balance in the self-care domain. Study II proposed that participants who experienced the deepest meaning experienced personal changes that led to growing in regards to self-worth, respect and competencies. Study II concluded that there seemed to be two processes working dynamically and symbiotically through the intervention – the group process and the individual process. Study III focused on the process of making changes. This process included participants valuing and caring for themselves, which further supported setting boundaries, pacing oneself, using available resources, and continuing to work on personal goals.

Some participants stressed the importance of processing grief from losses related to not being able to work, lost opportunities related to their mental health problems, and experiencing loss or lack of close personal relationships. Related to this, it was appreciated to start focusing on the occupations, opportunities, and relationships they wanted to cultivate in their lives. As mentioned in Study III, they could learn to discern from relationships that were devaluing or energetically depleting, contrasted with mutual relationships based on love and respect. This seemed important as many participants had experiences of being controlled or manipulated by friends, colleagues, or loved ones in the past, and not being able to set boundaries with these people. Participants could also have a hard time to identify their own needs regarding relationships and occupational engagement. BEL seemed to support learning to discern and set boundaries regarding the amount, quality, and properties of occupations and relationships in their lives. Part of this process was weighing the positive and negative attributes, and getting in touch with how it made them feel when they were engaged in a certain occupation, or with a certain person. Valuing Self was a key in taking these steps.

Study III explored how coming to terms with oneself could include reflecting on how previous life experiences and struggling with mental health affected one's ability to perform in different areas of their life such as work/studies, house work, organization and structure, as well as creating and maintaining positive personal relationships. For some this meant acceptance, while for others, it was acknowledging that they did not

accept certain aspects of their lives. A common experience was feeling shame or frustration that they could not work "like everyone else." The exercises and discussions in BEL could also help participants see their productivity in life areas other than paid work, and the value of their contributions. There seemed to be a catharsis in sharing these experiences with the others. Yalom and Leszcz write that nonjudgmental acceptance in a group can create a positive, self-reinforcing loop when participants can trust others, self-disclose, receive empathy and acceptance, which then leads to trust again (2005). This is also supported by the Shame Resiliency Theory (Brown, 2006) which proposes that shame is experienced when one feels trapped, powerless, and isolated. But through acknowledging personal vulnerability, increasing critical awareness through normalizing one's short-comings or previous experiences, and through reaching out to others and speaking about shame in a safe environment, people can move towards empathy which includes connection, power, and freedom.

Related to valuing self, self-compassion as a construct has more recently been explored as a comparison to self-esteem (Neff, 2003). According to Neff, self-compassion is a concept that comes from Buddhist philosophy and consists of three components. The first is self-kindness which includes being kind and understanding to oneself, instead of taking a harsh or self-critical approach, when experiencing pain or failure. The second is seeing oneself as normal and flawed, and part of common humanity, rather than as separated and isolated. The third focuses on mindfulness as a way to be with "painful thoughts and feelings in balanced awareness rather than over-identifying with them" (p. 89). Studies II and III seemed to support the notion of improved self-compassion through the BEL intervention as participants described that breaking old patterns of being self-critical, and learning to befriend, value, and care for Self. A self-compassionate approach seemed to contrast all-or-none thinking, which in another study was identified as a barrier for mental health service users making changes (Yarborough et al., 2016). Study III concluded that self-compassion may be the key to participants allowing themselves to utilize strategies and resources in order to dare to take steps toward change in their lives, which could break the cycle of perceived failure. What is interesting is that many participants reported that they still struggled with self-esteem, but that they had learned to accept themselves better. In comparison with self-compassion, self-esteem has been linked with how one compares oneself socially with others (Neff, 2003). Furthermore, self-compassion has been shown to act as a buffer against anxiety when encountering negative events, and increased self-compassion has been associated with increased psychosocial well-being (Neff, Kirkpatrick, & Rude, 2007). It is possible that BEL supported increased self-compassion which could contribute to the improved occupational aspects, psychosocial functioning, and quality of life as was shown in the RCT study (Eklund, Tjörnstrand, et al., 2017). However, this is only a hypothesis, and would need to be explored further.

Balancing life and lifestyle

Related to lifestyle, life balance is an important topic for experiencing and promoting health and well-being, which in this dissertation could mean increasing one's activities or trying new ones, breaking isolation to connect with others, incorporating rest to pace oneself, and identifying what is meaningful in one's life and relationships as a way to prioritize one's energy. Participants described learning that balance is not an all-or-none state, but rather a process of pacing oneself, learning to listen to the body and mind, and making adjustments accordingly. It seemed that it was important to learn and experience that it was through setting small goals and taking small steps that personally significant change towards a more balanced (and meaningful) life could occur.

As BEL incorporated learning about different life and lifestyle areas, and then setting personal goals, it is perhaps not surprising that participants' descriptions of the changes they made towards a more balanced lifestyle could include very different-seeming life areas. This included eating less sugar and meat and more vegetables, finding new opportunities (often with another person or pet) to go out and exercise, organizing one's schedule to rest and sleep *more*, organizing one's schedule to sleep *less*, setting boundaries with time, energy, or people, and finding new opportunities for recreational activities such as horseback riding, photography, art, or gardening. Some found new opportunities for supported employment, while others found that they needed to reduce or space out their work-like activities because it affected their over-all well-being. Although not a topic covered in BEL, participants also mentioned medication in relation to finding balance, whether it meant increasing, decreasing, or changing medications. The results from this dissertation support the domains included in Wagman's definition of life balance (2012). This includes occupational balance through discovering the right amount and variation of activities, and experiencing better balance in body and mind, relationships, and with time. All of these areas were covered when participants described balance.

Balance can also be described as an interaction of oppositional, contrasting states. Stephen Mitchell, an English translator of the ancient Chinese text Tao Te Ching (Tzu, 2006), describes the concept of *wei wu wei*, which can be described as "doing not-doing." There are many translations and applications of this, but Mitchell cautions that "not-doing" should not to be confused with passivity, but is instead the purest form of action. Occupational therapy studies have suggested that mental health service users who are recovering from an intense period of psychosis or similar symptomology need time to disengage from occupations in order to rest and recuperate (Sutton et al., 2012). However, disengagement can also stem from not feeling connected to reality, and feeling that it is void of meaning (Bejerholm & Eklund, 2006; Sutton et al., 2012). This dissertation touched upon aspects of participants' and group leaders' experiences with BEL that suggested a sort of dance between seemingly contrasting states. Although

Study I found the BEL group to generally be under-occupied in regards to occupational balance at baseline, many participants reported that they learned to value their time in a new way, and that pacing and decreasing their tempo was an important part of finding balance, as mentioned in Study III. Slowing one's daily pace could, it seemed, allow them to ultimately do more as they experienced less "all or none" activity patterns, which has been described in the literature (Leufstadius & Eklund, 2008). So it seems that by doing not-doing they could ultimately do more and feel better. Practicing skills and routines are other forms of doing not-doing, as one can do more without needing to think about each step. This dissertation suggests that simply adding activities may not be an appropriate approach to increasing occupational engagement and balance, but rather, it is through learning to balance one's daily rhythms, finding structure through routines, and setting boundaries to support caring for Self. For example saying no to extraneous activities and instead focusing on the important ones is a way of practicing self-care and finding better balance. Another example is finding a more balanced approach to Self, as suggested by Neff (2003), by seeing one's short-comings as being part of humanity, and acknowledging one's strengths as well.

This thesis seemed to touch on many contrasting notions that relate to the value of finding balance. For example, the process of making changes toward a more balanced lifestyle in Study III could be said to be made up of contrasts as strategies may be more active "doing" states, while inner changes could be more reflective, inner changes. This is similar to the division suggested by Prochaska and Velicer in regards to the Transtheoretical Model (1997). Something BEL participants often described was the difference in their energy and occupational engagement during the "good days," contrasted with the "bad days." However, some participants reported that they had attended BEL sessions even on the bad days, instead of staying in bed as they normally would do. Knowing that they would be accepted and understood by the group motivated them to come, even if it meant commuting over an hour on public transport, because they reported that attending the group helped them feel better. Alternatively, participants also reported relief that they would be understood by the group if they could not come to the group on a bad day. Thus, having a supportive social environment also seemed to help maintain better balance. Another contrast was that those in Study II who reported most fear of joining a group often experienced the most meaning from the social connection. Still another, Study IV found that although the structure of the BEL intervention was appreciated by participants and group leaders, flexibility was also highly desired. Overall, balance seemed to indicate a process of adjusting to life as needed, allowing flexibility for each day and circumstance.

Personal recovery

All four studies included in this dissertation addressed recovery in some way. Participants reported experiencing more control in one's life, improving belief in one's abilities, as well as valuing and caring for Self, all of which are important for personal recovery (Davidson et al., 2004; Onken et al., 2002). Making lifestyle and relationship changes seemed to contribute to a sense of connection, hope, self-competency (identity), meaning, and empowerment, supporting the recovery processes described in the CHIME framework (Leamy et al., 2011; Slade et al., 2014). Psychological empowerment (Zimmerman & Eisman, 2017) was mentioned in Study III as participants felt more empowered and competent when they were able to initiate change through gaining skills and daring to try to make personally-significant changes. Feeling more empowered also seemed to support participants in prioritizing and setting boundaries, pacing oneself, and ultimately, in caring for a valued Self. In a review of the literature done by Davidson, Shahar, Lawless, Sells, and Tondora (2006) it was emphasized that mental health service users should be active in setting their goals and directing their lives. Studies II-IV suggest that BEL achieved this, as both participants, and group leaders in Study IV, stressed the importance of the intervention being person and strength-focused, instead of illness and symptom-focused. This suggests that BEL's use of a personal recovery framework was experienced as positive by the stakeholders.

In regard to CHIME, one study with international focus groups validated the framework, but added that other factors were also important for mental health service users, including practical support such as accessing "wider life opportunities or simply to survive on a day-to-day basis at times when they were less able to manage daily activities and tasks" (Bird et al., 2014). Studies II-IV suggest that BEL, with its focus on daily life, using inner and outer resources, as well as finding balance and meaning, seemed to address these concerns. In a literature review, Doroud, Fossey, and Fortune (2015) found mental health recovery to be an on-going occupational process of gradual re-engagement. The first of three themes, "doing to get started" related to starting to engage in simple everyday tasks in the early stages of recovery. The later stages included re-engaging into everyday occupational life, and then full community participation which often meant work. As participants were not in an acute phase when joining the BEL intervention, the first phase is not applicable. However, the category of BEL as a bridge can be similar to transitioning from everyday life engagement (the second phase) to participation in the community (the third phase). At the same time, as the concept of doing not-doing was mentioned earlier, the results of Study III and IV suggest that pacing oneself, rest, gaining an overview of one's overall daily patterns, and establishing routines helped participants engage more productively and consistently in their lives. It can be suggested that although increased engagement was in fact shown for the BEL group (Eklund, Tjörnstrand, et al., 2017), the importance of self-compassion, becoming aware of one's needs, and pacing oneself could be explored further as

potential supporting factors of personal recovery. Furthermore, perhaps these factors could be part of the bridge that supported the occupational journey through re-engagement as described by Sutton et al. (2012) and Doroud et al. (2015).

Lifestyle intervention - wisdom gained

Predicting factors

Overall, few factors were found in Study I that predicted clinically important improvement in the targeted outcomes. This can be viewed as a positive finding, as it means that making changes in occupational aspects and quality of life were available to the diverse group that made up the BEL participants, often regardless of their socio-demographic details, diagnosis, psychosocial functioning level, severity of symptoms, or self-related factors at baseline. Furthermore, as care context was not found to be a predictor of clinically important improvements, BEL seems to be a suitable intervention in both outpatient psychiatry and community-based mental health settings.

Importance of joining and connecting

The importance of joining the group, and over-coming fear to be able to socialize and connect with others, was illustrated in Studies II and IV. Participants, and in Study IV also group leaders, reported that fear of groups was a significant barrier for some participants, but that overcoming this fear and being able to share with others could be very meaningful It seems that the fear of joining groups may be an important factor to consider when designing interventions, recruiting participants, and educating group leaders. Roberts and Bailey (2013) suggested that fear of joining groups has not received appropriate attention as a barrier to group participation, and found that social interaction could act as a barrier as well as an incentive. These findings are supported by Studies II and IV in this dissertation.

Fun and recreation

Engaging in leisure/recreation occupations was a change in lifestyle that many participants reported in the interviews. Study I found that having a close friend was a predictor of belonging to the group that made clinically important positive change in the occupational balance leisure category both at BEL end and at the six-month follow-up. Having fun was a category from Study II that involved participants being able to joke with each other and have fun together in the group during the BEL intervention. Study IV highlighted the importance of the last session of BEL, when many groups had

some sort of field trip or outing. New research suggests that engaging in occupations that involve connecting with others and are categorized as fun (versus meaningful or obligatory) can activate the reward pathways of the brain which can affect positive mood (Ikiugu, Hoyme, Mueller, & Reinke, 2016). Having time for leisure and friends has been found to be a predictor of self-rated health in women (Håkansson and Ahlborg, 2010). In addition, Davidson, et al. (2006) stress the importance of recreation and fun occupations as a part of mental health interventions as a way to support personal recovery, instead of only focusing on reducing symptoms. Thus, lifestyle interventions should not overlook the importance of fun and leisure activities as part of the intervention, as well as an important life area to address.

Mutual support

The mutual-support group format was chosen for the BEL intervention to offer a supportive social environment with the opportunity to expand one's network of positive relationships and support one's path of personal recovery (Argentzell & Eklund, 2012). Results from Studies II-IV seem to suggest that the BEL intervention's format and structure may support strengthening one's concept of self-competencies, making personally-meaningful changes, and connecting to a deeper meaning in one's life, which are key tenets of personal recovery (Shepherd, Boardman, & Slade, 2008a; Slade et al., 2014). Even though diversity in the groups was generally appreciated by the participants interviewed, they also mentioned that too-different functioning levels could be a barrier to connection and a feeling that everyone was engaged in the process.

Desiring flexibility

As mentioned above, the contrast between appreciating the structure and content of BEL, yet desiring flexibility was a finding of Study IV. Therapists reported following the manual as they had been directed to do so as being part of the RCT. However, extended flexibility in exercises, references, examples, and course content was desired as there was a wide range of functioning levels, occupational needs, and diagnoses of BEL participants. Group leaders described incorporating more flexibility with groups run after the study concluded. This brings up the challenge of having guidelines for those implementing an intervention to follow it as presented. Study IV concluded that some built-in flexibility in the intervention could benefit the group leaders and participants.

Time

Related to flexibility, many group leaders and participants desired more time for the intervention. BEL was initially planned to be longer than 16 weeks (up to 24 weeks), but both service users in a feedback panel and occupational therapists working in the

mental health field argued that the time should be shorter as it is hard to recruit participants for longer interventions. Participants desired more sessions to address the lifestyle changes they wanted to make, and to have continued support. After the RCT, the BEL intervention and manual were updated by the authors based on feedback from the occupational therapists and participants. Three sessions were added to part B (see Figure 1), extending the course duration from 12 weeks to 15 weeks (Argentzell & Eklund, 2017). This allows more time for the social life and sleep/rest subjects, as well as an additional catch-up session which participants can choose a goal or topic in which they need additional support. With two booster sessions spaced out to every other week, the revised BEL is 19 weeks long.

Another aspect of time concerned participants who felt that due to family and/or work obligations, they had too many responsibilities in their daily lives which then competed with having time to work on goals or course work. It is possible that these participants could feel less connected to the others who were trying to fill their time with new activities, social opportunities, or working together on goals. These findings suggest that it could be important for group leaders to support participants in similar situations to set appropriate goals that are not too time-intensive, and instead perhaps focus on using one's resources for support, prioritizing tasks in daily life, removing less important tasks, and establishing routines.

Importance of group leaders and a safe emotional environment

The emotional environment of BEL was very important as many participants reported generally being afraid of being in a group, but "felt safe" in the BEL group. This seemed to be an important component for participants, especially when trust issues or fears prevented such connection before. Studies II-IV support the literature which stresses the importance of group leaders in supporting positive participant interactions as well as group leaders interacting with participants as equals and with respect (Forsberg, Lindqvist, Bjorkman, Sandlund, & Sandman, 2011; McDevitt, Snyder, Miller, & Wilbur, 2006; Molin, Graneheim, & Lindgren, 2016; Roberts & Bailey, 2013; Yalom, 2002). BEL participants found meaning in feeling listened to and believed, and reported they felt on more equal terms or as friends with the group leaders. Therapeutic use of self, which has been discussed in the occupational therapy literature (Taylor, Lee, Kielhofner, & Ketkar, 2009), was therefore an important factor.

Implementation

Study IV found that occupational therapists experienced few barriers in implementing BEL. This is likely because there was little or no additional cost to take part in the research study, receive the training and materials, and implement BEL. The group format supported treatment efficiency for the occupational therapists, and they

reported that the participants helped one another in a way that just the therapist could not. Although the aim of Study IV was not an implementation study per se, the results touched upon certain aspects. Acceptability, as defined by Proctor et al. (2011), was regarded as positive from the BEL group leaders and participants. The structure, topics and manual of BEL helped to reduce time required for preparation by the group leaders, and it was perceived to fill a need for interventions that incorporate research, occupation-focused content, as well as incorporating a person and recovery-focused approach. It was reported that co-workers were positive to co-lead the BEL groups. Implementation barriers included availability of basic resources such as a group room and projector, and one setting needed to sometimes rent a room outside the facility if a group room was not available.

Methodological considerations

Study I

The BEL intervention included 133 participants, 106 of whom came from out-patient psychiatry settings and 27 from community-based psychiatry settings. Although unintentional, this skewness reflects how the psychiatric services with access to an occupational therapist are organized in Sweden, as the opportunities are fewer in community-based psychiatry. Nevertheless, psychiatric care context was only weakly associated with quality of life upon completion of BEL, and did not become a predictor in the multivariate analysis.

Gatekeepers were used to recruit participants to the BEL research study. Registration of participants not wishing to join was limited, thus the number of nonparticipants could not be exactly estimated and limits the generalizability of this study. Another issue was attrition that included 33 participants (25%) from baseline to completed BEL, though these did not differ from the participants who completed BEL on sociodemographic or clinical characteristics. Furthermore, the fact that women were over-represented may limit generalizability, and may suggest that participation in a group-based lifestyle intervention based on balancing daily life was more attractive to women.

Regarding the statistical analyses, the cut-off at an effect size of 0.5 for the outcome variables to indicate clinically important improvement may be discussed. According to Cohen (1988), dichotomization can decrease the measured strength of associations, due to loss of some of the variance in the dichotomized variable. This might explain why only a few of the associations based on bivariate analyses (using the full variation in the target variables) became statistically significant in the multivariate analyses (with dichotomized outcomes). The choice of method for estimating clinically important

change may also be discussed, but Cohen's ES used in this study has been shown to be reliable compared to other mathematical methods (G. R. Norman, Kathleen, & Donald, 2007). The results of Study I should be interpreted with caution as identified predictors explained a small portion of the variance, and some confidence intervals were quite wide.

This study focused on investigating sociodemographic and self-factors as predictors of the targeted outcome variables. The baseline values of the targeted outcome variables were not controlled for in the multivariate analyses. The rationale for this approach was to inform decisions in clinical practice, where sociodemographic and clinical factors are often known and can make a basis for how to compose a BEL group, whereas self-factors are more seldom routinely assessed in the occupational therapy arenas where the BEL intervention is delivered.

Studies II - IV

Using the grounded theory method (Charmaz, 2014), data collection and analysis was an iterative process. Initial sampling (i.e. early interviews) informed early and tentative theories and categories which were then challenged, added to, edited, and re-formatted based on later interviews which were part of theoretical sampling. At the end of the process, follow-up interviews were used to conclude theoretical sampling and move into final theory testing. Creswell suggests that "a grounded theory study has 'movement' or some action that the researcher is attempting to explain" (2013, p. 85). Performing data collection at different times related to the BEL intervention allowed the research team to better investigate the processes, or developments, that participants experienced. This included the process of meaning-making through group participation (Study II), making life and lifestyle changes (Study III), and general experiences of the intervention (Study IV).

Theory testing aimed to ensure that the proposed theory stay grounded in participant experiences (Charmaz, 2014). Analyst triangulation and peer debriefing (Patton, 2015) were utilized through the analysis process as co-authors read and coded selected transcripts, challenged category properties and gave feedback throughout the writing process.

Limitations of these studies could be a positive bias from the fact that more "agreeable" participants, and those who had positive experiences with the intervention, may have been more apt to agree to be interviewed. To mitigate this, gatekeepers were specifically asked to recruit participants who may have differing views, including less positive experiences. Another limitation is that all participants grew up in Sweden, which limits generalization of the findings. A related limitation could be the intervention's inclusion criteria of having sufficient knowledge of Swedish for group participation. Regarding reflexivity (Charmaz, 2014), the author of this dissertation and the co-authors of the

studies discussed assumptions, values, and possible preconceptions when interpreting the data. This included the influences from culture (the dissertation author is American, the co-authors of the studies are Swedish), professional backgrounds (all authors are female occupational therapists, though with different professional backgrounds), and life, work and educational experiences (the main supervisor has a doctoral degree in psychology). For example, changes such as prioritizing self might not be seen as a positive change in communal cultures. It became a prominent finding since both participants and authors were from Western cultures, but limits the generalization of findings.

Conclusions and clinical implications

The results from this dissertation add to the limited literature on occupation-based lifestyle interventions for people with mental disorders.

- Study I, together with previous studies showing positive results, suggests that BEL can be an appropriate occupational therapy intervention in community and clinical settings.
- As few of the examined factors were found to be predictors, BEL seems to support participants with diverse socio-demographic, clinical, and self-related characteristics to make improvements in occupational engagement, balance, activity level, and quality of life.
- Having a close friend may be a predictor of clinically important improvement in occupational balance in the leisure domain. Furthermore, making friends and having someone to be accountable to can support mental health service users when working toward lifestyle improvements. Interventions that facilitate making connections with peers may support service users expand their social networks.
- Participant fears from previous adverse experiences can create an initial barrier to joining a group, though these same participants may benefit most from interacting with others in a supportive social environment.
- Occupation and recovery-based lifestyle interventions that focus on participants' strengths and competencies versus illness and symptoms can support mental health service users in making personally-meaningful change and connections in their lives.
- The interplay of concrete strategies for making changes, combined with inner changes toward a more self-compassionate approach may help clients make continued progress toward changes that support a more balanced lifestyle.
- Making life and lifestyle changes is an on-going process that takes time and support. Learning to set manageable goals for meaningful change and feeling as if one is making progress is important for participants to not give up prematurely.

- Meaning-making can occur through connection with others, finding purpose through helping others, and feeling as if one is respected, valued, and worthy.
- Occupations perceived as fun or recreation are appreciated as part of a lifestyle intervention, and may play an important role in mental health and well-being.
- Having a structure and manual for mental health interventions supports the group leaders and participants, yet having built-in flexibility may also be an important factor to consider.
- Group leaders play an important role in establishing a warm, safe group environment in which participants feel listened to, supported, and treated as equals.

Implications for future research

As mental health is a leading public health issue, incorporating such interventions on a wider scale could be beneficial to both service users and society.

As BEL was designed and evaluated in a Swedish context, it could be valuable to implement and evaluate the intervention in other countries and cultures, while adapting as needed.

Future research could explore self-compassion in relation to intervention processes and occupational and quality of life outcomes. It could be of research interest to contrast self-compassion with other self-factors such as self-esteem and self-mastery.

Men were under-represented in the BEL population. Barriers of attracting male participants to the BEL intervention could be explored in an attempt to make the intervention more attractive to men.

Two processes were presented in this dissertations, the process of meaning-making through group participation, and the process of making changes toward a more balanced lifestyle. These proposed processes could be tested for generalizability with different populations participating in group interventions and/or wishing to make personally-meaningful lifestyle changes.

Some final words

I have had the honor to interview and speak with many BEL participants. I felt it fitting to end with some words from one of the participants.

> We (the group) have to find some way meet, a reason to meet, because life gets so much better for everyone. **It becomes so much heart in the whole, it becomes so much heart.** And there were no bad vibes at all. It's hard to explain, it probably has to do with self-confidence, that…people listen to what you say, and you notice that everyone wants to do well, and it works. My self-confidence grew, both by listening and talking. It was weird, in fact… I was 20 years old when I had my first psychosis… I have been in the hospital many years, and a group home and a lot. So I haven't experienced something this positive at any point. And that depends a lot on the staff who were in the group, they listened to us, they didn't stress us with shuffling papers when we had talked 15 minutes too much… And we talked about everything. So, as I said, there were no limitations. I do not understand how they managed the whole course, but in some way we went through bit by bit ... then you get to know many people too and they talk about everything. It was not just about the bad, that I feel bad, and I feel bad, I feel bad, but it was progressive in a way. I have never experienced that in any group before, never… The goals you set yourself. Because I had the goal from the beginning that I would [travel to] meet my mom and dad. Then it got closer and closer. Now I have talked with my mom, so soon… I will just buy the tickets. So it goes slowly but surely, no goals that could go wrong really.
>
> -Ben

Summary in Swedish/ Svensk sammanfattning

Bakgrund

Att ha en psykisk sjukdom kan påverka en persons förmåga att strukturera vardagen, engagera sig i meningsfulla aktiviteter och ha nära personliga relationer. Världshälsoorganisationen rapporterar att psykisk sjukdom är ett av världens ledande folkhälsoproblem, och att en tredjedel av befolkningen kommer att uppleva en psykisk sjukdom någon gång under livet. Symtom relaterade till psykisk sjukdom kan göra det svårt att möta kraven som ställs när det gäller arbete, familj och andra livsaktiviteter. Exempelvis kan symtom från depression göra det svårt att sova, koncentrera sig, organisera en dag och ha en positiv syn på livet. Tillsammans med missbruk utgör psykisk sjukdom den största orsaken till förlorad arbetstid på grund av funktionshinder, vilket kan få negativa effekter för individens livskvalitet, känsla av mening och att ha ett syfte. Detta kan i sin tur skapa en obalans i dennes livsstil, med mer passiva aktiviteter och mindre socialisering. Social isolering och ensamhet har identifierats som problem hos personer med långvarig psykisk ohälsa, liksom livsstilsrelaterade sjukdomar som hjärtsjukdomar och diabetes. Internationellt och i Sverige efterlyses därför hälso-och sjukvårdsåtgärder för en förbättrad livsstil och livskvalitet för personer som lever med psykisk sjukdom.

Arbetsterapeuter stöder människors engagemang i de dagliga aktiviteterna som utgör våra liv. Det kan vara allt från personlig omvårdnad, planering och matlagning, lek med barn och socialisering med andra. Att känna att man har rätt mängd och variation av aktiviteter kan definieras som aktivitetsbalans. Forskning har visat att det finns ett samband mellan livskvalitet och engagemang i meningsfulla aktiviteter, relationer och vår hälsa. Att uppleva mening i livet är också relaterat till dessa faktorer. Forskning om arbetsterapeutiska interventioner som syftar till en mer engagerad, hälsosam och meningsfull livsstil har visat sig att förbättra den psykiska och fysiska hälsan hos äldre personer i eget boende, ökad återgång i arbete för kvinnor med stressrelaterad sjukdom, och minskade ångestsymtom hos personer med psykisk ohälsa.

År 2012 lanserade de svenska forskarna Eklund och Argentzell Vardag i Balans (VIB), en gruppbaserad livsintervention som syftar till att stödja klienter inom specialistpsykiatrin eller den kommunala psykiatrin att uppnå en mer balanserad och

meningsfull vardag, samt förbättrad livskvalitet. VIB var organiserad som en 12-veckors kurs där klienterna deltog en gång i veckan antingen i den psykiatriska öppenvården eller i kommunal daglig sysselsättningsverksamhet. Gruppledarna ledde de veckovisa grupptillfällena efter kurshandboken. VIB fokuserade på att reflektera över sitt förflutna och nuvarande engagemang i meningsfulla aktiviteter, mening och syfte i livet, och att lära sig om aktivitetsbalans och obalans. Veckovisa teman innefattade vila och avkoppling, mindfulness, näringslära, motion, fritidsaktiviteter, samhällsliv och relationer, och produktivitet. Deltagarna diskuterade ämnet och formulerade personliga mål att arbeta med fram till följande träff där de kunde rapportera hur det gått och få feedback och stöd. Gruppen träffades ytterligare två gånger under månaden som följde efter kursslut för att stödja lärandet och ge deltagarna extra stöd.

Över 200 personer deltog i studien, varav hälften erbjöds VIB-interventionen medan den andra hälften fick den psykiatriska behandlingen och rehabiliteringen som de normalt skulle få. I slutet visade sig VIB gruppen ha betydligt mer engagemang i meningsfulla aktiviteter, de upplevde bättre balans i vardagen och visade sig också ha mindre symtom och bättre psykosocial funktion. Många av dessa positiva förändringar kvarstod 6 månader senare, och VIB-gruppen visade sig också ha en signifikant förbättrad livskvalitet. Dessa fynd var viktiga eftersom få sådana interventioner finns för personer med psykisk ohälsa, och mer forskning behövs.

Doktorsavhandling - en sammanfattning av de fyra studierna

Eftersom VIB är en ny intervention, och forskningsbaserade arbetsterapeutiska interventioner som är inriktade mot psykisk hälsa är få, var det viktigt att undersöka erfarenheterna från VIB-deltagare och gruppledare samt faktorer som påverkar utfallet av interventionen. Det övergripande syftet med denna avhandling var en djupgående undersökning av beståndsdelarna i VIB-interventionen, särskilt utifrån deltagarnas och arbetsterapeuternas perspektiv. Också att få insikt huruvida vissa faktorer hade en avgörande betydelse för förbättrad aktivitet och livskvalitet. En blandning av metoder användes i denna avhandling som innehöll ett kvantitativt (statistiskt) tillvägagångssätt i studie I för att undersöka möjliga avgörande faktorer för utfallet och ett kvalitativt tillvägagångssätt för studierna II-IV som innehöll djupintervjuer med ett en utvald mindre grupp av VIB deltagare. Intervjuerna och analyserna gjordes med hjälp av en konstruktivistisk grundad teorimetod. Istället för att ha en förutbestämd hypotes, uppmuntrar grundad teori forskaren att fokusera på framväxande kategorier i intervjuerna och följa upp dessa i senare intervjuer med deltagarna för att testa nya teorier. På så sätt påverkar både forskarnas och deltagarnas interaktioner, med deras respektive erfarenheter och bakgrund, uppbyggnaden av en teori.

Faktorer avgörande för förändring -Studie I

Syftet med denna studie var att undersöka huruvida sociodemografiska-, kliniska och självrelaterade faktorer och sjukvårdkontext kunde vara avgörande faktorer för utfallet av VIB-interventionen när det gällde aktivitets- och balansfaktorer samt livskvalitet. Deltagarna var vuxna i arbetsför ålder som fick vård inom specialistpsykiatrin eller den kommunala psykiatrin. Deras diagnoser inkluderade depression, ångest, bipolär sjukdom, psykos, ADHD och autism/Aspergers. Alla deltagare var sjukskrivna på halvtid eller heltid på grund av psykisk ohälsa. Innan de började VIB-interventionen (refererad till som baslinje) fyllde i 133 deltagare frågeformulär angående deras sociodemografiska och kliniska uppgifter, psykosocial funktion, självkänsla, egenkontroll, livskvalitet och aktivitetsengagemang, aktivitetsnivå och aktivitetsbalans. Uppföljningar ägde rum 16 veckor senare vid avslutning, liksom sex månader efter. Ett visst bortfall förekom mellan uppföljningarna, vilket är vanligt förekommande, vissa deltagare slutförde inte interventionen, andra ville inte fortsätta i studien, ytterligare orsaker var arbete, hälsa och krav från familjelivet.

Statistiska analyser utfördes på data för att se om vissa sociodemografiska, kliniska, och självfaktorer kunde vara prediktorer, vilket innebär att de skulle öka möjligheterna för att tillhöra de grupper som gjorde kliniskt viktiga förbättringar. Först gjordes bi-variata statistiska analyser för att identifiera potentiellt avgörande faktorer, dvs. prediktorer. Många av ovan nämnda faktorer visade sig ha ett samband med en förbättring i aktivitetsengagemang, aktivitetsnivå, aktivitetsbalans och livskvalitet. Därefter gjordes ett antal multi-variata regressionsanalyser. Få faktorer visade sig vara avgörande för att öka chansen för att göra kliniskt viktiga förbättringar. Av de avgörande faktorerna som framkom var en av de starkaste att ha en nära vän, vilket ökade oddsen med fyra gånger vid VIB-slut och fem gånger vid uppföljningen, för förbättrad aktivitetsbalans när det gällde fritidsaktiviteter. Kvinnor visade sig ha nästan sex gånger ökade odds för förbättringar i aktivitetsbalansen i samband med personlig omvårdnad vid slutet av VIB. Kvinnor har i forskning visats sig ha högre odds för att utföra för många aktiviteter i sin vardag och därmed uppleva en aktivitetsobalans, så det kan vara en relaterad faktor. Deltagare som hade barn hade en nästan fyra gånger ökad chans att göra förbättringar i aktivitetsengagemang (som mättes i form av tillfredsställelse med en mängd aktiviteter, balans, mening och rutiner). De utan barn hade ökade odds för att öka mängden dagliga aktiviteter. De med högre självkänsla hade minskade odds för förbättring av aktivitetsbalans i hushållsaktiviteter. Deltagare med högre psykosocial funktion och utbildningsnivå visade sig ha något lägre odds för att tillhöra gruppen som gjorde kliniskt viktiga förbättringar i när det gällde generell aktivitetsbalans. Många faktorer visade ett samband med livskvalitet, men inga faktorer visade sig vara prediktorer. Slutsatsen blev att interventionen VIB i stort sett fungerade oberoende av socio-ekonomiska och kliniska förutsättningar och därför är lämplig för den breda grupp av klienter från psykiatrisk öppenvård och kommunal psykiatri som ingick i studien.

Tillhörighetens betydelse - Studie II

Ur den större VIB-gruppen valdes 19 deltagare som intervjuades om sina erfarenheter av VIB-interventionen, intervjuerna används i studierna II-IV. Gruppen betydelse för deltagarna var en kategori som framkom tidigt i intervjuprocessen. Således beslutades det att i Studie I fokusera på deltagarnas uppfattning om gruppen och vad som ger mening i en gruppintervention. Sammanlagt 26 intervjuer ägde rum. Deltagarna intervjuades en till sex månader efter att VIB hade slutförts, och några deltagare intervjuades mer än en gång, inklusive mitt under interventionen och 1,5-3 år efter VIB för att få ett longitudinellt perspektiv. En process för meningsskapande genom gruppdeltagande konstruerades. Alla deltagare upplevde inte alla kategorier i processen. Deltagarna som upplevde mest mening var de som övergick från att känna sig ensamma till att ha kontakt med andra, en känsla av tillhörighet, och genom grupprocessen kunde värdesätta sig själva och känna sig respekterade. Gruppledarna var en viktig del av gruppen och bidrog till att skapa en trygg social miljö. För många deltagare var att övervinna rädsla för att vara med i gruppen av personlig betydelse, särskilt när de kände att de efter några grupptillfällen kunde prata om vad som helst med gruppen. Deltagarna rapporterade att det var en lättnad att få reda på att de inte var de enda som kämpade med det dagliga livet, och det uppskattades att kunna ha kul och skoja i gruppen, samt utöka sin vänskapskrets. Gruppen hjälpte också deltagarna eftersom de kunde diskutera tidigare känslor och känna sig värdesatta av de andra gruppmedlemmarna för sina styrkor och kompetenser istället för uppfattade begränsningar. Att kunna ge råd eller hjälpa andra bidrog till en känsla av syfte och mening, eftersom deras egna livserfarenheter kunde användas till något gott.

Processen att göra ändringar mot en mer balanserad vardag - Studie III

Den tredje studien hade samma 26 intervjuer med 19 deltagaren som studie II, plus tre till uppföljningsintervjuer med deltagare. Studien belyste vilka förändringar deltagarna gjorde i sin vardag och i sin självbild som ledde till en känsla av förbättrade balans. De flesta deltagarna var nöjda med de förändringar de hade gjort, även om några rapporterade att de inte hade gjort ändringar. Deltagarna beskrev hur de ofta upplevt en känsla av misslyckande när de försökt göra förändringar tidigare i sitt liv eftersom de satt upp för stora mål som de sedan övergav när de kände att de inte gjorde framsteg. Att göra ändringar i livet inkluderade att lära sig att balans inte är ett antingen-eller tillstånd, utan snarare en dynamisk process i en takt som passar personen själv, lära sig att lyssna på kropp och sinne och göra de anpassningar som behövs. Det verkade som om det var viktigt att lära sig, och uppleva, att det var genom att sätta upp små mål och ta små steg som en förändring av personlig betydelse mot ett mer balanserat (och meningsfullt) liv kunde inträffa. Förändringarna kunde indelas i fem olika kategorier – inse att förändringar tar tid, få stöd för att utvecklas men ge sig själv tillstånd att våga och misslyckas, prioritera och sätta gränser, anpassa sig till en hållbar balans, och att värdesätta och ta hand om sig själv. För varje förändring kunde också en viss strategi

identifieras, såsom att använda inre och yttre resurser för att bli sin egen vän. Det verkade som om självmedkänslan (att vara vän med sig själv) var viktig och att tillåta sig själv att använda de strategier och resurser som kunde göra livet bättre. Det var också viktigt att lära sig att bedöma egenskaper hos aktiviteter och relationer - de som ger energi eller tar energi. Deltagarna var ofta förvånad hur relationer blev bättre när de började att sätta gränser.

Erfarenheter av VIB - Studie IV

I den fjärde studien redovisas de erfarenheter deltagare och gruppledare hade av själva interventionen. Utöver de 29 intervjuer med 19 deltagare som beskrivs tidigare, deltog 12 gruppledare i fokusgrupper och/eller individuella intervjuer. Båda parter (dvs. deltagare och gruppledare) upplevde att de hade haft stor nytta av den struktur som finns inbyggd i VIB, och det faktum att den är manualbaserad. Det gav struktur till deltagarnas vardag och kunde stärka gruppledarna i deras professionella roll. Samtidigt upplevde man från båda håll att det hade varit bra med mer flexibilitet, så som exempelvis att längre tid kunde ägnas åt ett visst tema. VIB upplevdes också skapa broar – till andra människor, till samhället i stort och till andra delar av vården. Gruppledarna uppskattade att VIB var aktivitets- och personfokuserad, med personens styrkor i fokus istället för sjukdomen. De upplevde att det var enkelt att genomföra interventionen på sina arbetsplatser. Deltagarna uppskattade gruppledarnas förmåga att hålla en struktur i gruppen, men ändå ge alla utrymme att prata, och att de kände sig respekterades och lyssnade på. De hindrande faktorer som beskrevs var delvis olika för gruppledare och deltagare. Gruppledarna nämnde främst materiella hinder, såsom avsaknad av lämplig lokal eller utrustning. Deltagarna hade exempelvis upplevt att alltför olika funktionsnivå gruppdeltagarna emellan kunde vara ett hinder.

Avhandlingens nyhetsvärde

Forskning som utvärderar arbetsterapeutiska interventioner är inte vanligt förekommande, speciellt inte när det gäller interventioner för personer med psykisk ohälsa. Avhandlingen ger ökad förståelse för de processer och faktorer som leder till bättre balans i vardagslivets aktiviteter och ökat välbefinnande för personer som genomgår VIB. Därmed ger den ett viktigt bidrag, även internationellt sett, till kunskapsbasen för arbetsterapeutiska interventioner inom det psykiatriska området.

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References

Anthony, W. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal, 16*(4), 11-23. doi:http://dx.doi.org/10.1037/h0095655

Argentzell, E., & Eklund, M. (2012). *Vardag i Balans. En manual för kursledare [Balancing Everyday Life. A manual for course leaders.]*. Hälsa, vård och samhälle. Lunds universitet.

Argentzell, E., & Eklund, M. (2017). *Vardag i Balans. En manual för kursledare [Balancing Everyday Life. A manual for course leaders.]*. Hälsa, vård och samhälle. Lund University.

Argentzell, E., Håkansson, C., & Eklund, M. (2012). Experience of meaning in everyday occupations among unemployed people with severe mental illness. *Scandinavian Journal of Occupational Therapy, 19*, 49-58.

Argentzell, E., Tjörnstrand, C., & Eklund, M. (2017). Quality of Life Among People with Psychiatric Disabilities: Does Day Centre Attendance Make a Difference? *Community Mental Health Journal*, 984-990. doi:10.1007/s10597-017-0084-0

Bejerholm, U. (2010). Relationships between occupational engagement and status of and satisfaction with sociodemographic factors in a group of people with schizophrenia. *Scandinavian Journal of Occupational Therapy, 17*(3), 244-254. doi:https://doi.org/10.3109/11038120903254323

Bejerholm U. (2011) *The Profiles of Occupational Engagement in people with Severe Mental Ilness - Self rating version*. Lund University: Department of Health Sciences/Work and Mental Health.

Bejerholm, U., & Eklund, M. (2004). Time-use and occupational performance among persons with schizophrenia. *Occupational Therapy in Mental health, 20*(1), 27-47. doi:https://doi.org/10.1300/J004v20n01_02

Bejerholm, U., & Eklund, M. (2006). Engagement in occupations among men and women with schizophrenia. *Occupational Therapy International, 13*(2), 100-121. doi:10.1002/oti.210

Bejerholm, U., & Eklund, M. (2007). Occupational engagement in persons with schizophrenia: relationships to self-related variables, psychopathology, and quality of life. *American Journal of Occupational Therapy, 61*(1), 21-32.

Bejerholm, U., Hansson, L., & Eklund, M. (2006). Profiles of occupational engagement among people with schizophrenia: Instrument development, content validity, inter-rater reliability, and internal consistency. *British Journal of Occupational Therapy, 69*, 58-68.

Bejerholm, U., & Lundgren-Nilsson, Å. (2015). Rasch Analysis of the Profiles of Occupational Engagement in people with Severe mental illness (POES) instrument. *Health and Quality of Life Outcomes*(1), 1-8. doi:10.1186/s12955-015-0327-0

Bird, V., Leamy, M., Le Boutillier, C., Williams, J., Slade, M., & Tew, J. (2014). Fit for purpose? Validation of a conceptual framework for personal recovery with current mental health consumers. *Australian and New Zealand Journal of Psychiatry, 48*(7), 644-653. doi:10.1177/0004867413520046

Bjorkman, T., & Svensson, B. (2005). Quality of life in people with severe mental illness. Reliability and validity of the Manchester Short Assessment of Quality of Life (MANSA). *Nordic Journal of Psychiatry, 59*(4), 302-306. doi:10.1080/08039480500213733

Björkman, T., & Hansson, L. (2002). Original article: Predictors of improvement in quality of life of long-term mentally ill individuals receiving case management. *European Psychiatry, 17*, 33-40. doi:10.1016/S0924-9338(02)00621-1

Brown, B. (2006). Shame Resilience Theory: A Grounded Theory Study on Women and Shame. *Families in Society: Journal of Contemporary Social Services, 87*(1), 43-52. doi:10.1606/1044-3894.3483

Butterly, R., Adams, D., Brown, A., & Golby, J. (2006). Client perceptions of the MUSCSEL project: a community-based physical activity programme for patients with mental health problems. *Journal of Public Mental Health, 5*(4), 45-52.

Cabassa, L. J., Ezell, J. M., & Lewis-Fernández, R. (2010). Lifestyle interventions for adults with serious mental illness: a systematic literature review. *Psychiatric Services, 61*(8), 774-782.

Chan, P. S., Krupa, T., Lawson, J. S., & Eastabrook, S. (2005). An outcome in need of clarity: building a predictive model of subjective quality of life for persons with severe mental illness living in the community. *American Journal of Occupational Therapy, 59*(2), 181-190.

Chapman, B. P., Duberstein, P. R., Sorensen, S., & Lyness, J. M. (2007). Gender Differences in Five Factor Model Personality Traits in an Elderly Cohort: Extension of Robust and Surprising Findings to an Older Generation. *Personality and Individual Differences, 43*(6), 1594-1603.

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative research*. London ; Thousand Oaks, Calif.: Sage Publications.

Charmaz, K. (2014). *Constructing grounded theory* (2nd edition ed.). London ; Thousand Oaks, Calif.: Sage.

Charmaz, K. (2015). Grounded Theory. In J. Smith (Ed.), *Qualitative psychology: A practical guide to research methods.* (pp. 53-84). Los Angeles, CA: Sage.

Christiansen, C. H. (2007). Adolf Meyer revisited: connections between lifestyles, resilience and illness. *Journal of Occupational Science, 14*(2), 63-76.

Christiansen, C. H., Clark, F., Kielhofner, G., & Rogers, J. (1995). Position paper: occupation. American Occupational Therapy Association. *American Journal of Occupational Therapy, 49*(10), 1015-1018.

Christiansen, C. H., & Matuska, K. (2006). Lifestyle balance: A review of concepts and research. *Journal of Occupational Science, 13*, 49-61.

Christiansen, C. H., & Townsend, E. (2010). An Introduction to Occupation. In C. H. Christiansen & E. Townsend (Eds.), *Introduction to Occupation. The Art and Science of Living* (pp. 1-34). Upper Saddle River [NJ]: Pearson.

Clark, F., Azen, S. P., Zemke, R., Jackson, J., Carlson, M., Mandel, D., . . . Lipson, L. (1997). Occupational therapy for independent-living older adults. A randomized controlled trial. *JAMA, 278*(16), 1321-1326. doi:http://dx.doi.org/10.1001/jama.1997.03550160041036.

Clark, F., Jackson, J., Carlson, M., Chou, C. P., Cherry, B. J., Jordan-Marsh, M., . . . Azen, S. P. (2012). Effectiveness of a lifestyle intervention in promoting the well-being of independently living older people: results of the Well Elderly 2 Randomised Controlled Trial. *Journal of Epidemiology & Community Health, 66*(9), 782-790. doi:10.1136/jech.2009.099754

Cohen, J. (1988). *Statistical power analysis for the behavioral sciences*. Hillsdale NJ: Lawrence Erlbaum.

Cole, M. B. (2012). *Group dynamics in occupational therapy* (4th ed.). Thorofare, NJ: Slack incorporated.

Connell, J., Brazier, J., O'Cathain, A., Lloyd-Jones, M., & Paisley, S. (2012). Quality of life of people with mental health problems: a synthesis of qualitative research. *Health Quality of Life Outcomes, 10*(1), 138.

Connell, J., O'Cathain, A., & Brazier, J. (2014). Measuring quality of life in mental health: are we asking the right questions? *Social Science & Medicine, 120*, 12-20.

Creswell, J. W. (2013). *Qualitative inquiry and research design: Choosing among five approaches*: Sage.

Davidson, L., O'Connell, M. J., Tondora, J., Lawless, M. S., & Evans, A. C. (2005). Recovery in Serious Mental Illness: A New Wine or Just a New Bottle? *Professional Psychology: Research and Practice, 36*(5), 480-487. doi:10.1037/0735-7028.36.5.480

Davidson, L., Shahar, G., Lawless, M. S., Sells, D., & Tondora, J. (2006). Play, pleasure, and other positive life events: "non-specific" factors in recovery from mental illness? *Psychiatry, 69*(2), 151-163. doi:10.1521/psyc.2006.69.2.151

Davidson, L., Shahar, G., Stayner, D. A., Chinman, M. J., Rakfeldt, J., & Tebes, J. K. (2004). Supported socialization for people with psychiatric disabilities: Lessons from a randomized controlled trial. *Journal of Community Psychology, 32*(4), 453-477. doi:10.1002/jcop.20013

Deegan, P. E. (1997). Recovery and empowerment for people with psychiatric disabilities. *Social Work in Health Care, 25*(3), 11-24.

Dey, I. (1999). *Grounding grounded theory: guidelines for qualitative inquiry*. San Diego, Ca: Academic Press.

Dey, I. (2013). Grounding Categories. In A. Bryant & K. Charmaz (Eds.), *The Sage Handbook of Grounded Theory* (pp. 167-190). Thousand Oaks, Ca: Sage.

Diener, E. (2006). Guidelines for national indicators of subjective well-being and ill-being. *Journal of Happiness Studies: An Interdisciplinary Forum on Subjective Well-Being, 7*(4), 397-404. doi:10.1007/s10902-006-9000-y

Doroud, N., Fossey, E., & Fortune, T. (2015). Recovery as an occupational journey: A scoping review exploring the links between occupational engagement and recovery for people with enduring mental health issues. *Australian Occupational Therapy Journal, 62*(6), 378-392. doi:10.1111/1440-1630.12238

Eek, F., & Axmon, A. (2015). Gender inequality at home is associated with poorer health for women. *Scandinavian Journal of Public Health, 43*(2), 176-182. doi:10.1177/1403494814562598

Eklund, M. (1997). Therapeutic factors in occupational group therapy identified by patients discharged from a psychiatric day center and their significant others. *Occupational Therapy International, 4*, 198-212.

Eklund, M. (1999). Outcome of occupational therapy in a psychiatric day care unit for long-term mentally ill patients. *Occupational Therapy in Mental health, 14*(4), 21-45. doi:10.1300/J004v14n04_02

Eklund, M., & Argentzell, E. (2016). Perception of occupational balance by people with mental illness: A new methodology. *Scandinavian Journal of Occupational Therapy*, 1-10. doi:10.3109/11038128.2016.1143529

Eklund, M., & Bejerholm, U. (2007). Temperament, character, and self-esteem in relation to occupational performance in people with schizophrenia. *OTJR: Occupation, Participation and Health, 27*(2), 52-58.

Eklund, M., & Bäckstrom, M. (2006). The role of perceived control for the perception of health by patients with persistent mental illness. *Scandinavian Journal of Occupational Therapy, 13*(4), 249-256.

Eklund, M., & Bäckström, M. (2005). A model of subjective quality of life for outpatients with schizophrenia and other psychoses. *Quality of Life Research, 14*(4), 1157-1168.

Eklund, M., Bäckström, M., & Hansson, L. (2003). Personality and self-variables: important determinants of subjective quality of life in schizophrenia out-patients. *Acta Psychiatrica Scandinavica, 108*(2), 134-143.

Eklund, M., Bäckström, M., & Hansson, L. (2018). Psychometric evaluation of the Swedish version of Rosenberg's self-esteem scale. *Nordic Journal of Psychiatry, 72*(5), 318.

Eklund, M., & Erlandsson, L.-K. (2011). Return to work outcomes of the Redesigning Daily Occupations (ReDO) program for women with stress-related disorders-A comparative study. *Women & Health, 51*(7), 676-692. doi:10.1080/03630242.2011.618215

Eklund, M., Erlandsson, L.-K., & Hagell, P. (2012). Psychometric properties of a Swedish version of the Pearlin Mastery Scale in people with mental illness and healthy people. *Nordic Journal of Psychiatry, 66*(6), 380-388.

Eklund, M., Erlandsson, L.-K., & Leufstadius, C. (2010). Time use in relation to valued and satisfying occupations among people with persistent mental illness: Exploring occupational balance. *Journal of Occupational Science, 17*(4), 231-238. doi:10.1080/14427591.2010.9686700

Eklund, M., Hermansson, A., & Håkansson, C. (2012). Meaning in life for people with schizophrenia: Does it include occupation? *Journal of Occupational Science, 19*(2), 93-105. doi:10.1080/14427591.2011.605833

Eklund, M., & Leufstadius, C. (2007). Relationships between occupational factors and health and well-being in individuals with persistent mental illness living in the community. *Canadian Journal of Occupational Therapy, 74*(4), 303-313. doi:10.1177/000841740707400403

Eklund, M., Leufstadius, C., & Bejerholm, U. (2009). Time use among people with psychiatric disabilities: implications for practice. *Psychiatric rehabilitation journal, 32*(3), 177-191. doi:10.2975/32.3.2009.177.191

Eklund, M., Orban, K., Argentzell, E., Bejerholm, U., Tjörnstrand, C., Erlandsson, L.-K., & Håkansson, C. (2017). The linkage between patterns of daily occupations and occupational balance: Applications within occupational science and occupational therapy practice. *Scandinavian Journal of Occupational Therapy, 24*(1), 41-56.

Eklund, M., & Sandlund, M. (2012). The life situation of people with persistent mental illness visiting day centers: A comparative study. *Community Mental Health Journal, 48*(5), 592-597. doi:10.1007/s10597-011-9410-0

Eklund, M., Tjörnstrand, C., Sandlund, M., & Argentzell, E. (2017). Effectiveness of Balancing Everyday Life (BEL) versus standard occupational therapy for activity engagement and functioning among people with mental illness–a cluster RCT study. *BMC Psychiatry, 17*(1), 363. doi:10.1186/s12888-017-1524-7

Endicott, J., Spitzer, R. L., Fleiss, J. L., & Cohen, J. (1976). The global assessment scale. A procedure for measuring overall severity of psychiatric disturbance. *Archives of General Psychiatry, 33*(6), 766-771.

Erlandsson, L.-K. (2013). The Redesigning Daily Occupations (ReDO) program: Supporting women with stress-related disorders to return to work - Knowledge base, structure, and content. *Occupational Therapy in Mental health, 29*(1), 85-101. doi:10.1080/0164212X.2013.761451

Erlandsson, L.-K., Eklund, M., & Persson, D. (2011). Occupational value and relationships to meaning and health: Elaborations of the ValMO-model. *Scandinavian Journal of Occupational Therapy, 18*(1), 72-80. doi:10.3109/11038121003671619

Falk-Kessler, J., Momich, C., & Perel, S. (1991). Therapeutic factors in occupational therapy groups. *American Journal of Occupational Therapy, 45*(1), 59-66.

Fazio, L. (2008). Developing Occupation-Centered Programs for the Community. *22*(4), 78-79.

Forsberg, K. A., Lindqvist, O., Bjorkman, T. N., Sandlund, M., & Sandman, P. O. (2011). Meanings of participating in a lifestyle programme for persons with psychiatric disabilities. *Scandinavia Journal of Caring Sciences, 25*(2), 357-364. doi:10.1111/j.1471-6712.2010.00834.x

Frankl, V. E. (2004). *Man's search for meaning*. London: Rider Books.

Goldberg, B., Britnell, E. S., & Goldberg, J. (2002). The relationship between engagement in meaningful activities and quality of life in persons disabled by mental illness. *Occupational Therapy in Mental health, 19*(2), 17-44. doi:doi: 10.1300/J004v18n02_03

Haertl, K., & Minato, M. (2006). Daily occupations of persons with mental illness: Themes from Japan and America. *Occupational Therapy in Mental health, 22*(1), 19-32. doi:https://doi.org/10.1300/J004v22n01_02

Hammell, K. W. (2004). Dimensions of meaning in the occupations of daily life. *Canadian Journal of Occupational Therapy, 71*(5), 296-305.

Hansson, L. (2006). Determinants of quality of life in people with severe mental illness. *Acta Psychiatrica Scandinavica, 429*, 46. doi:10.1111/j.1600-0447.2005.00717.x

Hasselkus, B. (2011). *The Meaning of Everyday Occupation, Second Edition*. Thorofare, NJ: Slack inc.

Hayes, R. L., & Halford, W. K. (1996). Time use of unemployed and employed single male schizophrenia subjects. *Schizophrenia Bulletin, 22*(4), 659-669.

Hitch, D., Pepin, G., & Stagnitti, K. (2013). Engagement in activities and occupations by people who have experienced psychosis: a metasynthesis of lived experience. *British Journal of Occupational Therapy, 76*(2), 77-86.

Horghagen, S., Fostvedt, B., & Alsaker, S. (2014). Craft activities in groups at meeting places: supporting mental health users' everyday occupations. *Scandinavian Journal of Occupational Therapy, 21*(2), 145-152.

Håkansson, C., & Ahlborg, G. (2010). Perceptions of employment, domestic work, and leisure as predictors of health among women and men. *Journal of Occupational Science* (3), 150.

Ikiugu, M. N., Hoyme, A. K., Mueller, B., & Reinke, R. R. (2016). Difference between meaningful and psychologically rewarding occupations: Findings from two pilot studies. *Journal of Occupational Science, 23*(2), 266-277.

Ikiugu, M. N., & Pollard, N. (2015). *Meaningful living across the lifespan: Occupation-based intervention strategies for occupational therapists and scientists*. Forest Hill, UK: Whiting and Birch.

Jackson, J., Carlson, M., Mandel, D., Zemke, R., & Clark, F. (1998). Occupation in lifestyle redesign: the Well Elderly Study Occupational Therapy Program. *American Journal of Occupational Therapy, 52*(5), 326-336.

Jensen, M. (2007). Defining lifestyle. *Environmental Sciences, 4*(2), 63-73.

Jensen, M. (2009). Lifestyle: suggesting mechanisms and a definition from a cognitive science perspective. *Environment, Development and Sustainability, 11*(1), 215-228.

Johanson, S., & Bejerholm, U. (2017). The role of empowerment and quality of life in depression severity among unemployed people with affective disorders receiving mental healthcare. *Disability & Rehabilitation, 39*(18), 1807.

Johansson, A., & Björklund, A. (2016). The impact of occupational therapy and lifestyle interventions on older persons' health, well-being, and occupational adaptation: A mixed-design study. *Scandinavian Journal of Occupational Therapy, 23*(3), 207-219.

Johnson, R., McGowan, M., & Turner, L. (2010). Grounded Theory in Practice: Is It Inherently a Mixed Method? *Research in the Schools, 17*(2), 65-78.

Keyes, C. L. (2013). Promoting and protecting positive mental health: Early and often throughout the lifespan. In C. L. Keyes (Ed.), Mental Well-Being: International Contributions to the Study of Positive Mental Health (pp. 3-28). Dordrecht, Netherlands: Springer. doi:10.1007%2F978-94-007-5195-8

King, G. A. (2004). The meaning of life experiences: application of a meta-model to rehabilitation sciences and services. *American Journal of Orthopsychiatry, 74*(1), 72-88. doi:10.1037/0002-9432.74.1.722004-10573-008 [pii]

Krueger, R., & Casey, M. (2009). Focus groups: A practical guide to applied science: Thousand Oaks, CA: Sage.

Krupa, T., Fossey, E., Anthony, W. A., Brown, C., & Pitts, D. B. (2009). Doing daily life: How occupational therapy can inform psychiatric rehabilitation practice. *Psychiatric rehabilitation journal, 32*(3), 155.

Lam, J. A., & Rosenheck, R. A. (2000). Correlates of improvement in quality of life among homeless persons with serious mental illness. *Psychiatric Services (Washington, D.C.), 51*(1), 116-118.

Lambert, N. M., Stillman, T. F., Hicks, J. A., Kamble, S., Baumeister, R. F., & Fincham, F. D. (2013). To belong is to matter: Sense of belonging enhances meaning in life. *Personality and Social Psychology Bulletin, 39*(11), 1418-1427.

Le Boutillier, C., Leamy, M., Bird, V. J., Davidson, L., Williams, J., & Slade, M. (2011). What does recovery mean in practice? A qualitative analysis of international recovery-oriented practice guidance. *Psychiatric Services, 62*(12), 1470-1476. doi:10.1176/appi.ps.001312011

Leamy, M., Bird, V., Le Boutillier, C., Williams, J., & Slade, M. (2011). Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. *British Journal of Psychiatry, 199*(6), 445-452. doi:https://doi.org/10.1192/bjp.bp.110.083733

Lehman, A. F. (1983). The well-being of chronic mental patients: Assessing their quality of life. *Archives of general psychiatry, 40*(4), 369-373.

Lehman, A. F. (1996). Measures of quality of life among persons with severe and persistent mental disorders. *Social Psychiatry and Psychiatric Epidemiology, 31*(2), 78-88.

Leufstadius, C., & Eklund, M. (2008). Time use among individuals with persistent mental illness: identifying risk factors for imbalance in daily activities. *Scandinavian Journal of Occupational Therapy, 15*(1), 23-33. doi:https://doi.org/10.3109/11038128.2014.952905

Leufstadius, C., Eklund, M., & Erlandsson, L. K. (2009). Meaningfulness in work - Experiences among employed individuals with persistent mental illness. *Work, 34*(1), 21-32. doi:10.3233/WOR-2009-0899

Leufstadius, C., Erlandsson, L. K., & Eklund, M. (2006). Time use and daily activities in people with persistent mental illness. *Occupational Therapy International, 13*(3), 123-141. doi:https://doi.org/10.1002/oti.207.

lifestyle. (2017). Retrieved from https://en.oxforddictionaries.com/definition/us/lifestyle

Link, B. G., Mirotznik, J., & Cullen, F. T. (1991). The effectiveness of stigma coping orientations: can negative consequences of mental illness labeling be avoided? *Journal of Health and Social Behavior*, 302-320.

Lloyd, C., King, R., & Bassett, H. (2002). A survey of Australian mental health occupational therapists. *The British Journal of Occupational Therapy, 65*(2), 88-96.

Lund, K., Argentzell, E., Leufstadius, C., Tjörnstrand, C., & Eklund, M. (2017). Joining, Belonging, and Re-valuing: A process of meaning-making through group participation in a mental health lifestyle intervention. *Scandinavian Journal of Occupational Therapy*, 1-13. doi:https://doi.org/10.1080/11038128.2017.1409266

Macdonald, E. M., Hayes, R. L., & Baglioni, A. J., Jr. (2000). The quantity and quality of the social networks of young people with early psychosis compared with closely matched controls. *Schizophrenia Research, 46*(1), 25-30.

Mandel, D. R., Jackson, J., Zemke., R., Nelson, L., & Clark, F. (1999). *Lifestyle redesign. Implementing the well elderly program*. Bethesda [MD]: American Occupational Therapy Association.

Mann, M., Hosman, C. M. H., Schaalma, H. P., & de Vries, N. K. (2004). Self-esteem in a broad-spectrum approach for mental health promotion. *Health Education Research, 19*(4), 357-372. doi:10.1093/her/cyg041

Marterella, A. L. (2010). *One size fits none: Theorizing weight management in the everyday lives of adults with serious mental illness.* (Doctoral Dissertation), University of Southern California.

Matuska, K. (2012). Validity evidence of a model and measure of life balance. *OTJR: Occupation, Participation and Health, 32*(1), 229-237.

Matuska, K., & Christiansen, C. H. (2008). A proposed Model of Lifestyle Balance. *Journal of Occupational Science, 15*, 9-19. doi:https://doi.org/10.1080/14427591.2008.9686602

McDevitt, J., Snyder, M., Miller, A., & Wilbur, J. (2006). Perceptions of barriers and benefits to physical activity among outpatients in psychiatric rehabilitation. *Journal of Nursing Scholarship, 38*(1), 50-55.

Mental Health Foundation. (2018). Terminology. Retrieved from https://www.mentalhealth.org.uk/a-to-z/t/terminology

Meyer, A. (1977). The philosophy of occupation therapy. Reprinted from the Archives of Occupational Therapy, Volume 1, pp. 1-10, 1922. *American Journal of Occupational Therapy, 31*(10), 639-642.

Minato, M., & Zemke, R. (2004). Time use of people with schizophrenia living in the community. *Occupuational Therapy International, 11*(3), 177-191.

Molin, J., Graneheim, U. H., & Lindgren, B.-M. (2016). Quality of interactions influences everyday life in psychiatric inpatient care—patients' perspectives. *International Journal of Qualitative Studies on Health and Well-being, 11*(1) 29897. doi: http://dx.doi.org/10.3402/qhw.v11.29897

Moll, S. E., Gewurtz, R. E., Krupa, T. M., Law, M. C., Larivière, N., & Levasseur, M. (2015). "Do-Live-Well": A Canadian framework for promoting occupation, health, and well-being: «Vivez-Bien-Votre Vie»: un cadre de référence canadien pour promouvoir l'occupation, la santé et le bien-être. *Canadian Journal of Occupational Therapy, 82*(1), 9-23.

Mountain, G., Windle, G., Hind, D., Walters, S., Keertharuth, A., Chatters, R., . . . Lee, E. (2017). A preventative lifestyle intervention for older adults (lifestyle matters): a randomised controlled trial. *Age and ageing*, 1.

National Board of Health and Welfare. (2011). *Nationella riktlinjer för psykosociala insatser vid schizofreni och schizofreniliknande tillstånd - stöd för styrning och ledning. [National guidelines for psychosocial interventions for schizophrenia and related disorder - support for management and leadership]*. Stockholm: Socialstyrelsen.

National Board of Health and Welfare. (2013). *Nationell utvärdering 2013 - vård och insatser vid depression, ångest och schizofreni [National evaluation 2013 - Care and measures for depression, anxiety and schizophrenia]*. Stockholm: Socialstyrelsen.

Neff, K. (2003). Self-compassion: An alternative conceptualization of a healthy attitude toward oneself. *Self and Identity, 2*(2), 85-101. doi:https://doi.org/10.1080/15298860309032

Neff, K., Kirkpatrick, K., & Rude, S. (2007). Self-compassion and adaptive psychological functioning. *Journal of research in personality, 41*(1), 139-154. doi:http://dx.doi.org/10.1016/j.jrp.2006.03.004

Nelson, D. L. (1988). Occupation: Form and Performance. *American Journal of Occupational Therapy, 42*(10), 633-641.

Norman, G. R., Kathleen, W. W., & Donald, L. P. (2007). The Mathematical Relationship among Different Forms of Responsiveness Coefficients. *Quality of Life Research, 16*(5), 815. doi:10.1007/s11136-007-9180-x

Norman, R. M., Malla, A. K., McLean, T., Voruganti, L. P., Cortese, L., McIntosh, E., . . . Rickwood, A. (2000). The relationship of symptoms and level of functioning in schizophrenia to general wellbeing and the Quality of Life Scale. *Acta Psychiatrica Scandinavica, 102*(4), 303-309.

NVivo. (2015). [Computer software, v. 11].

Nyström, M., Dahlberg, K., & Segesten, K. (2002). The enigma of severe mental illness: A Swedish perspective. *Issues in Mental Health Nursing, 23*(2), 121-134.

Oliver, J., Huxley, P., Bridges, K., & Mohamad, H. (1996). *Quality of life and mental health services*. London: Routledge.

Onken, S. J., Dumont, J. M., Ridgway, P., Dornan, D. H., & Ralph, R. O. (2002). *Mental health recovery: What helps and what hinders? A national research project for the development of recovery facilitating system performance indicators. Phase one research report: a national study of consumer perspectives on what helps and hinders recovery.* Alexandria, VA: National Technical Assistance Center for State Mental Health Planning.

Parks, J., Svendsen, D., Singer, P., Foti, M. E., & Mauer, B. (2006). Morbidity and mortality in people with serious mental illness. *Alexandria, VA: National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council, 25*(4).

Patton, M. Q. (2015). *Qualitative Research & Evaluation Methods* (4 ed.). Thousand Oaks, Ca: Sage Publications, Inc.

Pearlin, L. I., Menaghan, E. G., Lieberman, M. A., & Mullan, J. T. (1981). The stress process. *Journal of Health and Social Behavior, 22*, 337-356.

Priebe, S., Huxley, P., Knight, S., & Evans, S. (1999). Application and results of the Manchester Short Assessment of Quality of Life (MANSA). *International Journal of Social Psychiatry, 45*(1), 7-12. doi:10.1177/002076409904500102

Priebe, S., Reininghaus, U., McCabe, R., Burns, T., Eklund, M., Hansson, L., . . . Wang, D. (2010). Factors influencing subjective quality of life in patients with schizophrenia and other mental disorders: a pooled analysis. *Schizophrenia Research, 121*(1-3), 251-258. doi:10.1016/j.schres.2009.12.020

Proctor, E., Silmere, H., Raghavan, R., Hovmand, P., Aarons, G., Bunger, A., . . . Hensley, M. (2011). Outcomes for implementation research: conceptual distinctions, measurement challenges, and research agenda. *Administration and Policy in Mental Health and Mental Health Services Research, 38*(2), 65-76.

Provencher, H. L., & Keyes, C. L. (2011). Complete mental health recovery: Bridging mental illness with positive mental health. *Journal of Public Mental Health, 10*(1), 57-69.

Public Health Agency of Sweden. (2017). *Folkhälsans utveckling - Årsrapport 2017*. Retrieved from Stockholm: https://www.folkhalsomyndigheten.se/pagefiles/31616/folkhalsans-utveckling-arsrapport-2017-16136-webb2.pdf

Rebeiro, K., Day, D., Semeniuk, B., O'Brien, M., & Wilson, B. (2001). Northern Initiative for Social Action: an occupation-based mental health program. *American Journal of Occupational Therapy, 55*(5), 493-500. doi:10.5014/ajot.55.5.493

Rebeiro, K. L. (2005). The recovery paradigm: Should occupational therapist be interested? *Canadian Journal of Occupational Therapy, 72*(2), 96-102.

Rebeiro, K. L., & Cook, J. V. (1999). Opportunity, not prescription: an exploratory study of the experience of occupational engagement. *Canadian Journal of Occupational Therapy, 66*(4), 176-187.

Roberts, S. H., & Bailey, J. E. (2013). An ethnographic study of the incentives and barriers to lifestyle interventions for people with severe mental illness. *Journal of Advanced Nursing, 69*(11), 2514-2524.

Rosenberg, M. (1965). *Society and the adolescent self image*. Princeton, NJ: Princeton University Press.

Ruggeri, M., Leese, M., Thornicroft, G., Bisoffi, G., & Tansella, M. (2000). Definition and prevalence of severe and persistent mental illness. *British Journal of Psychiatry, 177*, 149-155.

Schwartzberg, S. L. H., M. C.; Barnes, M. (2008). *Groups: Applying the Functional Group Model*. Philadelphia, PA: F. A. Davis Company.

SFS. (2001:453). *Socialtjänsten (SoL) [The Social Services Act].* Stockholm: Socialdepartementet.

Shepherd, G., Boardman, J., & Slade, M. (2008a). *Making recovery a reality*: Citeseer.

Shepherd, G., Boardman, J., & Slade, M. (2008b). Putting recovery into mental health practice. *Mental Health Today*, 28-31.

Slade, M. (2010). Mental illness and well-being: the central importance of positive psychology and recovery approaches. *BMC Health Services Research, 10*, 26. doi:https://doi.org/10.1186/1472-6963-10-26

Slade, M., Amering, M., Farkas, M., Hamilton, B., O'Hagan, M., Panther, G., . . . Whitley, R. (2014). Uses and abuses of recovery: implementing recovery-oriented practices in mental health systems. *World Psychiatry, 13*(1), 12-20.

Socialdepartementet. (2012). *PRIO psykisk ohälsa – plan för riktade insatser inom området psykisk ohälsa 2012–2016*. Retrieved from Stockholm:

Startup, M., Jackson, M. C., & Bendix, S. (2002). The concurrent validity of the Global Assessment of Functioning (GAF). *British Journal of Clinical Psychology, 41*(4), 417-422. doi:10.1348/014466502760387533

Stavrova, O., & Luhmann, M. (2016). Social connectedness as a source and consequence of meaning in life. *The Journal of Positive Psychology, 11*(5), 470-479.

Stillman, T. F., Baumeister, R. F., Lambert, N. M., Crescioni, A. W., DeWall, C. N., & Fincham, F. D. (2009). Alone and without purpose: Life loses meaning following social exclusion. *Journal of Experimental Social Psychology, 45*(4), 686-694.

Sundsteigen, B., Eklund, K., & Dahlin-Ivanoff, S. (2009). Patients' experience of groups in outpatient mental health services and its significance for daily occupations. *Scandinavian*

Journal of Occupational Therapy, 16(3), 172-180. doi:https://doi.org/10.1080/11038120802512433

Sutton, D. J., Hocking, C. S., & Smythe, L. A. (2012). A phenomenological study of occupational engagement in recovery from mental illness. *Canadian Journal of Occupational Therapy, 79*(3), 142-150. doi:10.2182/cjot.2012.79.3.3

Swedish Institute. (2018). Facts about sweden - Health care. Retrieved from: https://sweden.se/society/health-care-in-sweden/

Taylor, R. R., Lee, S. W., Kielhofner, G., & Ketkar, M. (2009). Therapeutic use of self: A nationwide survey of practitioners' attitudes and experiences. *The American Journal of Occupational Therapy, 63*(2), 198.

Thornicroft, G., & Tansella, M. (2004). Components of a modern mental health service: a pragmatic balance of community and hospital care: overview of systematic evidence. *The British Journal of Psychiatry, 185*(4), 283-290.

Tjörnstrand, C. (2012). *Engagement in community-based day centres for people with psychiatric disabilities.* (Doctoral dissertation), Lund University, Lund.

Tjörnstrand, C. (2010). Skapande Aktivitet. In Eklund, M.; Leufstadius, C. (Ed.), *Aktivitet & Relation* (pp. 217-244). Lund: Studentlitteratur AB.

Tzu, L. (2006). *Tao Te Ching: A New English Version* (S. Mitchell, Trans.).

Wagman, P. (2012). *Conceptualizing life balance from an empirical and occupational therapy perspective.* School of Health Sciences, Jönköping University.

Wagman, P., Hakansson, C., & Bjorklund, A. (2012). Occupational balance as used in occupational therapy: a concept analysis. *Scandinavian Journal of Occupational Therapy, 19*(4), 322-327. doi:https://doi.org/10.3109/11038128.2011.596219

Webster, D., & Schwartzberg, S. L. (1992). Patients' perception of curative factors in occupational therapy groups. *Occupational Therapy in Mental health, 12*(1), 3-24.

Ventegodt, S., Thegler, S., Andreasen, T., Struve, F., Enevoldsen, L., Bassaine, L., . . . Merrick, J. (2007). Self-Reported Low Self-Esteem. Intervention and Follow-Up in a Clinical Setting. *The Scientific World Journal, 7*, 299-305 doi:10.1100/tsw.2007.88

Wilcock, A. (2000). Development of a personal, professional and educational occupational philosophy: An Australian perspective. *Occupational Therapy International, 7*(2), 79-86.

Wilcock, A., Chelin, M., Hall, M., Hamley, N., Morrison, B., Scrivener, L., . . . Treen, K. (1997). The relationship between occupational balance and health: A pilot study. *Occupational Therapy International, 4*(1), 17-30.

Wilcock, A., & Hocking, C. S. (2015). *An Occupational Perspective of Health, Third Edition*. Thorofare, NJ: Slack.

Wilcock, A. (1998). Reflections on doing, being and becoming. *Canadian Journal of Occupational Therapy, 65*, 248-256.

World Federation of Occupational Therapists. (2018) Retrieved from: https://staging.wfot.org/about-occupational-therapy

World Health Organization. (1995). The World Health Organization Quality of Life assessment (WHOQOL): position paper from the World Health Organization. *Social Science & Medicine (1982), 41*(10), 1403-1409.

World Health Organization. (2013). The European Mental Health Action Plan. *Çeşme Izmir, Turkey: WHO Regional Office for Europe*.

World Health Organization. (2015). *Mental Health Atlas 2014*. Retrieved from Geneva, Switzerland: http://www.who.int/mental_health/evidence/atlas/profiles-2014/en/

World Health Organization. (2018). *Mental health: strengthening our response*. Retrieved from http://www.who.int/en/news-room/fact-sheets/detail/mental-health-strengthening-our-response

Wästberg, B., Erlandsson, L.-K., & Eklund, M. (2013). Client perceptions of a work rehabilitation programme for women: The Redesigning Daily Occupations (ReDO) project. *Scandinavian Journal of Occupational Therapy, 20*(2), 118-126.

Yalom, I. D. (2002). *The gift of therapy: An open letter to a new generation of therapists and their patients*. New York, NY: Harper Collins.

Yalom, I. D., & Leszcz, M. (2005). *Theory and practice of group psychotherapy*. NY: Basic books.

Yarborough, B. J., Stumbo, S. P., Yarborough, M. T., Young, T. J., & Green, C. A. (2016). Improving lifestyle interventions for people with serious mental illnesses: Qualitative results from the STRIDE study. *Psychiatric Rehabilitation Journal, 39*(1), 33-41. doi:https://doi.org/10.1037/prj0000151

Yerxa, E. (2000). Occupational science: A renaissance of service to humankind through knowledge. *Occupational Therapy International, 7*(2), 87-98.

Yerxa, E. J., Clark, F., Frank, G., Jackson, J., Parham, D., Pierce, D., . . . Zemke, R. (1990). An introduction to occupational science, a foundation for occupational therapy in the 21st century. *Occupational Therapy in Health Care, 6*(4), 1-17.

Zimmerman, M. A., & Eisman, A. B. (2017). Empowering interventions: Strategies for addressing health inequities across levels of analysis *APA handbook of community psychology* (pp. 173-191). Washington, DC: American Psychological Association.

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Balancing Everyday Life

There is limited research that evaluates occupational therapy and lifestyle interventions, especially for mental health service users. This thesis provides increased knowledge and understanding of the processes and factors that led to better quality of everyday life, engagement in meaningful activities, and balance for participants who took part in the Balancing Everyday Life (BEL) intervention.

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