Personal journeys of recovery: Exploring the experiences of mental health service users engaging with the Kawa 'River' model.

A thesis submitted for the degree of Doctor of Philosophy

by

Kee Hean Lim

College of Health and Life Sciences
Brunel University London

September 2018

Abstract

This longitudinal qualitative study examined the lived experiences of a group of mental health service users over a year, as they journeyed through their own recovery.

The research aims were:

- To examine the personal experiences of mental health recovery from a phenomenological perspective.
- To examine the experiences that participants identified as influencing their personal journeys of recovery, using the Kawa model.
- To examine the value of the Kawa model as a visual tool in exploring personal journeys of recovery.

The eight participants, aged between 48-67 with mental health histories of over 30 years and a range of diagnoses, were recruited via a mental health charity. Each participant was interviewed five times at three monthly intervals throughout one year and created a Kawa map of their personal recovery at each interview.

The interviews were analysed via Interpretative Phenomenological Analysis, to establish convergent and divergent themes. The five themes were: meanings of recovery; feeling more socially connected; looking outwards and getting involved; coping with life's challenges; and an evolving journey. The Kawa maps were analysed via the Kawa model framework index (KMFI), which highlighted patterns and trends in supporting recovery and enhanced self-discovery.

All participants valued creating the Kawa maps and highlighted the clarity and simplicity of the Kawa model concepts as a positive. Limitations of the study included the lack of diversity of the participants and restrictions with evaluating the participants' insights solely from the maps.

Participants identified having a positive outlook, social connections and meaningful involvement in occupations as essential to their recovery. The contribution of the Kawa model was supported with participants deriving insight, identifying with the river metaphor and feeling empowered to influence their own recovery. The clinical implications for use of the Kawa model included enhanced service user awareness, monitoring of their own mental health and promoting personal recovery.

Table of Contents

Acknowledgements

I am grateful for the support I have received throughout my doctorate research and would like to thank everyone who has guided, supported and encouraged me throughout my journey in completing my thesis.

In particular, I would like to thank the local mental health charity for providing me access to their members and the individual participants who kindly gave their time, patience and energy to take part in the research, and share with me their personal recovery narratives and journey.

I would especially like to thank my original first research supervisor, Dr Frances Reynolds who has been extremely patient, supportive and understanding, always available to encourage, assist and advise me. Dr Anne Chappell who was always sympathetic, encouraging and had a belief that I could get the thesis completed and spurred me on during the final stages. Dr Pam Alldred who was always understanding of the challenges I faced and confident of my ability to complete the PhD thesis.

I would also like to thank Professor Michael Iwama for first introducing me to the Kawa 'River' model and supporting me throughout the process and agreeing to be part of my research advisory team. Dr Bella Vivat for her wisdom, insight and alternate perspectives and my occupational therapy peers at Brunel University London, who supported me in big and little ways in getting my research completed.

I am grateful to my wife Caroline and four children Hannah, Joel, Joshua and Naomi who have endured untold emotional stress and persevered with my nocturnal habits in completing the thesis.

Finally I would like to thank the Royal College of Occupational Therapists for their funding grant and Brunel University London in supporting me in completing my PHD.

List of Related Publications and Presentations

Book

McKay, E., Craik, C., Lim, K.H. and Richards, G. (2008) *Advancing Occupational Therapy in Mental Health Practice*. Blackwell Scientific

Book Chapters

Lim, K.H. and Iwama, M. K. (2011) *The Kawa 'River'* Model In: Duncan, E.A.S. (ed), *Foundations for Practice in Occupational Therapy*. (5th Ed) Edinburgh, Elsevier Churchill Livingstone, pp. 117-137

Lim, K.H. (2008) *Working in a Transcultural Context.* In: Creek, J. and Lougher, L. (eds) *Occupational Therapy and Mental Health*. (4th Ed) Edinburgh, Elsevier Churchill Livingstone, pp. 251-274

Lim, K.H. (2008) *Cultural Sensitivity in Context*. In: McKay, E., Craik, C., Lim, K.H. and Richards, G. (eds) *Advancing Occupational Therapy in Mental Health Practice*. Blackwell Scientific, pp. 30-47

Journal Article

Lim, K.H. (2009) *'Ebb and Flow: Reflections on the Kawa Model in practice and education'*, Mental Health Occupational Therapy, 14(2), pp. 55-57

Published Report

Lim, K.H. (2015) *Longitudinal study exploring the value of occupation in the recovery of mental health service users within the Kawa Model.* UKOTRF Final Project Report

Peer Reviewed National and International Conference Presentations

Lim, K.H. (2014) *Utility of the Kawa Model as a Recovery Framework.* 1st International Kawa Symposium, Yokohama, World Federation of Occupational Therapy Congress in Yokohama, Japan 2014

Lim, K.H., Reynolds, F., ViVat, B. and Iwama, M.K. (2012) *Recovery, it's Personal*. Refocus on Recovery Conference, London, United Kingdom 2012

Lim, K.H. Reynolds, F. and Iwama, M.K. (2011) *The role and value of occupation in promoting mental health recovery within the Kawa Model Framework*. Asia Pacific Occupational Therapy Congress. Changmai, Thailand 2011

Lim, K.H., Iwama, M.K., Reynolds, F. and Vivat, B. (2011) *Exploring the value of occupation in supporting mental health recovery.* Royal College of Occupational Therapists Conference, Brighton, UK 2011

Lim, K.H., Reynolds, F., Vivat, B. and Iwama, M.K. (2011) *Mental Health Recovery: A personal Journey.* Brunel University Postgraduate School Research Poster Conference, Uxbridge, UK 2011

Lim, K.H., Iwama, M.K., Reynolds, F. and Vivat, B. (2010). *Longitudinal study exploring the value of occupation in the recovery of mental health service users within the Kawa Model framework*. World Federation of Occupational Therapy Congress in Santiago, Chile 2010

Iwama, M.K. and Lim, K.H. (2010) *The Kawa (River) Model: Extended Workshop.* World Federation of Occupational Therapy Congress in Santiago, Chile 2010

Lim, K.H., Iwama, M.K. and Reynolds, F. (2009) *Recovering our Lives.* Royal College of Occupational Therapists specialist section in Mental Health Conference, Manchester, United Kingdom 2009

Lim, K.H., Iwama, M.K. and Reynolds, F. (2008) *The Utility of the Kawa Model in Mental Health practice.* Council Occupational Therapy European Countries Congress, Hamburg, Germany 2008

Iwama, M.K., Higman, P., Lim, K.H., Renton, L., Robinson, K., DeVries, L. and Steggink, L. (2008) *The Kawa (River) Model: The power of*

culturally relevant occupational therapy. European Occupational Therapy Congress Extended Workshop, Hamburg, Germany 2008

Invited Lecture and Keynote Presentation

Guest Lecture: Lim, K.H. (2015) *The Kawa model and mental health recovery.* European Occupational Therapy Masters Programme, Hogeschool van Amsterdam Occupational Therapy School, Amsterdam, Netherlands 2015

Guest Lecture: Lim, K.H. (2013) *The Utility of the Kawa Model in Mental Health practice.* HANs University, Occupational Therapy School, Nijmegen, Netherlands 2013

Key Note Presentation: Lim, K.H. (2011) *Occupation in mental health recovery: A Kawa model perspective*. European Occupational Therapy Masters Programme Conference, Hogeschool van Amsterdam Occupational Therapy School, Amsterdam, Netherlands 2011

Guest Lecture: Lim, K.H. (2010) *The Kawa 'River' Model.* University of Salford, Manchester, United Kingdom 2010

Key Note Presentation: Lim, K.H. (2010) *Meaning and relevance in the practice of occupational therapy: The Kawa 'River'Model.* British Association of Occupational Therapists, West Midlands Region Study Event, Coventry, United Kingdom 2010

Key Note Presentation: Lim, K.H. (2009) *The value of occupation in the recovery of mental health service users within the Kawa Model framework.* South London and Maudsley NHS Trust Annual Conference, London, United Kingdom 2009

Keynote Presentation: Lim, K.H. (2008) *Meaningful and Relevant Occupational Therapy*. British Association of Occupational Therapists South-West Region Annual Conference, Somerset, United Kingdom 2008

Grants and Awards

United Kingdom Occupational Therapy Research Foundation Research Career Development Grant (2009) in support of Doctorate research study (£10000).
Brunel Postgraduate Research Award (2008) for Doctorate research study (£500).

Study Day

Organisation and presentation of research at Kawa Model Masterclass Event. Brunel University, Uxbridge, United Kingdom 2010

List of Abbreviations

MHR	Mental health recovery
KMFI	Kawa model framework index
MHC	Mental health charity
COT	College of Occupational Therapists
IPA	Interpretative phenomenological analysis
BUL	Brunel University London
REC	Research Ethics Committee

Tables

List of Tables

Diagrams

List of Diagrams

Chapter 1 Introduction

Mental health affects all of us, with United Kingdom statistics indicating that 1 in 4 people will experience a mental health condition each year (Mental Health Foundation, 2015). No other health condition has such prevalence and extensive impact as compared with mental illness (DoH, 2009) and the economic cost of mental illness in the United Kingdom is approximately £70 to £100 billion a year (McManus, Bebbington, Jenkins and Brugha, 2016). Despite the high incidence of mental illnesses affecting the general population, societal knowledge and understanding of mental health remains limited. Poor prognosis and outcomes are often associated with individuals who have mental health problems, with their capacity to get better, achieve a higher quality of life and mental health recovery overlooked (Mental Health Foundation, 2015).

This thesis is concerned with the personal stories, challenges and lived experiences of individuals with mental health problems and their journeys of recovery. Deegan, a well-known mental health activist and service user highlighted her personal experience as an example of the challenges that individuals with mental illness face. She described an extremely negative interaction with her psychiatrist, when initially diagnosed with psychosis. Deegan was told her future prospects would be poor and this left her feeling depressed and despondent (Deegan, 1996a). However, Deegan subsequently chose an opposing position and embraced the concept of mental health recovery and hope. She described developing personal belief and sense of optimism about her future and refused to allow her mental illness to define and dominate the rest of her life (Deegan, 1996a).

Embracing mental health recovery requires a transformative attitude and belief that having a mental illness does not restrict the individual from having a productive and satisfying future (Allot, Loganathan and Fulford, 2004). Anthony (1993) described mental health recovery (MHR) as a unique and personal experience which requires the individual to have

hope and belief that their lives can change and improve. The individual looks beyond their illness, seeking new meaning, purpose and strives for a satisfying and contributing life (Slade, 2009). Indeed recovery within the context of mental health looks beyond cure or the elimination of symptoms, with an emphasis on acquiring insights, having hope, setting goals, achieving fulfilment and attaining better quality of life (Slade, 2009). To appreciate what recovery means and how it influences each individual requires a way of uncovering the lived experiences, narratives and stories that reflect personal journeys of recovery.

Overview

This thesis is an in-depth study of the biographical accounts of a group of mental health service users as they journey through their personal recovery and the application of the Kawa Model in discovering personal narratives of recovery. I will examine the changing context of mental health practice, the origins of mental health recovery and introduce key concepts associated with the Kawa Model. I will also explore the relationship between occupation, health, well-being and recovery.

Key Research Aims

The research has two key aims, firstly to establish a phenomenological perspective of mental health recovery and secondly to explore the contribution of the Kawa model as a visual and narrative-provoking tool in exploring the recovery journey of mental health service users.

Personal Reasons for the Research

I have always been interested in mental health and remembered from a young age on several occasions following my father to his place of work at a large mental health institution in Singapore. I was fascinated by the patients I saw and recalled asking my father and some of the psychiatric nurses a multitude of questions. Why were the patients living within the

institution? What illnesses did they have? What did they do with their time? What helped them to get better? These individuals, their stories and what their lives were like intrigued me, and my fascination led me to later train as an Occupational Therapist in the United Kingdom (UK) and eventually to work within mental health services. Although I found the complexity of mental illness intriguing and challenging throughout my ten years in clinical practice, what captivated me most were the personal stories and autobiographical accounts of the service users lives. Indeed my research represents a return to listening to those personal stories and lived experiences of recovery.

My professional training as an occupational therapist and subsequent mental health employment reinforced my decision to explore the area of mental health recovery. My occupational therapy professional values and principles have influenced my perception and understanding of mental health and well-being. I have also been interested in the potential benefits of the Kawa Model within the field of mental health and in supporting service users to explore, gain insight and better understand their own recovery experiences. The focused of my research is to discover the contribution of the Kawa Model as a visual and narrative-provoking tool in exploring personal recovery. The Kawa Model I felt would provide participants the opportunity to visually explore their recovery experiences over time and offer insights into their unique journeys of recovery.

In order to understand the contextual roots of mental health recovery, the next section will examine the changing context of mental health policy and practice in the UK over the last few decades. The concept of health and illness from a biological and sociological perspective will also be examined in relation to mental health recovery.

Evolving Context of Mental Health

Mental health services have evolved substantially over the last 30 years in the UK (Killaspy, 2007; DoH, 2014). The era of ‘mental health patients’

being detained within asylums indefinitely, was replaced by a focus on integrating them back to living in the community with the introduction of the Community Care Act (DoH, 1990). However despite government policies and initiatives to promote de-instutionalisation, relocating and assimilating former patients within local communities produced mixed results (Sainsbury Centre for Mental Health, 2004). Community Care was severely lacking with patients unprepared for living in the community and often poorly supported. Issues of stigmatisation, isolation and discrimination continued to be widespread and restricted community integration (DoH Modernising the NHS, 1997; Barham and Hayward, 1998).

The modernisation agenda in the United Kingdom brought about radical changes in the way mental health policy and practice were perceived and operationalised (Beresford, 2002; Killaspy, 2007; Bonney and Stickley, 2008). The National Service Framework for Mental Health (1999) for example, highlighted the importance of health and social care professionals actively engaging service users in exploring the key elements that supported their health and recovery from mental illness. The policy document 'The Journey to Recovery' (DOH, 2001) outlined the (New Labour) Government's vision for mental health care and required health services to focus on promoting recovery and not be fixated with reducing mental health symptoms. This was accompanied by a further shift in policy towards combating social exclusion for those with serious mental health problems and supporting more recovery-orientated services in UK (Social Exclusion Report, 2004; Killaspy, 2007; Slade, 2009).

Several government policies and clinical guidelines (including the Community Care Act, 1990; Care Programme Approach, 1991; Modernising the NHS, 1997; NHS Plans, 2000; Service User Involvement and Empowerment, 2000; Social Exclusion Report, 2004; Amendment to the Mental Health Act, 2006; National Social Inclusion Programme: Vision

and Progress, 2009), were subsequently introduced by the Department of Health with a focus on promoting better access to mental health services, delivering best practice, enhancing community provision, supporting social inclusion, reducing isolation, tackling discrimination and promoting collaborative involvement with service users (Social Exclusion Unit, Mental Health and Social Exclusion, 2004). These national strategies and policies focused on enhancing the care provided to mental health service users, empowering them with additional knowledge and information to exercise better choices and achieve improved health outcomes (Slade, 2009). The promotion of social inclusion and service user involvement enhanced the quality and effectiveness of mental health care and promoted the recovery approach.

Newer health policies and initiatives like 'Mental Health: New Ways of Working for Everyone, 2007; Putting People First: Self-directed support, 2009; New Horizons: A Shared Vision for Mental Health, 2009' (DoH, Mental Health Strategy for England, 2011) reinforced the importance of personal recovery and promoted mental health for all. Service user organisations including of Rethink, MIND and the Mental Health Foundation similarly highlighted that health and social care professionals should focus on the individual, what matters to them and invest time in understanding the perspectives and experiences of service users (Sainsbury Centre for Mental Health, 2009).

The Conservative government's mental health strategy 'No Health without Mental Health' (2011), dictated how health services could incorporate mental health and well-being within all areas of care provision. Mental health was established on a par with physical health, emphasising the close relationship between the two. Newer government policies prioritised the personal recovery agenda and ensured that service users had a voice and continued to be influential in dictating the treatment and support they received (Slade, 2009). The need to narrow the funding gap between mental and physical health led to several additional policy initiatives

including the ‘NHS 5 year plan for Mental Health services, 2016; Closing the Gap: Priorities for Essential Change in Mental Health, 2014; Making Mental Health Services More Effective and Accessible, 2013; National Framework to Improve Mental Health and Well-being, 2012’. These various policy initiatives ensured that mental health services were more accessible, available, focused and effective in supporting personal recovery.

Overview of Mental Health Recovery

The beginnings of Mental Health Recovery Movement arose out of the mental health ‘survivors’ movement, which in turn emerged out of the civil rights movement in the United States (USA) in the late 1960s and early 1970s (Ahern and Fisher, 2001; Meehan, King, Beavis and Robinson, 2008). The negative experiences of psychiatric patients around the poor care they received and the dissatisfaction they felt about their treatment, led to demands for more rights and influence (Deegan, 2002; Slade, 2009). The move away from institutionalised care within psychiatry and the growing strength of the consumer movement in the 1990s, eventually led to the emergence of the recovery movement in the USA (Onken, Craig, Ridgeway, Ralph and Cook, 2007; Bonney and Stickley, 2008; Meehan *et al*., 2008).

Similarly in New Zealand, Australia, Canada and the United Kingdom, the recovery movement gained support and strength as service user groups battled for better mental health provision and began to campaign against the poor treatments that mental health patients received (Chamberlin, 1990; Roberts and Wolfson, 2004; Ramon, Heay and Renouf, 2007; NSW Consumer Advisory Group, 2009). Dissatisfaction with a lack of choice, power, influence, opportunity and the continued stigma and discrimination, encouraged opposition to the status quo (Blackman, 2001; Allot, Loganthan and Fulford, 2004; Noorani, 2013). Those at the receiving end of these negative experiences emerged to challenge the injustice they felt, forming a political movement in which service users

voiced their dissatisfaction in hope of seeking better mental health care (Rogers and Pilgrim, 1991; Sayce, 2000).

In the United Kingdom (UK) many mental health charities and service user groups collaborated to argue for their civil rights and to fight against discriminatory practices (Blackman, 2001; Pilgrim, 2009). This matched the aims of the disability rights movement, which challenged for equal opportunities and rights for all. Disability activists worked to break institutional, physical, and societal barriers that prevented people with disabilities from having the same opportunities as other citizens (Sayce, 2000; Beresford, 2000). This led to the establishment of groups such as the Hearing Voices Network, the Mental Health Service User Rights Movement and organised demonstrations such as the 'Mad Pride' parades (Blackman, 2001; Reaume, 2008). The concept of mental health recovery was coined within the midst of this fight for justice, as the mental health survivor movement in the UK began to rise in prominence and influence (Allot *et al*., 2004; Bonney and Stickley, 2008; Slade, 2009).

Understanding Recovery

Mental health recovery may be considered as the individual regaining their own psychological, emotional, physical health and well-being (Ridgeway, 2001; Ramon *et al*., 2007; Bonney and Stickley, 2008). Mental Health Foundation (2018) suggest that recovery can mean different things to different people, for many, recovery is about the realisation of goals, and the development of relationships and skills that support a positive life, with or without ongoing mental health problems.

Although consensus exists within the UK in endorsing mental health recovery, understanding and promoting of this concept varies widely. The UK government, Department of Health, Health and Social Care Trust, charitable organisations, mental health groups and individual service users, have expressed varied interpretations and perspectives on how mental health recovery is conceptualised, interpreted and understood. An

examination of the literature around mental health recovery provides an indication of the similarities and differences (Blackman, 2001; Blackman, 2007; Bonney and Stickley, 2008; Slade, 2009).

The notion of mental health recovery acknowledges that each individual is unique and experiences a journey of recovery personal to them (Anthony, 1993; Deegan, 2002; Bonney and Stickley, 2008; Sutton, Hocking and Smythe, 2012). This personal perspective of recovery is distinct, and reflects the lived experience of each person within their own recovery journey (Deegan, 1996a; Sayce, 2000; Borg and Davidson, 2008; Slade, 2009; Repper and Perkins, 2012; Hummelvoll, Karlsson and Borg, 2015). Recovery within the mental health context is understood as a process or journey rather than an end point (Anthony, 1993; Allot *et al.,* 2004; Ramon *et al*., 2007) and considered to be non-linear, but fluid and evolving (Baker and Strong, 2001).

Mental Health recovery looks beyond being 'cured' and symptom elimination towards building resilience and helping each person to manage their health, achieve their goals, gain fulfilment and derive a better quality of life (Anthony, 1993; Deegan, 1996; Beresford, 2002; Ramon *et al*., 2007; Cameron, Readon, Brooker, Neale, Harris, Kemp and Pople, 2016). This personal approach to recovery is concerned with how each individual makes sense of their own experiences and recognises the importance of having a voice, influence, choice and opportunity to achieve personal goals (Deegan, 1996a; Shepherd, Boardman and Slade, 2008; Noorani, 2013). Mancini (2007) explored the views of service users in terms of their own recovery, with participants describing recovery as a change in their attitude, beliefs and accepting that recovery was possible. Participants in the study expressed the importance of finding meaning, value and purpose in their lives, which they achieved through contributing to the welfare of others and having influence over their own recovery.

The research and literature around mental health recovery falls within three broad categories. The first category is service users' perspectives of their own recovery and experiences of having a mental health condition, regaining autonomy and personal experiences of recovery. The second category is health care providers or policy makers' views on recovery with specific interest in examining effective models, practice approaches and interventions that promote recovery, often motivated by a desire for cost effectiveness in service provision and outcomes. The third is what positively or negatively contributes to mental health, well-being and recovery.

Several studies have highlighted the importance of gaining appreciation of the lived experience, i.e. what it is like to have and live with a mental health condition (Mancini, 2007; Shepherd, Boardman and Slade, 2008; Harper and Speed, 2012; Hummelvoll *et al*., 2015). Whilst studies by (Ramon *et al*., 2007; Shepherd *et al.*, 2008; Slade, 2009; Kartalova-O'Doherty, 2010; Cameron *et al*., 2016) reinforced the importance of supporting and empowering individuals to achieve their own goals in promoting personal recovery. Research has also outlined the importance of ensuring that mental health service users have the opportunity to voice their recovery experiences and concerns, highlight their ambitions and provide expert perspective of what helps or hinders their own recovery (Deegan, 1993; Roberts and Wolfson, 2004; Adame and Knusdon, 2007; Mancini, 2007; Repper and Perkins, 2012; Noorani, 2013; Hummelvoll *et al*., 2015).

Different recovery approaches and models have been researched with a focus on effective outcomes (NIMHE, 2004; Bonney and Stickley, 2008). These have included research on the social model of disability and recovery, which adopts a social model approach in addressing recovery (Secker *et al*., 2002; Repper and Perkins, 2003; Tew, Ramon, Slade, Bird, Melton and Le Boutillier, 2012); the use of outcome measures in assessing levels of recovery (Gough and Trehy, 2011; Chang, Heller,

Pickett and Chen, 2013; Boniface, Humpage, Awatar and Reagon, 2015) the 'Tidal Model', with a focus on empowering those with mental distress (Barker, 2001; Cook, Phillips and Sadler, 2005) and the effectiveness of recovery colleges in support of recovery (Rinaldi and Wybourn, 2011; Perkins, Repper, Rinaldi and Brown, 2012; Meddings, Guglietti, Lambe and Byrne, 2015). In a study by Rinaldi and Wybourn (2011), 70% of participants who had attended the Recovery College, were still engaged in education, employment or voluntary work, 18 months post attending the Recovery College, highlighting the positive contribution of recovery approaches in supporting recovery.

Factors that positively or negatively impacted upon mental health recovery, included the importance of peer support (Davidson, 2005; Repper and Carter, 2011; Leamy, Bird, Le Boutillier, Williams and Slade, 2011) and the value of engagement in meaningful activities and occupations in supporting recovery (Mee and Sumsion, 2001; Buchanan-Barker and Barker, 2006; Stewart and Wheeler, 2005; Kelly, Lamont and Brunero, 2010; Fieldhouse, 2012; Doroud, Fossey and Fortune, 2015; Bjorkedal, Torsting and Moller, 2016; Lagace and Desrosiers, 2016; Cameron *et al*., 2016). In a cross-sectional survey study by (Lloyd, King, McCarthy and Scanlan, 2007) involving 44 participants examining the relationship between being engagement in leisure occupations and mental health, the results indicated a positive association between leisure engagement, motivation, social interactions and mental health recovery.

The importance of social networks, support and a sense of belonging have also been identified within research studies by, (Ridgeway, 2001; Buchanan-Barker and Barker, 2006; Copeland, 2008; Carter and Repper, 2011) to be instrumental in promoting recovery. In a qualitative study by Petersen, Friis, Haxholm, Nielsen and Wind (2015) involving 12 participants examining what they perceived as facilitators and barriers to their recovery, the participants identified having a goal to aim for, peer support and relationships as facilitators of their recovery. Unsupportive

interactions with staff and being socially isolated were considered barriers to remaining well. Further research has reinforced the value of Rediscovering hope, the self and identity (Martyn, 2002; Repper and Perkins, 2003; Mancini, Hardman and Lawson, 2005; Sutton *et al*., 2012; Cameron *et al*., 2016); Schiff (2004) a service user, described her determination to recapture what she felt she had lost to her mental illness. Schiff was determined to rediscover herself, make plans for her future and establish a fresh identity. Having control and feeling empowered were also highlighted in studies by (Martyn, 2002; Repper and Perkins, 2003; Leamy *et al*., 2011); while support from professionals was also identified as being influential in supporting recovery (Sayce, 2000; Roberts and Wolfson, 2004; Parish, 2009; Leamy *et al*., 2011; Chowdhury, 2014; Katsouri, 2014).

Haracz and Ennals (2015) highlighted re-establishing hope, meaning, belief and confidence as crucial in restoring health, well-being and recovery. The value of meaningful involvement, roles and identity in supporting recovery were also indicated in studies by (Anthony, Rogers and Farkas, 2003; Farkas, Gagne, Anthony, and Chamberlin, 2005; Stewart and Wheeler, 2005; Fieldhouse, 2012; Doroud *et al*., 2015). Leufstadius, Erlandsson, Bjorkman and Eklund (2008) in their study examining the relationship between 'time use, daily activities and quality of life in people with persistent mental illness' involving 103 participants, established the importance of work in helping participants to maintain their health and well-being. Participants indicated the roles and identities acquired through being engaged in work as vital for their self-esteem and recovery. However the term occupation within the scope of occupational therapy extends beyond just work or employment. McColl, Law and Stewart (2015) described occupation as purposeful or meaningful activities which humans engage in as part of their normal daily lives; these can include leisure activities like walking, self-care activities like cooking food or productive activities like assisting as a volunteer. Occupations that individuals and communities engage in can also be

culturally defined and shaped and therefore be subjective in their sense of meaning and purpose (Cutchin and Dickie, 2013). Wilcock (2006) also highlights the importance understanding the socio-cultural context, when considering the value of different occupations and the contribution to the individual's overall health, well-being and recovery.

Health and Illness

Health is often assumed as a concept that is easy to explain, universally understood and agreed upon by all. However, Bury (2005, pg. 1) stated that 'Health is something of an enigma', a concept that can be perplexing and problematic to explain, but easily recognised when absent. Blaxter (2010) proposed that the concept of health is often understood in relation to an absence of illness or disease. While Annandale (1998) suggested that it is commonly accepted that an individual's health is compromised if illness or disease exists and cure is not achieved. Sweeney and Kernick (2002) indicated that this view of health is consistent with the biomedical perspective which equates achieving health with a total absence and eradication of illness. This biomedical perspective of health, illness and disease, reflects a reductionist philosophy where the aim is for illness or disease be diagnosed, problems isolated, symptoms eliminated and ailments removed, in order for health to be restored (Helman, 2007). However this biomedical approach neglects the wider set of contextual, social and physical influences that impact upon the individual (Blaxter, 2010). It also fails to consider the complex interplay of factors connected with an illness that may contribute to a presenting condition and the associated difficulties (Ahn, Tewari, Poon and Phillips, 2006; Helman, 2007). The biomedical model, it could be argued, is far more concerned about restricting the impact of the illness, reducing the symptoms rather than promoting the overall health, well-being and quality of life of the individual (Bury, 2005).

In contrast, the ethos of mental health recovery looks beyond the elimination of symptoms and curing of diseases. Equal importance is

accorded to instilling hope, restoring a sense of control, promoting healthy roles, supporting meaningful participation and encouraging self-management (Allott et al., 2004; Slade, 2009; Repper and Perkins, 2012; Blank, Harries and Reynolds, 2015; Cameron et al., 2016). This approach is more in line with the social model of health and disability, which proposes a holistic and sociological perspective of health and illness. Helman (2007) highlighted that the social model of health and disability is concerned about the impact that society and the wider context has upon the individual's health, well-being and participation. Societal attitudes, perspectives, the root causes and consequences of an illness or condition are equally important and need to be addressed (Fruend, 1990; Annandale, 1998; Blaxter, 2010). Pilgrim (2009) described how contextual factors such as government policy, societal standards, poverty, poor housing, social class, diet and discrimination are equally influential in determining the individual's health, well-being and recovery, reinforcing the need to adopt a holistic approach to promoting health and well-being.

The sociological perspective also embraces the contextual and socio-cultural interpretations of health and illness and recognises the influence of socio-cultural attitudes and views, in supporting or restricting participation, engagement and inclusion (Sayce, 2000; Wilcock, 2006; Lim, 2008a, b; Hammell, 2008). These societal standards limit our expectations of those with a disability or illness and their ability to have fulfilling and satisfying lives beyond their health condition. I believe we need to move away from such restrictive societal views that symptom elimination or disease removal are the only way to restore well-being and recovery and that there needs to be a focus on the broader range of contextual factors that promote health, recovery and inclusion (Hasselkus, 2002; Lim and Iwama, 2006; Hitch and Davey, 2016).

Over the ten years I was employed as an occupational therapist in mental health services in London, I developed an appreciation of how political,

economic and socio-cultural attitudes and behaviours had the potential to create an even greater divide between mental health service users and the wider community. Working primarily with those who had a long-term condition made me realise how medically orientated mental health services were, where focus was on containment rather than empowerment. Many mental health services were also financially constrained, where cost effectiveness and preventing admissions seemed to be the only priority (Kelly et al., 2010; Fieldhouse, 2012) Client-centred services focused on enabling service users to manage their health, enhance their quality of life, promote enjoyment and personal fulfillment, seemed to be disregarded (Leamy *et al*., 2011; Cameron *et al*., 2016). Being meaningfully engaged in different activities, socially involved with others, and learning to psychologically and emotionally manage one's health and recovery seemed much less a priority. My clinical experiences during this period have contributed towards my desire to assist mental health service users' to explore and understand their own recovery.

Occupational Therapy and Mental Health Recovery

The Royal College of Occupational Therapists (RCOT) highlighted a commitment to promoting mental health recovery with the publication of the Recovering Ordinary Lives, ten year strategic document (RCOT, 2006). The document highlighted the importance of understanding the unique value and role of occupation and occupational therapy in contributing to personal recovery. It also focused on how occupational therapists could work collaboratively and in partnership with service users to enhance the quality and effectiveness of their care.

Such a collaborative approach required occupational therapists to reconsider their clinical practice and methods, when working with service users. Understanding the perspective and needs of the service user beyond their presenting condition was crucial to supporting their overall health and recovery. Deegan (1996a) outlined the importance for health

professionals to have knowledge but also to develop wisdom. She suggested that wisdom is acquired through an active process of gathering and understanding unique individual perspectives and experiences. This perspective has been recognised by the RCOT Mental Health Strategy (2006) which reinforced the importance of adopting a more person-centred and collaborative approach to mental health provision. The RCOT Mental Health Strategy further emphasised the importance of gathering personal narratives, appreciation of the lived experiences and supporting social inclusion. The ability to engage in productive and meaningful occupations were also highlighted as influential in enhancing health, well-being and personal recovery (RCOT, 2006) which matched the philosophy of occupational science, a key theory within occupational therapy.

Occupational Science

Central to the practice of Occupational therapy is the belief that engagement in meaningful occupation promotes an individual's health and well-being (Whiteford and Hocking, 2012). Townsend & Wilcock (2004) suggested that humans are occupational beings and benefit psychologically, emotionally and physically from being engaged in meaningful, culturally relevant and purposeful activities. Yerxa (1989, pg. 6) defined occupational science as 'the study of the human as an occupational being, including the need for and a capacity to engage in orchestrate daily occupations.' Occupational science proposes that humans have an innate need to be engaged in occupations and by doing so derive a sense of purpose and structure in their lives, which enhances their overall health and well-being (Wilcock, 1998). This corresponds with existing research by (Leufstadius *et al.,* 2006; Lloyd, King and McCarthy, 2007; Fieldhouse, 2012; Doroud *et al.*, 2015, Blank *et al*., 2015) which support the health benefits that individuals gained from active occupational engagement and participation.

Occupational science proposes that the individual develops a sense of identity, purpose and self-worth through being involved in meaningful occupations (Wilcock, 1998; Whiteford and Hocking, 2012). Conversely, being denied the opportunity to be meaningfully engaged in occupations of choice or discriminated from participation can result in a negative impact upon the individual's self-identity and esteem (Wilcock, 1998; Taylor and Kay, 2015). Within occupational science theory this is described as occupational alienation, where there is a lack of opportunity to be meaningfully engaged due a dearth of opportunities or meaningful activities available. Townsend and Wilcock (2004) suggested that occupational alienation occurs when one's inner needs are unmet due to a lack of purpose and meaning in 'doing'. An example would be working on an assembly line undertaking the meaningless task of putting lids on bottles repeatedly. This can lead to feelings of frustration, powerlessness or psychological strain, as one's inner needs are left unsatisfied due to having to engage in menial and meaningless task (Christiansen and Townsend, 2004).

Another concept within occupational science is occupational deprivation, where the individual is excluded from engaging in occupations that have meaning and purpose due to factors outside their immediate control (Whiteford and Hocking, 2012). The individual incarcerated in prison or within an inpatient psychiatric ward may have several restrictions placed upon their choices and liberty, which results in occupational deprivation. This loss of freedom or choice can result in negative consequences for the individuals as they are restricted from being meaningfully occupied and involved, which can be detrimental to their health and well-being.

One of the key priorities within occupational science is achieving occupational balance where the individual establishes equilibrium through engaging in a balance of occupations within their lives, which promotes overall health and well-being. This is in contrast to the concept of occupational imbalance, which is said to occur because engagement in

occupation fails to meet one's health needs for physical, social and psychological stimulation. Here the lack of opportunity and choice to engage in meaningful and productive occupations can negatively affect the individuals' mental health and well-being. The goal is therefore to ensure that individuals have the choice, capacity and opportunity to be meaningfully engaged, which promotes their health, well-being and personal recovery (Sutton *et al*., 2012).

Contemporary Approaches in Occupational Therapy

The value of occupational engagement in supporting recovery is highlighted within several research studies including those by (Lloyd Waghorn and Williams, 2008; Blank, Harries and Reynolds, 2011; Sutton *et al*., 2012; Doroud *et al*., 2015; Lagace, Briand, Desrosiers and Lariviere, 2016; Saavedra' Perez, Crawford and Arias, 2017). One such study by Saavedra *et al.,* (2017) examined the use of creative arts with a group of participants with severe mental illness. Engagement in creative arts was found to improve the participants' level of social inclusion, psychological well-being and personal recovery.

Studies that examined the adoption of an occupational perspective and approach to recovery have included (Rebeiro, 2005; Kelly *et al*., 2010; Frogett and Little, 2012; Synovec, 2015; Cameron *et al*., 2016). Research focused on evaluating outcome measurement within mental health and recovery have included studies by (Ennals and Fossey, 2009; Gough and Trehy, 2011; Chang *et al*., 2013; Boniface *et al.*, 2015), while studies examining occupational therapists adopting recovery approaches include those conducted by (Cleary and Dowling, 2009; Lal, 2010; Chowdhury and Katsouri, 2014). Chowdhury and Katsouri (2014) in their study involving interviews with 14 mental health and forensic mental health occupational therapists in the UK, found that all the participants felt that the occupational therapy concepts and perspectives related well with the recovery philosophy, however what the participants found challenging in applying recovery approaches in their clinical practice were the

organisational structures and attitudes of fellow health professionals, which limited the way they were able to work within a recovery approach.

Research examining the use of occupational therapy interventions in supporting recovery included studies by (Dowling and Hutchinson, 2008; Gibson, Jaffe and Arbesman, 2011; Fieldhouse, 2012; and Urlic and Willimason, 2012). Participants in the research by Van Lith, Schofield and Fenner (2011) involved in creative arts, described how it helped their self-worth, confidence and enabled them to take greater control of their lives and supported their mental health recovery. The number of studies within the occupational therapy literature focused on ascertaining the lived experience of personal recovery were more limited (Sutton *et al*., 2012; Skipper and Page, 2015), as were studies looking at the use of specific practice models in supporting mental health recovery (Synovec, 2015).
Within occupational therapy, establishing the evidence and value of occupation continues to be a research priority. The Royal College of Occupational Therapists: Building the Evidence for Occupational Therapy: Priorities for Research document (RCOT, 2007), outlined the importance of establishing the relationship between occupation, activity, health and well-being.

Introduction to the Kawa Model

The Kawa model is an occupational therapy theory and practice model that came into existence in 2000 (Iwama, 2006). The Kawa model is also known as the ‘River model’, because the Japanese word for ‘River’ is ‘Kawa'. The core philosophy of the Kawa model is based around the concept of a river and that ‘rivers’ can be a symbolic representation of our lives and reflect our experiences and personal journeys through life (Okuda, Iwama, and Hatsutori, 2000; Iwama, 2006).

I was first introduced to the Kawa model at an Occupational therapy conference in 2003. Michael Iwama a Canadian Occupational therapist of Japanese descent who was one of the co-founders of the Kawa model

discussed the philosophy and workings of the Kawa model within his presentation. I identified with the theories and concepts behind the Kawa model and the collaborative approach it promoted, as it related to the occupational therapy ideals of valuing the individual and client-centred practice. The visual and narrative qualities of the Kawa model also resonated with me and I began to examine the key concepts and workings of the Kawa model and to consider its' potential use both in clinical practice and within education.

I felt drawn to the Kawa model as it was unique compared to other Occupational therapy models. The Kawa model views the service user as the expert in their life and highlights the importance of personal narratives. The Kawa model provides a visual dimension through the creation of personal maps that reflect one's life and considers contextual factors that impact upon each individual. The Kawa model also emphasises the value of collaboration, with the occupational therapist working in partnership with the service user in creating the personal maps. Having used the Kawa model in practice as a therapeutic tool and observed the clinical benefits, I wanted to research it usefulness. I felt the unique qualities of the Kawa model would make it an appropriate research tool in ascertaining the lived experiences of mental health service users as they journeyed through their personal recovery.

History of the Kawa Model

Since Occupational therapy as a profession came into existence at the beginning of the 20th century in the United Kingdom and United States of America, many of the concepts and theories of the profession have been grounded in western values and ideals (Wilcock, 2006). The Kawa model was the very first occupational therapy model that was developed outside of the previous dominant Western context (Iwama, 2004). A group of Japanese occupational therapists based in Okayama, Japan felt that the Western theories and models they were required to use in practice, did not resonate with them, or with the perspectives and experiences of their

clients. They also struggled to make sense of how Western models such as the Model of Human Occupation (USA) and the Canadian Model of Occupational Performance (Canada), which were shaped by Western values and philosophy would explain, describe and predict phenomena within such a different Japanese context (Iwama, 2006).

This subsequently led to the formation of a research group and eventually the Kawa model founding group which consisted of 20 occupational therapy clinicians, students and educators who embarked upon a process of evaluation and discourse of their clinical practice. Under the stewardship of Michael Iwama, a Japanese Canadian Occupational Therapy academic working in Japan, and through the use of grounded theory methodology, the Kawa model was then conceived (Iwama, 2006). In 2004, I was asked by the editor of a core Occupational therapy textbook in the UK (Foundations for Practice in Occupational Therapy) to co-author an introductory chapter on the Kawa model, which I completed so with Michael Iwama. Having worked on the book chapter and also used the Kawa model in practice I was therefore familiar with how it could be used clinically. However I had never conducted any form of research into the Kawa model and the PhD research offered me the opportunity to do so and more specifically to examine the use of the Kawa model as a research tool in exploring the lived experiences of those with a mental health condition.

Key Philosophy of the Kawa Model

The Kawa model as indicated previously embraced a radically different approach and adopted a much more naturalistic philosophy, less complicated by jargon and technical foundations often associated with Western theoretical models (Iwama, 2006). The central concept of the Kawa model is the metaphor of a River as symbolising each individual's personal journey through life. The Kawa model acknowledges each individual as having a unique personal river which is symbolic of their lived experience and journey, flowing through time and space (Lim and

Iwama, 2006). The key concepts and components of the Kawa model are associated with the natural elements within a river system and will be explained next, starting with the basic concepts and component parts of the Kawa model.

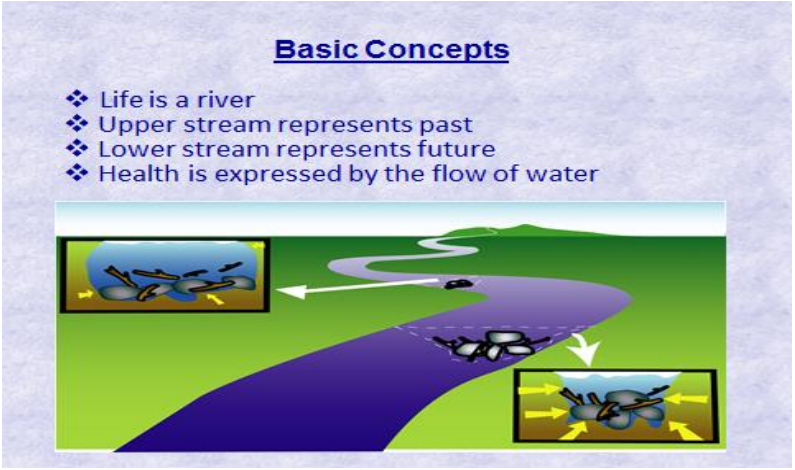


Diagram 1 Basic Concepts of the Kawa Model
(Lim 2015b European OT Masters Lecture slides)

In accordance to the river metaphor, the flow of water represents the flow of life. Life begins at the source of the river and ends when the river meets the sea. The upper stream represents the past and the lower stream represents the future as seen in Diagram 1 above. An optimal state of well-being in one's life or river can be metaphorically portrayed by an image of strong, deep, unimpeded flow. The Kawa components are related to natural elements associated with rivers like: river bank, rocks and driftwoods, with the position and size of these components within one's river representative of how one perceives their life flow and well-being (Iwama, 2006).

Components of the Kawa River Model

The four basic concepts (water, river banks, rocks and driftwoods) outlined in the Kawa Model and their metaphorical counterparts are listed and explained in the following section and illustrated within Diagram 2.

These diagrams are used to communicate the framework accessibly for instance to survivors who might employ the metaphor.

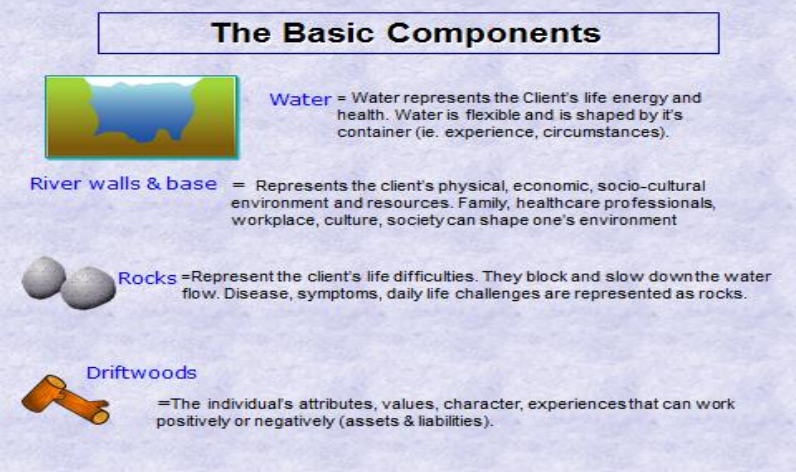


Diagram 2 Basic Components of the Kawa Model
(Lim 2015b European OT Masters Lecture slides)

Mizu (Water)

Mizu, Japanese for 'water', metaphorically represents the individual's life energy or life flow. Fluid, pure, cleansing and renewing are only some of the meanings and functions commonly associated with this natural element. Just as people's lives are bounded and shaped by their surroundings, experiences and circumstances, the water flowing as a river is moulded and shaped as it comes into contact with the rocks, river sides and base and all other elements that form its context (Lim and Iwama, 2006). The volume, direction and rate of flow can reflect one's state of health; that is, when life energy or flow weakens, the individual may be said to experience a state of ill health. Water is fluid and adopts the form of its container, so similarly the environment has the impact to shape the individual self. In such an experience, the interdependent self is deeply influenced and even determined by the surrounding social context, at a given time and place (Iwama, 2006; Lim and Iwama, 2006).

Kawa no soku-heki (River side-wall) and kawa no zoko (River base)

The river's sides and base are the structures that represent the individual's environment. These are perhaps the most important determinants of a person's life flow within a collectivist social context because of the primacy afforded to the environmental context in determining the construction of self, experience of being and subsequent meanings of personal action. In the Kawa Model, the river walls and sides can represent family members, workmates, friends, social relationships (Lim and Iwama, 2006).

The surrounding socio-cultural environment can affect the overall flow (volume and rate) of the individual's kawa (river). Harmonious relationships could enable and complement life flow, whilst financial constraints and lack of family support could results in a negative effect on the individual's life flow. If there are obstructions (rocks and driftwoods) in the watercourse, the flow of the river would be compromised. The restriction in life flow could represent poor health and state of being (Lim and Iwama, 2006).

Iwa (Rocks)

Iwa (Japanese for 'large rocks') represent challenges or difficulties that are considered to be impediments to one's life flow. They are life circumstances perceived by the individual to be problematic and difficult to remove and can be symbolic of life long conditions, challenges and health concerns. Most rivers, like people's lives, contain rocks or impediments of varying size, shape and number. The impeding effect of rocks by themselves or in combination with other rocks, jammed against the river walls and sides (environment), can profoundly impede and obstruct flow. The individual's rocks may have been there since the beginning, such as with congenital conditions. They may appear instantaneously, as in sudden illness or injury, and even be transient, as

in the form of a concern like an electricity bill that arrives and creates added worry (Lim and Iwama, 2006).

A person's bodily impairment becomes disabling when faced with a restrictive environment, however a barrier-free environment can decrease one's disability. Once the individuals' perceived rocks are known (including their relative size and situation), the therapist can help to identify potential disabling circumstances, areas of intervention and strategies to enable better life flow. Occupational therapy intervention can therefore include treatment strategies that expand beyond the traditional patient, to their social network and even to policies and social structures that ultimately play a part in setting the disabling context (Iwama, 2006; Lim and Iwama, 2006).

Ryuboku (Driftwoods)

Ryuboku is Japanese for 'driftwoods' and represents the individual's personal attributes and liabilities. Resources, such as values (e.g. honesty), character (e.g. optimism, stubbornness), personality (e.g. reserved, outgoing), special skill/interest (e.g. carpentry, public speaking), and immaterial (e.g. friends, siblings) and material assets (e.g. wealth, special equipment) that can positively (attributes) or negatively (liabilities) affect the individual's circumstance and life flow. Like driftwoods, they are transient in nature and carry a certain quality of fate or serendipity. They can appear to be inconsequential in some instances and significantly obstructive in others, particularly when they settle in amongst rocks and the river sides and walls. However, they can collide with the same structures to nudge obstructions out of the way (Lim and Iwama, 2006).

A client's religious faith and sense of determination can be positive factors in persevering to erode or move rocks out of the way. Receiving a grant to acquire specialized assistive equipment can be the piece of driftwood that collides against existing flow impediments and opens a greater channel for one's life to flow more strongly. Driftwoods may form

parts of each river and often resemble intangible components possessed by each unique person. Effective therapists pay particular attention to these components of an individual or community's assets and circumstances, and consider their potential effect on the client's situation (Iwama, 2006; Lim and Iwama, 2006).

Application of Kawa Model

Application of the Kawa model requires the occupational therapist to undertake a process of explaining the basic philosophy and concepts related to the Kawa model. The individual/service user then decides if they would like to create an image of their lived experience over time (longitudinal image) or at a particular point in time (cross-sectional image). Following the creation of the river map which takes the form of a physical sketch or drawing as demonstrated in Diagram 3, a narrative discussion takes place between the occupational therapist and the individual to better understand what has been represented within the Kawa maps (Lim and Iwama, 2011).

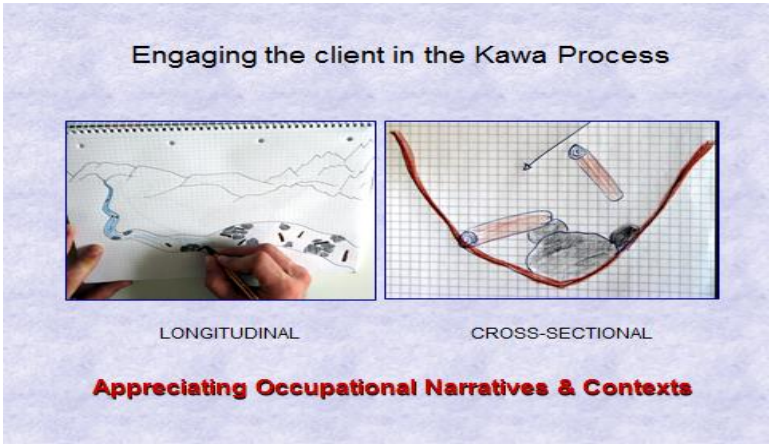


Diagram 3 Creating the Kawa maps, Longitudinal and Cross-sectional (Lim, 2015b European OT Masters Lecture slides)

The narrative discussion provides the occupational therapist the opportunity to derive a clearer sense of the lived experiences of the individual /service user and to gain an appreciation of their narrative and

life circumstances. Only through engaging in this two-step process can insight be derived in order to best appreciate the goals and targets to be set in helping the individual (Iwama, 2006).

The Kawa model compels the occupational therapist to view the individual within their own context (Lim and Iwama, 2006). Occupations or activities are viewed as integral to the self and the wider community to which the individual inseparably belongs, and not viewed as mechanical tasks or individual functions. Indeed within the Kawa Model, phenomena and life circumstances are rarely considered to occur in isolation. By changing one aspect of the individual's world, all other aspects of their life world (river) may change and alter accordingly, reinforcing the interconnectedness between all aspects (Lim and Iwama 2011).

By using Kawa model in partnership with the client, focus is directed at reducing obstruction of life energy/flow and towards seeking opportunity to enhance the individual's health and well-being. Aspects of the environment and phenomenal circumstances, like structures found in a river, can be examined for how they affect life flow (Lim and Iwama, 2006). Rocks (challenges and life circumstances), river walls and base(environment) and driftwoods (assets and liabilities) are all considered as inseparable parts of the individuals river that determine its boundaries, shape and flow as illustrated with case example Diagram 4. The Kawa model recognises each individual as the expert in their own experience and emphasises the need to involve the client in all aspects of their self-assessment, goal planning and intervention. The purpose of occupational therapy in this metaphorical representation is to enable and enhance life flow, which ultimately promotes health, wellness and recovery.

The Kawa model also recognises the unique, dynamic nature and diversity of each individual's occupational narrative and provides a framework within which occupational therapists can appreciate each

client in the context of their day-to-day realities and circumstances. Hagedorn (2001) highlighted how important it is for occupational therapists to be educated in learning how to think, as opposed to being told what to think or what to do. This approach also complements Deegan's statement in (1996a) of needing to cultivate wisdom in health professionals rather than focusing on merely acquiring knowledge.

The Kawa model arguably fulfils this purpose, as it encourages exploration, debate and discussion, and does not prescribe a fixed and predominant view or way of understanding each situation (Lim and Iwama, 2011). The Kawa model seeks to enlighten the individual in thinking, appreciating and understanding more about their life circumstances. It further empowers the client by giving credence to their personal and occupational lives and validating their personal perspective rather than imposing a prescribed framework of concepts and principles (Iwama 2006, Lim and Iwama, 2006). The visual aspects of the Kawa model also provides an alternate way of understanding the complexity of people's lives and presents a pictorial record that can benefit the individual as they seek to gain awareness and understanding of their life circumstances and this is a notable advantage of the Kawa model.

Many qualitative research methods are textually based, for example with interviews or focus groups where questions are asked and responses are provided (Smith, 1996) where the interview data, diary notes or textual reflections of participants are analysed for common themes. However having alternative ways of eliciting subjective experiences beyond just a textual method/ process could enhance insight, self-reflection and understanding too (Harper, 2002; Emmison and Smith, 2000; Rose, 2016). Photo narratives, artwork, video records are some of the additional ways in which personal accounts of daily life and experiences can be captured and provide an added means of self-examination, reflection and avenue for added insight (Radley, 2010; Reavey, 2011; Rose, 2016; Mannay, 2016).

This is a unique quality of the Kawa model within research, as it has the capacity to create a new ways of understanding recovery by visualising the collection of circumstances that are experienced by the individual in their recovery journey. The Kawa model as a framework in exploring recovery provides the opportunity for participants to create, construct, experiment, map, narrate and examine their lived experiences and recovery. This study seeks to explore how participants derive personal insights and understanding of what shapes their lived experiences through creating a series of Kawa maps over the course of the research.

Paradigm Shift and the Kawa Model

Iwama (2009) suggested that there has been a paradigm shift in occupational therapy heralded by the introduction of the Kawa Model, with a move away from the therapists being in control towards the service user. The Kawa model considers the service user as central and supports empowering them to make choices and take control of their lives. This leads to a shift in focus, with the lived experience and daily realities of the client being considered a priority as opposed to prescribed standardised assessments and interventions predetermined by the therapist. This paradigm shift is consistent with the ideology of the recovery movement, where the individual and their lived experience is esteemed and regarded as central to understanding how best to assist them to get better (Pitt *et al*., 2009).

Contribution to Research

There has been research into the use of the Kawa model as a reflective tool, with studies focused on students and clinicians using it to reflect upon their education, placement experiences or clinical practice (Carmody, Nolan, Chonchuir, Curry, Halligan and Robinson, 2007; Renton, 2010; Bai, 2015; Paxton, 2015). However the use of the Kawa model as a reflective tool for mental health service users is limited and

the proposed research will add to the knowledge and literature around the Kawa model in this respect.

Within the field of mental health, the Kawa model, has been used by occupational therapists in clinical practice or within research, however these have mostly consisted of single case studies or small sample studies (Iwama, 2006; Ostyn, 2013; Gregg, Howell, Quick and Iwama, 2015). These case studies have nevertheless derived some positive outcomes, including service users being able to actively engage in using the Kawa model, helping them in their goal planning; assisting them in the reflective process and promoting understanding of their own mental health experiences (Lim and Iwama, 2011). To date there has not been any research into the use of the Kawa model as a personal recovery framework in mental health, which enhances the value of the proposed research in creating new knowledge.

The current research aims to examine the contribution of Kawa model as a visual and narrative tool in exploring the recovery journey of mental health service users and to provide insights into their personal experiences of recovery. It will also focus on factors that individuals' perceive as enhancing or limiting their personal recovery and may highlight the role and value that occupations and activities have in contributing to the recovery experiences of mental health service users. I believe that the research will therefore contribute to the existing knowledge regarding the usefulness and value of the Kawa model, as current literature and research in relation to its utility in all fields of practice is limited.

Additionally, within the area of mental health with only a handful of research studies having examined the use of Kawa model, the impact of the Kawa model as a recovery framework will contribute new knowledge. The research will further contribute to the Royal College of Occupational Therapists' Mental Health Strategy, Recovering Ordinary Lives (RCOT,

2006) in examining the value of occupational therapy frameworks and approaches in enhancing personal recovery. Further it will contribute towards the Royal College of Occupational Therapists'; Building the Evidence for Occupational Therapy: Priorities for Research (2007) targets, by evaluating the contribution of occupation and occupational therapy in promoting health, well-being and recovery.

Summary

In summary the above chapter has provided an introduction to the thesis, highlighting the relevance of mental health and my personal reasons for the embarking on the research topic and the key research aims. The evolving context of mental health has been highlighted and an overview of mental health recovery outlined. The differing perspectives of health, illness and recovery have also been highlighted. The relationship between health and well-being, occupation and mental health recovery has also been discussed with a focus on occupational science theory. An introduction to the Kawa model, it's historical and theoretical principles have also been outlined, with the different component elements of the Kawa model explained. The contribution of the Kawa model as a research tool and the impact of the research in deepening the personal insights to mental health recovery have also been indicated.

Outline

Chapter 1 Introduction

This chapter provides an introduction to the current study outlining the background and rationale for the research. The evolving context of mental health in the UK and the concept of mental health recovery have been highlighted. The relationship between occupation, occupational therapy, occupational science, and mental health recovery has also been indicated with an introduction to the Kawa model. The reasons for establishing a personal perspective and understanding of recovery has

been explained and the potential contribution of the Kawa model as a visual and narrative tool in exploring the unique nature of recovery highlighted.

Chapter 2 Literature Review

The literature review chapter will examine and provide a critique of the current research and literature around the Kawa model with a focus on establishing the theoretical discussions, clinical evaluations, case studies, alternative perspectives and research related to the Kawa model. The gaps in the existing research will be identified and the reasoning for the research study will be indicated.

Chapter 3 Research Methodology

The methodology chapter will examine the philosophical principles of epistemology, ontology, subjectivity, phenomenology, followed by a discussion contrasting quantitative and qualitative methodology. The historical foundations and philosophical doctrines of Interpretative Phenomenological Analysis (IPA) will also be discussed and the appropriateness of IPA as a methodological and analytical framework for this study highlighted. The theoretical grounding of the Kawa model will be highlighted and its appropriateness to the research indicated.

Chapter 4 Research Methods

The methods chapter will outline the research methods adopted within the current research. This will include the research approach and design, data collection, method of analysis, ethical considerations, research procedure, consent and confidentiality issues relevant to the research. There will also be a discussion on issues of reflexivity, positional power and subjectivity.

Chapter 5 First Findings Chapter (Meanings of recovery: an interpretative phenomenological analysis)

The first findings chapter will focus on the personal experiences of mental health recovery and examines what participants considered influential within their own recovery from a phenomenological perspective and via the use of Interpretative Phenomenological Analysis (IPA). The chapter will then present the convergent and divergent views across the cohort of participants in respect of the super-ordinate and sub-ordinate themes that arose from analysis of the interviews.

Chapter 6 Second Findings Chapter (Collective perspectives of the Kawa Model)

The second findings chapter will examine the contribution of the Kawa model and maps in promoting insight and understanding of personal recovery. The chapter adopts a collective focus highlighting the perspectives of the whole cohort of participants as they experience and reflect upon the use of the Kawa maps across the research year. The use of the Kawa Model Framework Index will be explained and its efficacy in examining the Kawa maps indicated. The collective views of the strengths and limitations of the Kawa model and maps will also be highlighted.

Chapter 7 Third Findings Chapter

The third findings chapter will adopt an idiographical approach, with a detailed examination of the lived experiences and recovery journey of two research participants. The focus involves a thorough analysis of the series of Kawa maps created by each participant, establishing a longitudinal perspective of their personal recovery through the year. The Kawa Model Framework Index will be employed in examining the Kawa maps.

Chapter 8 Discussion

The discussion chapter will examine and discuss the results from the current research, drawing upon published literature, policy documents and past research. It will examine personal interpretations of recovery and the different factors participants considered to be influential in their personal recovery. The value of engaging in meaningful occupation in support of health, well-being and recovery will also be indicated. The contribution of the Kawa model in assisting mental health service users to understand their recovery journey will be discussed, and a critique of the strengths and limitations of the current research outlined. My reflections of the research process and journey will also be highlighted.

Chapter 9 Conclusion

The final chapter will review the methodological approaches adopted in the research. The specific contributions to knowledge derived from the current research and the unique contribution of the Kawa model will be outlined. The contributions to the theory and knowledge based of the Kawa model and implications for future research, occupational science, educational developments and clinical practice will also be highlighted.

Chapter 2 Literature Review

In this chapter I will examine the existing literature in relation to the Kawa model. The research question is to examine the contribution of the Kawa model in exploring the personal journeys of recovery of mental health service users. The literature review will critically examine the published literature, inclusive of books, chapters, theoretical discussions, case studies and research related to the Kawa model. I will also indicate my existing publications related to the Kawa model.

As highlighted in the previous chapter, I found the Kawa model to be fundamentally different from the other occupational therapy models I was familiar with. The simplicity of the concepts within the Kawa model and use of visual maps was something I related to. I felt it was a practice model that was easily understandable and encouraged a more client–centred approach with scope for service users to share and explain their personal perspectives.

Due to my interest in the Kawa model and experience of using it with service users in practice, I was approached in 2004 by the editor of *'The Foundations in Occupational Therapy'* (Edward Duncan) to co-author a book chapter on the Kawa model with Michael Iwama one of the co-founders of the Kawa model. This resulted in the chapter *'Emerging Models-An Asian Perspective: The Kawa (river) Model'* (Lim and Iwama, 2006). This theoretical chapter introduced the foundational concepts and explained the rationale for the Kawa model, with a single case study detailing the practical application of the Kawa model with a mental health service user. I was subsequently involved as a co-author in the revised chapter titled *'The Kawa 'river' model'* (Lim and Iwama, 2011) in an updated version of the same book 'The Foundations in Occupational Therapy' (Duncan, 2011).

In addition I was the sole author of two further chapters examining cultural competence within mental health occupational therapy practice, which discussed the value of using the Kawa model. The first was *'Cultural Sensitivity in Context'* (Lim, 2008a) located in the book edited by McKay, Craik, Lim and Richards (2008), entitled *'Advancing Occupational therapy in Mental Health Practice'* and the second *'Working in a Transcultural Context'* (Lim, 2008b) located in the book edited by Creek and Lougher (2008) *'Occupational Therapy and Mental Health'*. Once again both chapters were published in UK Occupational therapy books examining the use of the Kawa model as a clinical framework and tool within mental health practice.

Although I have contributed to these chapters on the Kawa model they have fundamentally been theoretical in content rather than based on empirical research. The chapters have provided the rationale for the existence of the Kawa model, introduced the key concepts and outlined the application of the Kawa model. All the case studies included in these chapters have been based on clinical examples and highlighted the use of the Kawa model as a clinical tool. In my PhD research I have decided to scrutinise the utility of the Kawa model as a research tool. This PhD seeks to explore the contribution of the Kawa model as a visual and narrative tool in exploring personal journeys of recovery. I hope that the outcomes from my research will eventually contribute to the research evidence on the Kawa model.

Literature Search

I began the literature search by identifying the key terms in relation to my research topic and focused on all relevant literature around the Kawa model and specifically those related to mental health and recovery. The search engines used were PsycINFO, Medline, HMIC, CINAHL, AMED through both the OVID and EBSCOHOST platforms and also OT Seeker and Otdbase, with the addition of a hand search of dissertations, books and chapters. I also undertook an advance search with a combination of

different terms including Kawa model and recovery, Kawa model and mental health and Kawa model in abstracts, titles and subject headings. The search terms included the Kawa model, Kawa River model, Kawa model and Occupational Therapy, with an identified search period between the years of 2000-2018. The date of 2000 was chosen because the first available published literature on the Kawa model was in 2000. The literature review includes an exploration of the developmental timeline, content and research related to the Kawa model.

Search Outcomes

The initial search **Kawa AND recovery** returned 4 relevant articles, whilst **Kawa AND mental health**, returned 6 relevant articles for review. Expanding the search further as indicated in Table 1, **Kawa AND Occupational Therapy** returned 8 relevant articles and a search of the term **Kawa model** only returned 16 relevant articles. Finally expanding the search using only the term **Kawa** returned a result of 42 articles, however not all these 42 articles were relevant as the word ‘Kawa’ means ‘river’ in the Japanese language. Using the term ‘Kawa’ only, derived collections of articles containing the word ‘Kawa’ or ‘river’, which had no relationship to the Kawa model at all. From the remaining articles that were relevant, I then removed any duplication from previous searches. I further examined each abstract for relevance and this reduced the number of articles to 16, which I then systematically reviewed.

I also undertook a library search of published dissertations and theses at the Royal College of Occupational Therapists and examined any additional grey (unpublished) literature by checking the Kawa model website and mental health resources. This resulted in a total of 25 relevant publications, located in books, chapter, dissertations, case studies and journal articles. The outline of the literature search process is illustrated in Tables 1 and Table 2. The majority of articles were qualitative research studies, practice evaluations or opinion pieces. I used

the Critical Appraisal Skills Checklist (CASP) qualitative research review to critique all the research articles.

Table 1 – Literature Search: Kawa model

Primary Search Terms	**AND search terms**
Kawa model* or Kawa*	Recovery* Mental Health* Occupational Therapy* Lived experience*

N.B. * denotes truncated associated words

Table 2 Search results

Search term/terms	**Search engines:** PsycINFO, Medline, HMIC, CINAHL, AMED	Results	Results following full text review
Kawa AND recovery		4	4
Kawa AND mental Health		6	6
Kawa AND Occupational Therapy		8	8
Kawa model		16	16
Kawa		42	16
Kawa model	Hand search including chapters, dissertations and conference presentations	9	9
Total after eliminating the duplication of literature			25

The publications located could be divided into several categories, firstly there were journal articles that introduced, supported and critiqued the value of the Kawa model (Okuda, Iwama and Hatsutori, 2000; Iwama, 2003; Iwama, Thomson and Macdonald, 2009; Wada, 2011).

Secondly, key occupational therapy books and chapters introducing and detailing the use of the Kawa model (Iwama, 2004; Iwama, 2006; Lim and Iwama, 2006; 2011 and Lim, 2008a; b). Included in this category was the key Kawa model book *'The Kawa model: Culturally Relevant Occupational Therapy'* in 2006, authored by Michael Iwama, one of the co-founders of the Kawa model. Within this category were also the two chapters I co-authored with Iwama, *'Emerging models- an Asian perspective: the Kawa model'* in 2006) *and 'The Kawa 'river' model'* in 2011) in Duncan's (2006; 2011), book *'Foundations for Practice in Occupational Therapy'*.

Thirdly, were studies that examined the clinical utility and relevance of the Kawa model with different service user groups and in various settings. This included researching the value of the Kawa model in exploring the perspectives of individuals living with multiple sclerosis (Carmody *et al.*, 2007); exploring the experiences of indigenous young Australians around health and physical activity (Nelson, 2007); exploring the narrative and lived experiences of adults with visual impairment (Teoh *et al.*, 2013) and exploring the experiences of victims of domestic violence (Humbert, Bess and Mowery, 2013; Humbert, Engleman and Miller, 2014), as well as clinicians' perspectives of using models in practice Owen (2014).

Fourthly were studies looking at the use of the Kawa model as a reflective tool with students in education or clinicians in practice. This included the use of the Kawa model to aid self-reflection (Cheng, 2010); as a professional development tool with students undertaking their occupational therapy education (Renton, 2010); and students reflecting

upon their clinical placement experiences using the Kawa model (Bai, 2015; Paxton, 2015).

Lastly, were articles on the Kawa model related to mental health; mental health practitioners using the Kawa model (Paxson, Winston, Tobey, Johnston and Iwama, 2009; Richardson, Jobson and Miles, 2010); Kawa model and client centred practice (Ostyn, 2013); research study which examined combat and operational stress (Gregg, Howell, Quick and Iwama, 2015).

In structuring the Literature Review, I decided to adopt a chronological approach in examining the existing literature and research. I chose such an approach as I wanted to highlight the evolving journey and development of the Kawa model and its use over time. This chronological approach to reviewing the existing literature was only possible because of the limited amount of published literature and research on the Kawa model. I also structured the literature into related sections, for example grouping the mental health articles together.

Review of Literature

The first journal article that introduced the Kawa model (KM) was by Okuda *et al.,* (2000). This article described how the Kawa model developed from clinical practice and highlighted the genesis of the Kawa model from a research project with a group of 20 Japanese occupational therapists. The group met monthly over an 18 month period and used Grounded Theory methodology to analyse common themes and concerns they experienced with implementing western occupational therapy models within their practice. The article described the beginnings and development of the Kawa model and detailed the Grounded Theory approach taken by the founding occupational therapists in the generalisation of knowledge and theory relevant to the development of the model. This first article was essentially a descriptive article based on the initial developments and core concepts of the Kawa model.

Iwama (2003), in his opinion piece *'Toward Culturally Relevant Epistemologies in Occupational Therapy',* prompted a philosophical debate around the generation and construction of knowledge and ideas. He discussed the epistemology of knowledge generation and challenged the view of a universal perspective and metanarrative. Iwama highlighted the position of social constructionism within the philosophy of the Kawa model and the belief that all truth and knowledge is socially constructed. The study emphasised how contextual and cultural factors may influence our perspectives and how we understand our experiences.

Further introductions to the Kawa model took the form of books and chapters that introduced and explained the fundamental concepts and workings of the Kawa model. This included the first chapter on the Kawa model by Iwama (2004) titled *'The Kawa (river) Model; nature, life flow & the power of culturally relevant occupational therapy'.* In the chapter, Iwama discusses the importance of cultural sensitivity and the relevance of metaphors and imagery. He highlighted the Kawa model as an example of a culturally relevant model that was created in response to the challenges experienced by practicing occupational therapists and explained the relevance of visual imagery within the model. Once again this was an introductory chapter that presented a theoretical base for the Kawa model.

The first book on the Kawa model *'The Kawa Model: Culturally Relevant Occupational Therapy'* was published in 2006 by Iwama. The book highlighted the origins of the Kawa model and the reasons for the existence of this new occupational therapy model. Included within the book were a series of case studies to illustrate the use of the Kawa model within several clinical fields, including acute and community mental health, cerebral palsy, stroke rehabilitation, osteoarthritis, supervision of students in fieldwork education, and students working with children from indigenous communities. The case studies were also based on different population groups from various countries including Japan, Canada, India,

Australia and the UK and demonstrated the broad range of use of the Kawa model. The use of the Kawa model across a diverse spectrum of clinical conditions, age groups and cultural context demonstrated its flexibility and adaptability.

Iwama, Thomson and Macdonald (2009) in their article highlighted the rationale for occupational therapists to explore a range of alternative models of rehabilitation in order to provide culturally responsiveness of occupational therapy. The article highlighted the underlying principles and foundations of the Kawa model and challenged current acceptance of 'standard western ideals' as ways of understanding personal experiences. It proposed that the practice and delivery of occupational therapy should be individualised, flexible and tailored to the personal needs of the individual and the need to take account of the contextual, social and cultural influences that impact on the individual.

Turning to the wider literature a qualitative study by Carmody *et al.* (2007) conducted in Ireland, focused on the experiences of two patients with multiple sclerosis and two student researchers using the Kawa model. The (student) researchers engaged in a double role of both implementing the use of the Kawa model with the participants, whilst also conducting research interviews. The (patient) participants were introduced to the Kawa model by the two (student) researchers who used the Kawa model as a framework in guiding their occupational therapy interventions with the two participants with multiple sclerosis. A qualitative grounded theory approach using case-study design was adopted in the study. Semi-structured interviews based on the Kawa model were completed with the (patient) participants before and after the eight weeks of occupational therapy intervention. Additionally the (student) researchers documented within their own reflective diaries their experiences of both working with the participants and their involvement in the research. The research findings indicated that the participants felt the Kawa model helped them to better understand their experiences and priorities within their own

rehabilitation. The (student) researchers felt that utilising the Kawa model helped them to form a deeper relationship with the (patient) participants, guiding their occupational therapy practice in more client-centred ways and facilitated occupation-based practice.

The strengths of the study included the (patient) participants' Kawa maps being included within the data collection, which provided additional details regarding their experiences of rehabilitation and use of the Kawa model. The (patient) participants were also involved in member checking and examining the transcripts of their interviews for accuracy which enhanced the rigour of the research. Both the (student) researchers kept reflective diaries throughout the research process when delivering the intervention and conducting the interviews, which demonstrated increased reflexivity. Recordings of the interviews and researcher's interview notes also provided a valuable evidence trail, enhancing the rigour of the study. Trustworthiness was enhanced as the research methodology was clearly explained and the analytical process was transparent and easy to replicate for a future study.

The limitations of the study were that the (patient) participants highlighted they were at times uncertain about how to draw their own Kawa maps and would have valued some additional support in doing so. The (student) researchers also indicated that they were at times unsure if they had been able to clearly explain the concepts and application of the Kawa model to the (patient) participants. A further limitation was the (student) researchers being involved both in the data collection interviews and also in delivering occupational therapy interventions, highlighting a possible conflict of interest and potentially influencing the outcomes of the research. Due to the small study size and time constraint of the study there was a lack of theoretical saturation for the grounded theory approach adopted in the research. An increase in the number of participants and length of the study would have allowed for a fuller and more complete use of grounded theory as an approach. Further, in

critiquing this research, the student researchers themselves highlighted their inexperience as interviewers and the short intervention sessions owing to time constraints, as possible limitations impacting the research outcomes. Exploring the participants' experiences could have been further enhanced by requiring the (patient) participants to complete their own reflective dairies where they could document their personal thoughts and views as they engaged in creating their own Kawa maps.

Paxson *et al.* (2012) conducted a qualitative pilot study in the USA, examining the experiences of two occupational therapists in mental health practice using the Kawa model. The two therapists utilised the Kawa model with one client over a six-week period and revealed that, although feeling initially apprehensive, they found that the Kawa model increased the level of communication they had with their client and extended the scope of their therapeutic interventions. Both the participants highlighted the "positive energy exchange" and "sense of ease" when discussing personal areas of difficulty that the client experienced. In addition to improving the two-way dialogue, the Kawa model appeared to strengthen the therapeutic relationship, by creating a more relaxed environment for discussions to take place.

The participants also highlighted that using the Kawa model provided them with an opportunity to explore and evaluate their clinical practice in greater detail. However the participants like those in the previous study by Carmody *et al.* (2007) indicated similar concerns as to whether they felt confident enough to explain the concepts of the Kawa model to their client despite having received appropriate training. Both participants also expressed some "self-doubt" in using a model so unconventional to them and indicate a level of concern, therefore limiting the potential utility of the Kawa model in their practice.

One of the strengths of the above study was that it adopted a phenomenological approach, which facilitated a more in-depth

understanding of the participant's perspective and experiences in using the Kawa model. Both the participants also kept a record of their reflections in using the Kawa model with their respective client and drew upon these thoughts and feelings when interviewed, which enhanced the accuracy of their perspectives in using the Kawa model. However, one of the limitations of the study was that the researchers could have involved the participants in member checking, to ensure the accuracy of the interview transcripts which would have enhanced the rigour of the study. Also the researchers did not provide a clear audit trail of their data analysis, which reduced the trustworthiness of the study. Both the participants could have used the Kawa model with more than just the one client and this would have enhanced the evaluation of the Kawa model, with a more diverse sample of clients. To enhance the research findings, the client could have also been interviewed to gain her perspective of the Kawa model in comparison to the therapists.

Buchan (2010) conducted a qualitative study as part of her MSc research dissertation at University of Brighton, UK with a focus on exploring the transitional experiences of newly qualified staff to establish their perception of their own learning needs. The study involved the use of two focus groups and personal interviews. The first focus group consisted of six Allied Health Professions (AHPs) and the second focus group three nurses. An additional eight AHPs and four nurses also took part in one to one interviews with the researcher. The participants in the focus group created a single Kawa map reflecting the collective experiences of their transitional journey as newly qualified staff, whilst the participants who were individually interviewed created a personal map each, reflecting their own transitional journey and experience as new staff.

The outcomes of the study indicated that using the Kawa model, provided the participants with a transitional narrative in which to explore the impact of contextual influences such as their work place environment on their transition as new practitioners. The participants also felt more able to

examine their own needs as newly qualified staff, discovering what they actually required in terms of training needs for their new roles. The findings indicated that the experiences and needs for preceptorship (practical training for the job) were unique to each individual, despite the NHS Trust plans to provide a standard preceptorship programme for all new employees. Peer supervision groups, having time away from the clinical area were considered an important aspect of the preceptorship process, allowing participants' time to reflect and consolidate their learning.

In terms of strengths, the research process was well documented and explained which allowed for the study to be replicated. The themes highlighted were also well supported with corresponding quotations from the research participants which enhanced the trustworthiness and rigour of the study. The researcher demonstrated reflexivity by alluding to her own experiences of preceptorship and documented her thoughts and feelings within her reflective diary. However one of the limitations of the study was the choice of geographical locations where the focus groups were held, which meant not all staff were able to attend and this led to fewer participants within the focus groups, limiting the possibly of differing views and opinions. The decision to invite participants to either the individual interview or to be part of the focus group could be more clearly explained and reasoned. Additionally more detail could be provided to explain the similarities and differences that arose between the individual maps created by the interview participants versus those created collectively by the whole focus group.

Fieldhouse (2008) undertook a practice evaluation to examine the use of the Kawa model with students as a reflective tool in the UK and to also ascertain the experiences of occupational therapists within community mental health. Fieldhouse noted that the Kawa model was embraced by occupational therapy students and that the Kawa model provided a link between acquiring theoretical knowledge and being able to apply the

knowledge to their clinical practice. The simplicity and visual qualities of the Kawa model were highlighted by the students in their reflective groups and they described having the space to experiment and derive new insights into their own learning as a benefit of using the Kawa model. With the community mental health occupational therapists, Fieldhouse indicated that they were willing to embrace the Kawa model due to its simplicity and visual qualities, which promoted the seamless application of the Kawa model. The occupational therapists also indicated how adopting the Kawa model in their practice helped them to derive new perspectives and insights of the service users they worked with. Although there were some interesting points raised from the article by Fieldhouse, it was based primarily on his personal experience of using the Kawa model with students and clinicians alike rather than research. Therefore in the context of research rigour and credibility the points made in the article and views shared must be tempered with some caution, as it might not be a representative view of all the students or mental health practitioners indicated in this practice evaluation.

In a practice report, Richardson *et al.* (2010) examined the use of the Kawa model in mental health practice, in the UK. Three occupational therapists with experiences of using the Kawa model in three different settings were interviewed. The outcomes highlighted that the participants felt that the Kawa model provided an alternative way for their service users to explain their own position and perspectives. It further provided a way in which participants were able to narrate the story of their own lived experiences. The participants also highlighted how the service users they worked with found the Kawa model easy to use. They were able to engage with the metaphor and create their own maps depicting their experiences. Richardson also noted from the participants' own experiences that whilst some service users were attracted to the Kawa model because of its visual qualities and being able to draw their Kawa maps, others found it challenging and preferred to use a Kawa template if available. The research also indicated that service users were able

identify areas they would like to work on, having created a visual image of their personal situation.

The limitations were that this was a practice evaluation rather than an empirical research study. Details of how the three occupational therapists were recruited and the interview questions asked were not fully explained and it was not possible to verify the accuracy of the analytical process due to a lack of transparency as to how the analysis was conducted. The evaluation could have been improved by including a clearer explanation of the interview process and questions posed for such an evaluation to be replicated in a future study. The provision of corresponding quotations to support the views expressed by the three occupational therapists would have also enhanced the practice evaluation.

Ostyn (2013) in her study conducted in Belgium researching the value of the Kawa model in occupational therapy in supporting client-centred care indicated that although client-centred practice is a term which is considered synonymous with delivering quality health care, the reality in trying to achieve client–centred care is far more complex. Delivering client-centred care needs to begin right at the start of the treatment process, from the initial interview, to assessment, to mutually agreeing on goals and the eventual intervention. The study involved applying the Kawa model with a total of nine long-term psychiatric patients within a psychiatric home and assessing the added value of using the Kawa model versus using the Canadian Occupational Performance Measure-Environment (COPM-E).

The study indicated that using the Kawa model provided additional personal information about the client such as their contextual circumstances and personal resources that was not available through using the COPM-E. Having this additional information derived from using the Kawa model proved beneficial in the planning of interventions for the individual clients. The research also indicated that using the metaphor of

a river as representing one's life journey, provides the client with the opportunity to share their own narrative and prompting a more individualised support from the occupational therapists. The Kawa model was found to be flexible allowing both the clients and the occupational therapists an added dimension of creativity in which to further explore the needs and interest of the former. However, the Kawa model was not found to be applicable for participants who had cognitive difficulties thinking metaphorically nor had cognitive impairments. It was concluded that the Kawa model provided an added value for the occupational therapy assessment phase and promoted client-centred practice.

One of the strengths of the study was that this was one of the first studies looking at the use of the Kawa model with individuals with long term mental health issues therefore providing valuable findings about the utility of the Kawa model. The study also involved the researcher examining the Kawa maps created by the participants, exploring their personal perspectives and experiences of their being in a psychiatric home, which provided valuable insight. Further a range of quotations were provided in supporting the findings derived from the research enhancing the trustworthiness of the research. However one limitation of the study was that the researcher did not involve the participants in checking of the transcripts for accuracy which would have enhanced the overall credibility and rigour of the research. In terms of conducting a comparison study the total of nine participants was too small to draw conclusive evidence that the Kawa model was more effective and beneficial than the COMP-E. Further the study's lack of peer review or audit in the analysis of the findings also limited its credibility and trustworthiness. Reflexivity could have also been enhanced by the researcher keeping a reflective diary of her own thoughts and views throughout the research process.

Gregg *et al.* (2015) conducted a research study which examined combat and operational stress control (COSC) and the use of the Kawa Model. The authors proposed the need to implement culturally relevant and

client-centred care within the USA military context. It was proposed that the Kawa model and metaphor could be used as a guiding clinical approach for occupational therapy interventions for military service personnel experiencing combat-related stress. The research highlighted that occupational therapy currently lacks a sensitive approach in addressing the needs of military personnel with combat and operational stress. A single case study was adopted in this research examining the impact of the applying the Kawa model as a clinical tool. The Kawa model was used both to frame the contextual experiences and challenges faced by the individual participant but also to examine how they perceived of their combat-related stress. The study identified how adopting the use of the Kawa model helped focus both the therapist and participant on the wider contextual factors related to the individual, beyond their presenting difficulties. These contextual factors included socio-cultural expectations of being military personnel, the military environment and family pressures. Adopting an individualised, strength-based approach with attention to contextual influences of being in the military was considered to be a valued approach in working with combat and operational stress.

The researchers also indicated that occupational therapists providing mental health services should select a theoretical model and framework that encompasses the tenets of recovery for persons with mental illness and that the Kawa model had the capacity to support this approach. Occupational therapy interventions in support of recovery in the areas of community integration and normative life roles for adults with serious mental illness, was considered to be essential in helping military personal to reintegrate back into society. The research indicated the Kawa model as having the capacity and sensitivity to explore the personal experiences, narratives and lived experiences of the individual with combat and operational stress.

One of the strengths of the study is the inclusion of Kawa maps created by the participant, which depicted how he perceived his situation before

and one after intervention. This, together with the interviews and quotations, provided rich data and illustrated changes over time as a result of the use of the Kawa model. The creation of the personal maps also enabled the participant to gain greater awareness of their circumstances and provided the occupational therapist with insight tailoring the proposed interventions. Gregg *et al.* (2015) also concluded that the Kawa model was sensitive tool for use in addressing the cultural needs of the military service members.

One of the limitations of the study was the use of a single case study within the research, where the use of the Kawa model with more participants/case studies would have provided more differing perspectives and experiences in relation to those encountering combat stress. Further the level of analysis and comparison between the two maps created by the participant prior and after intervention could have been examined in more detailed to identify the specific contribution of the Kawa model versus others forms of occupational therapy approaches and intervention used. The researcher could have kept a reflective diary of their thoughts and experiences in implementing the Kawa model and examined their own position as military personnel, which would have enhanced reflexivity. Quotations from the participant could have been included in the research article in supporting of the benefits that the participant found in the using the Kawa model.

Nelson (2007) conducted a qualitative study examining the cultural perspectives and values of children and their families regarding health and well-being. In depth interviews were conducted with 15 indigenous Australian young people (eight female and seven male), around their perspectives of health and physical activity. In addition the Kawa model was introduced to the participants to assist them in reflecting upon their own experiences. The study promoted biographical accounts of the personal perspectives and experiences of indigenous young people which provided rich findings. The study also noted varied results in terms

of how helpful the participants found using the Kawa model to understand their own lived experiences. Some of the participants identified with the river metaphor, whilst others were uncertain about what to include within their river maps. Young women in the study engaged more with the river drawings and related more with the metaphor.

One of the strengths of the research was that the participants were able to represent and relate their personal stories through examining their visual maps. It was also noted that in using the Kawa model the participants gained additional insight and understanding of their life circumstances. Another was that the researcher acknowledged her own personal values based upon western ontologies and recognised that these might have impacted on how she made sense of the interviews especially as the participants were from a distinctly different cultural group. Additionally she also discussed the potential power relationship between herself as both more highly educated (university professor) and of white ethnicity and economically privileged relative to the participants. The researcher also discussed how the power differentials might impact upon her interactions with the participants and influenced the research participants in sharing their views in the interviews.

One of the possible limitations of the study was that the interviews took place in the school environment and the participants might have felt obliged to provide certain answers to the questions posed as the research took place in an institutional context. Additionally, the authors indicated that the results reported in the article were only from the preliminary findings of the study and had not been further analysed to derive further outcomes. A further limitation as acknowledged by the researcher was whether the perceived position of power that the she possessed or represented might have influenced the participants responses within the interview process.

Teoh *et al.* (2013) conducted a qualitative pilot study exploring the lived experiences of Malaysian Adults with visual impairments. The study aimed to provide insights into the experience of visual rehabilitation in Malaysia by acquiring firsthand narratives. It was also focused on identifying how occupational therapists could contribute towards enhancing and improving this field of practice. This comparative study, like the research by Ostyn (2013) examined the use of the Kawa model in comparison to the Canadian Model of Occupational Performance, but with adults with visual impairment instead of mental health challenges. It sought to elicit the narratives of five participants with visual impairment to determine what the participants regarded as being of personal importance in their lives. Due to their visual impairment the participants were not required to create Kawa maps but instead used the Kawa model as a cognitive framework to organise and structure their thoughts. The researcher developed a Kawa model manual to guide the semi structured interviews used in the study and to assist the participants to more easily comprehend the use of the Kawa model.

The findings indicated that besides work, education, leisure activities and community management, Malaysian adults with visual impairments also regarded self-worth, being able to live life on their own terms, social activities and social environments as being important. The findings also provided a basis of comparison for applying different frameworks and how they could influence the focus of occupational therapy on a specific population. The research demonstrated the adaptability of the Kawa model as it was used as a cognitive framework to organise the interview questions rather than as a visual tool, due to the visual impairments of the participants involved.

The strengths of this work included a clear explanation of how the study was conducted which allow for it to be replicated. Additionally the development of the Kawa model manual as a guide for the semi structured interviews was a specific and valuable contribution of this

research. Teoh *et al.* (2013) also demonstrated flexibility in using the Kawa model beyond the reliance of having drawn Kawa maps, by utilising the 'river' metaphor to assist the participants in structuring their narrative accounts of their personal experiences. The themes highlighted were also well supported with corresponding quotations from the research participants which enhanced the trustworthiness of the study.

The limitations of the study were that it did not actually involve the participants physically creating their Kawa maps, which would could enhanced the utility of the Kawa model. One way of doing so could have involved developing a template of physical model where the participants were not limited to drawing their own Kawa maps but able to construct a physical model. The researcher could have also enhanced the research outcomes by engaging member checking and a peer audit of the interview findings, which would have enhanced the trustworthiness and rigour of the research. Further the researcher did not provide details of their personal reflections of the research process and therefore this limited the level of reflexivity within the research.

Use of the Kawa Model as a Reflective Tool

Cheng (2010) examined the use of the Kawa model as a tool to develop her professional knowledge and reflective practice. Cheng who was a healthcare practitioner described her own experience of creating the Kawa maps and using the metaphor of a river to represent her life circumstances. She indicated that using the Kawa model helped her to understand her circumstances better, gain more insight and transform her practice. Connections between the use of other art forms like painting and reflective practice were also discussed by the author. However as this article was not based on any form of empirical research but the personal views of the author, it could not be scrutinise against research criteria.

Renton (2010) conducted a pilot qualitative study evaluating the utility of the Kawa model with occupational therapy students in Edinburgh, UK.

The study examined the perspectives of students who used the Kawa model for their professional development, learning and reflections. Renton recruited a total of 56 student participants, who were all introduced to the Kawa model in their first year of studies and used the Kawa model within group work activities. In their second year, the students used the Kawa model in working through case studies, whilst in the third year they formulated assessments and interventions based on the Kawa model. The students then completed an academic assignment based on the Kawa model in their fourth year. Throughout their four years of studies the students also used the Kawa model as a reflective tool and created Kawa maps which reflected their personal development needs throughout their occupational therapy education.

The responses were collected via interviews and thematic analysis was applied. The study outcomes indicated that the students felt that the Kawa model enabled them to undertake a deeper exploration of their learning experiences. By creating a series of Kawa maps throughout their studies the students were able to conduct a longitudinal examination of their personal development journey over time. They were also able to visualise their future goals and plan towards achieving them. The Kawa maps provided an alternative way for the students to capture their experience beyond written reflections of their learning and development, which suited some students. However those who were not naturally visual learners felt more concerned about using the Kawa model to aid their reflections. Some of these students mentioned preferring to use ‘mind maps’ and ‘lists’, whilst other students who were not keen on symbolism and metaphors, preferred to use the existing reflective models. Overall the results from the study demonstrated the potential of the Kawa model as an alternate reflective model which enabled students to have a more visually stimulating way of examining their learning and personal development.

One of the strengths was that it was a longitudinal study and comprehensively organised over the four years and provided a clear methodology and structure for replication. The student participants provided a detailed collection of perspectives and view about the Kawa model, allowing for a comparison of how their view might have changed over time. The researcher also acknowledged her own position in terms of her prior interest in the Kawa model and provided a reflective diary of her thoughts and experiences, which enhanced reflexivity. However there were some potential limitations to the study as all the participants were students of the researcher who was also their academic lecturer and this might have influenced some of the responses made. The student participants might have felt obligated to provide a positive response around the usefulness of the model as they were aware of the lecturer's own interest in the Kawa model. This could be indicative of the power and position that the researcher held over the student participants and might have influenced the responses the students provided in relation to the benefits of the Kawa model. The Kawa model was also linked to a final year assignment and this might have created a bias in support of the benefits of the Kawa model.

Bai and Paxton (2015) conducted a qualitative pilot study in London UK, exploring the experiences of occupational therapy students' using the Kawa model as a reflective tool within their clinical placement. A total of eleven pre-registration first year occupational therapy students took part in the research. All participants were introduced to the Kawa model and asked to complete a Kawa map at three fixed time intervals during their first clinical placement; just before starting the placement, at mid-point and immediately upon completion of their four week placement experience. The participants were interviewed at the end of their placement to explore their experiences of using the Kawa model to reflect upon their clinical practice. The results were analysed via thematic analysis. The positives included ease of use, being able to engage with the river metaphor, having a visual reflective model, flexibility of the

model and being able to monitor progress over time. The longitudinal perspective was also considered a positive, as participants in this study highlighted that the ability to reflect over time was something they particularly liked about the Kawa maps. Participants occasionally identified some of the concept as confusing, lacking a defined structure for reflection and the lack of scope for reflecting on emotions as some of the shortcoming of the Kawa model.

One of the strengths of the research was that the methodology, research design and analysis was clearly outlined and enabled the research to be replicated with ease and therefore supported the trustworthiness of the research. By providing a clear audit trail and undertaking a peer audit the rigour of the research was further enhanced. Both researchers also kept reflective dairies throughout the research process which captured their feelings, values and thoughts during the research which enhanced reflexivity. Despite this being a small scale pilot study, the outcomes were helpful as a starting point in planning for larger scale research which could involve students using several different reflective models to gauge their utility and value. A possible limitation of the research was that both researchers could have been familiar with some of the participants on a social level as they were for the same Division; however a plan was put in place to counteract this by ensuring that the two researchers swap interviewing any potential participants they were familiar with. Both researchers also indicated that they had little experience in conducting qualitative interviews and were worried this might affect the quality of the research interview and findings. To counter this, the researchers indicated that they attended some interviewing sessions with their research supervisor and also undertook a couple of practice interviews with the fellow research students.

Humbert *et al.* (2013) conducted a qualitative study in the USA exploring how women who had experienced intimate partner violence (IPV) made sense of their personal situation. This phenomenological study involved

the use of the Kawa model as a reflective tool in exploring the perspectives of the participants with regards to their recovery process. The study involved six participants who were interviewed, with the researcher using the Kawa model as a framework in structuring the interviews. Particular attention was focused on the personal, social, spiritual factors that positively influenced the recovery process the women experienced. Four themes were identified within the study: Relationships, Starting Over, Spirituality and Expansion of Self. The findings indicated that by using the Kawa model there was a shift in focus away from the individual towards the spectrum of contextual factors, personal, spiritual and social factors that might have contributed to IPV. This focus away from the individual and towards contextual factors, minimises the tendency for self-blame on the part of the women who would have often blamed themselves for the violence they experienced.

The findings from the interviews were analysed via thematic analysis and indicated that the participants felt more able to express themselves using the Kawa model concepts and metaphor. The participants also completed two different Kawa maps, one depicting their current life and one showing how they hope their lives would be like in six months. This provided the researchers with rich sources of information to undertake a phenomenological inquiry into the complex experiences of IPV.

The phenomenological approach with in depth interviews was one of the strengths of the research as it provided rich personal perspectives and insights unique to each of the participants. The strengths of the study were the clear methodology and transparency within the study. The use of quotations to support themes highlighted also enhanced the credibility of the study. Further the main researcher kept a reflective diary recording her own experiences and views whilst engaged in the research process and also her personal thoughts about IPV, which enhanced reflexivity within the research.

One limitation of the research was that the researchers were unable to perform member checking because of time and scheduling difficulties following the completion of the initial interviews. Performing member-checking may have strengthened the study's findings, as the researchers would have had the opportunity to verify the interview transcripts for accuracy. Another limitation of the current study was that it only captured the experiences of one cohort of women at a particular point in their recovery and therefore did not provide transitional details over the course of their recovery.

Humbert *et al.* (2014) conducted a second phenomenological qualitative study, exploring women's expectations of recovery following intimate partner violence (IPV). The focus of this study was to explore the women's recovery needs for the first six months after leaving their abusive relationships. As with the previous study, the participants were asked to complete Kawa river drawings with the researcher, prior to in depth interviews, that were then guided by the drawing they had created. Participants reported that creating the Kawa maps helped the participants to explore and discuss how they anticipated and experienced the progress within their own recovery and the obstructions and challenges they would face. The participants were able to use the Kawa maps and components to illustrate the potential barriers they perceived and identify what the change would be like in their future recovery.

The Kawa model provided the researchers with valuable insight in understanding the participants' recovery journeys from IPV. The researchers used the Kawa model as an interview tool to facilitate open conversation about their experiences and to assist the individual participants to examine her past, present, and future life circumstances. The six themes that arose from the study were *'I Want to Make a Better Life for My Children, This Will Make Me Stronger, I Have to Try to Get Stability in My Life, Learning How to Have a Relationship with Myself, and I Know That I Can Do It on My Own.*' The remaining theme, *'I Know in My*

Heart That It Gets Better' was identified by the participants as a future goal they wanted to aim towards. Participants were also able to identify several obstructions and challenges they expected to face in their future recovery processes from IPV using the Kawa Model's concepts. This was made possible because the river drawings were able to illuminate significant concepts for each of the participants. The researchers were provided with an opportunity to merge themselves into the data and become acquainted with the women and their expectations for recovery through their Kawa river illustrations.

The strengths of the research included the in-depth biographical accounts of participants as they explore their personal experiences IPV. Additionally the themes identified were supported by quotations from the participants that enhanced the trustworthiness of the research. The researchers also used the triangulation strategies of researcher data comparison and reflexivity throughout the data collection and analysis processes and this enhanced the credibility the findings. The researchers prior to the start of the research held several sessions among themselves to discuss the issues surrounding IPV and their individual perspectives about the recovery process; this helped in examining issues of subjectivity and reflexivity which were valuable to the study.

Limitations in the study included, two researchers not having used the Kawa model prior to conducting the interviews which may have affected how they explained the Kawa concepts and analysed what was communicated by the participants around their own experiences of the Kawa maps. The participants also commented that the Kawa model did not provide them with in depth ways to further explore and understand their specific situations and circumstances without additional prompting and dialogue with the researchers. In terms of research limitations, time constraints imposed restrictions on member checking which meant that the participant's interviews could not be checked for accuracy, which would have enhanced the rigour of the research.

Owen (2014) explored the perceptions of occupational therapists regarding the occupational therapy models they applied within their clinical practice. The study adopted a survey method and the questionnaire contained closed and semi-structured questions. Twelve participants' views of, and reasons for, using particular models were gathered. The participants were drawn from a group that were attending a Kawa model workshop and had volunteered to take part in the study prior to undertaking the workshop training. The survey questions were focused upon practice context, demographic factors related to the use of various models and the reasons participants used various models in their practice.

The results from the study indicated that the participants' educational background, their level of practice experience and their work setting were influential in dictating which model they used. Time constraint, the type of the patient/client group and their cognitive ability also played a role in the practice models selected. Additionally the clinicians' overall attitude towards new theory and practice frameworks were also influential in determining which models were chosen. The use of practice models were seen as providing valuable structure and assisted the occupational therapists in delivering occupationally focused and evidence-based intervention.

The choice and use of models further influenced how these models impacted upon the 'doing' of occupational therapy. The level of experience of the participants was highlighted as a factor, with less experienced clinicians relying on more regulated models of practice as they felt such models helped them to think more clearly and provided structure in understanding the client and planning interventions. Post-graduate qualified participants in the study who were generally older and had more life experience were noted to favour less rigid practice models such as the Kawa Model as they were more comfortable with the reduced structure of the model. Additionally some participants indicated that

Kawa, with its non-western concepts and approach, was a model they were either more or less at ease in using in practice dependent upon their comfort levels and personal identification with the philosophy behind the model.

However, limitations to the study included that participants were only those who attended the workshop on the Kawa model and there was a lack of depth in the data collected due to the use of a questionnaire and qualitative in depth interviews could have derived more detail about the participants' perspectives. Since responses were gathered from participants attending a Kawa model workshop they may have been more favourable then, others would be towards the Kawa model.

The Kawa model was first introduced to the wider occupational therapy profession in 2003; however it has only been in the last decade that it has begun to be recognised as an alternative model and practice framework (Bai and Paxton, 2015). Despite the increased adoption of the model in different fields of clinical practice, there has been a scarcity of published research examining its utility and scope (Bai and Paxton, 2015; Teoh, 2013). The paucity of research and clinical evaluation into the use of the Kawa model has resulted in limited published critique of the model. Although there are criticisms of the Kawa model, some of the main criticisms have come from authors and initiators of alternate conceptual models within occupational therapy.

In examining the existing research and literature, four main themes were identified as possible limitations of the Kawa model as indicated in Appendix section 13.

- Identification and assurance with using the Kawa model
- Kawa models' perceived lack of an occupational perspective
- Applicability of the Kawa model within a western context
- Level of insight or cognition required

The literature reviewed included research involving researchers and participants as well as clinical evaluations of the Kawa model by clinicians and the patients/clients they engaged with in practice. Discussion of this literature will be organised by the particular groups or individuals.

Identification and assurance with using the Kawa model

Researcher or clinician perspective and confidence:
Perception, familiarity and confidence were concerns raised by some researchers in respect of the Kawa model as an interview tool or as part of the research process. This was seen as influential in terms of the level of confidence felt by researchers or clinicians in using the Kawa model due to its unconventional concepts and structure. Cardomy *et al.* (2007) indicated how the researchers in her study expressed anxiety around whether they had understood and therefore explained the Kawa model concepts clearly enough in order for the participants to create their own Kawa maps. Similarly, Humbert *et al.* (2014) in her study highlighted how the researchers indicated that being new to the Kawa model with its unconventional concepts and structures created initial apprehension as they attempted to explain the different concepts to their participants and to structure their interview schedules in line with the model. This however improved in time as the researchers regularly practiced using the model and felt more confident (Humbert *et al*., 2014).

Owen (2014) also expressed this concern based on her research that although the participant (clinicians) in her study had attended Kawa model workshops prior to using it, they still expressed concern about their ability to explain the concepts to their patients and to create the Kawa maps. They also indicated how being used to more conventional and structured occupational therapy practice models meant they were less confident in using the Kawa model with its' more unorthodox and flexible application. These concerns were similarly echoed by Paxson (2012), where the participants in her study, who were clinicians too, indicated they were worried about explaining the Kawa model clearly enough to

their patients in order for them to understand and create their own Kawa maps. However the participants mentioned how additional practice and affirming evidence from the patients in creating their own Kawa maps helped clinicians to feel more reassured about their ability in working with the Kawa model.

Participant or patients' perspective and confidence:

In the study by Carmody *et al*. (2007) responses from participants who were patients also indicated concerns around understanding the Kawa model concepts and requiring reminders about the different component within the Kawa model. They also mentioned feeling some uncertainty when drawing their own Kawa maps due to the more abstract construct of the model. Richardson (2010) highlighted that participants in his study mentioned that at times they felt self-conscious about having to draw their own Kawa maps and worried about the quality of their drawings. Physically drawing their own maps seemed to create anxiety for some, especially around the quality of the image produced.

Owen (2014) explained that the participants in her study echoed similar concerns and mentioned how the patients they worked with would seek reassurances in relation to their maps. There seem to be an unnecessary focused on the image produced rather than the exploration and discussion that followed the creation of the maps. This view was similarly supported by Bai and Paxton (2015) where the participants within their study indicated that they would have liked more structure and guidance in constructing their own maps as they wanted to be certain they had depicted it accurately. They also mentioned feeling self-conscious about their ability to create a map that reflected their personal circumstances.

Identification with symbolism and metaphors:

Working with the Kawa model required researchers and participants alike to be able to identify with symbolism and metaphor. Those who related to the 'river metaphor' were more at ease with utilising the model, whilst

those who were unaccustomed to metaphor and symbolism, found it more difficult to use the Kawa model. Renton (2010) indicated that participants who were not visual learners found it more difficult to use the Kawa model to reflect upon their learning experiences at University and preferred to use more structure reflective models that had clear stages and processes of reflection than other learners. Similarly participants in the study by Owen (2014) who were less familiar with using more projective techniques or the use of metaphor described a less positive experience in applying the Kawa Model. In an earlier study by Nelson (2007) it was similarly indicated that the participants who did not identify with the metaphor of a river as symbolising their journey through life, found it more difficult to use the Kawa model in reflecting upon their own lived experiences.

Lack of structure and guidance to explore narratives and experiences:
Another criticism of the Kawa model was the perceived lack of guidance in exploring personal narratives. Following on from creating the Kawa maps, clinicians were expected to begin a process of exploring the Kawa maps with the individual patient to elicit their narrative and perspective. Several clinicians and researchers alike mentioned being unsure how to initiate this process and expressed the need for more direction in undertaking this aspect of the process. Renton (2010) highlighted how some of the student participants in her study indicated that they were unsure how to go about exploring and unpicking their narratives alongside their maps. They felt that more explicit guidelines would help them to develop the skills and confidence to undertake this aspect more successfully.

Humbert *et al.* (2014) similarly indicated that researchers were unclear about the appropriateness and depth of their questioning of participants within their study. They wanted specific guidance on how to explore the personal narratives from the created Kawa maps and what questions they should ask in order to gather relevant details. Bai and Paxton (2015)

found that their participants -students using the model to reflect upon their clinical placement experiences, were unsure how they should proceed in examining their own maps in order to acquire greater personal insight. Again these participants highlighted they wanted more specific instructions and guidance on the interpretation process. This unease may however been due to a lack of familiarity and confidence rather than insufficient guidance, as instructions were provided on how to elicit and explore personal narratives and gain understanding.

Kawa models perceive lack of an occupational perspective and assessment

Lacking an occupational perspective:

The Kawa model was perceived to lack a sufficient focus on the centrality of occupation in promoting health and well-being by some critics. As an occupational therapy practice model, it was anticipated that the model would seek to endorse the role and value of occupation in supporting health and rehabilitation. However the Kawa model has a non-Eurocentric focus regards occupation, the individual and their environment, which are seen as integrated whole rather than as separate entities (Iwama, 2006 cited in Wada 2010). The Kawa model provides a framework within which to understand how the various factors that impact upon the individual, for example their health condition, the environment, family support or occupations impact upon the individual (Iwama *et al.,* 2006; 2009). Nelson (2007) in her study highlighted that the Kawa model does not merely focus on aspects of occupational participation, but on the individuals' lived experiences and considers all the contextual elements that have an impact upon their lives. This was similarly indicated in the study by Teoh *et al.* (2013) where the adoption of the Kawa model provided insight into the lived experience of the individual and explored what they considered to be meaningful within their lives in whole, rather than just their occupational performance and experiences.

However Wada (2010) considered the lack of a specific examination of occupation as a limitation of the Kawa model. She highlighted the need for an occupational therapy practice model to ascertain both the positive and negative impacts of occupation and to capture the relationship between occupation and the development of a sense of belonging. Wada indicated the importance of the individual feeling part of their wider context, which would promote a greater sense of connectedness. Keilhofner (2008), the founder of the Model of Human Occupation who originated his own practice model, highlighted how occupational therapy models should focused on occupational performance and highlight the value and contribution of occupation to the individual, thereby supporting the view proposed by Wada. Forsyth and Keilhofner (2011) indicated that in order to promote the value of occupation and occupational therapy, practice models must explicitly evaluate the impact of meaningful engagement in occupation and health and well-being.

Owen (2014) highlighted that clinicians in her study also emphasised the importance of occupation in promoting health and well-being, and felt it reinforced their valued role as occupational therapists. Participants mentioned that instead of focusing on occupation as a separate entity, the Kawa model considers occupation as an integral part of 'the self' where the person, their environment and occupation are interconnected. Understanding the place and position of occupation to 'the self' therefore requires consideration of the wider context (Iwama, 2006).

Kawa model does not have a dedicated assessment measure:
Unlike the majority of occupational therapy models which had dedicated assessment or outcome measures, for example the Model of Human Occupation with the Model of Human Occupation Screening Tool or the Occupational Performance History Interview (Forsyth and Keilhoner 2011, Lee *et al*., 2012), the Kawa model does not possess a dedicated assessment measure. The Kawa model is somewhat unique in this aspect as it is focused upon appreciating and understanding the

individual lived experience and what influences their overall health and well-being. The Kawa model is instead regarded as a framework within which the individual's narrative, experiences, challenges in life and socio-cultural context can be better understood in order for the most suitable assessment measure to be selected and appropriate treatment provided.

However the lack of a specific assessment measure within the Kawa model is viewed in some quarters as a potential limitation. Keilhofner (2008) emphasised the importance of evidence-based practice and the need for appropriate assessment measures to evaluate the effectiveness of interventions provided. Lee *et al.* (2012) highlighted the importance of models of practice to support the gathering of sufficient evidence to support clinical effectiveness. Wong and Fisher (2015) agree the need for occupational therapy models to be focused upon evaluating the value of occupation in order to promote the evidence for occupation and occupational therapy. The absence of a dedicated assessment measure is therefore viewed as a limitation of the Kawa model.

Wada (2011) also highlighted that within the Kawa model, that occupation is neither clearly articulated nor exclusively identified as a component of the individual's actual river and this can lead to confusion as to how meaningful occupation can be presented as a positive contribution. However, as previously highlighted, the model provides a framework within which all the aspects of the individual's lived experience can be examined and their personal narrative recognised. The Kawa model was not devised merely to capture an occupational perspective nor focus solely on the occupational performance abilities of the individual concern.

Contextual applicability of the Kawa model

Applicability within a western context:

The Kawa model departs from a Eurocentric perspective of focusing solely on the individual and what is important to them. Carmody *et al.* (2007) indicated that in her study the researchers had to familiarise

themselves with a different way of situating the 'inner self' within the Kawa model and appreciating the experiences of the participants. The Kawa model is a departure from other western occupational therapy models they have a more individual orientation and a more problem focused approach. The model is also unique as it treats the individual as not being discretely located but depicts the 'self' as fully integrated within an inseparable wider context, which may be a more difficult concept to grasp (Wada, 2010). Wada (2010) indicated that individuals from Eastern collective cultures typically control their inner aspirations, desires and emotions to maintain harmony. Whereas people from individualistic western cultures are often more concerned about asserting their inner aspirations in order to dictate and control the outer aspects of their lives. This may therefore influence the usability of the Kawa model within western society and with individuals more familiar with asserting their personal goals and interests.

Bai and Paxton (2015) suggested that participants within their study found it either easier or more difficult to identify with the Kawa model and its' primary concepts dependent upon their socio-cultural and personal standpoint. Participants who subscribed to a more collectivist perspective were more comfortable with the philosophical view embedded in the Kawa model and therefore related to using it more easily. Those individuals with a more individual orientated and western perspective took longer to identify and feel at ease with the Kawa model and its core concepts.

Absence of the 'Inner self' presented within the Kawa model:

Wada (2010) regarded the lack of focus on the 'self' and what might motivate each individual, as a limitation of the Kawa model, as it might reduce its appropriateness within a western context. Without embracing the 'inner self', individuals may struggle to present their personal aspirations, needs and interests within the model, which may be essential to maintaining motivation. Owen (2014) in her study in South Africa

highlighted how the participants in her study indicated that their connectedness with the Kawa model was influenced by their cultural familiarity with the philosophy behind the Kawa model and how they identified with the notion of the centrality of the self in achieving good treatment outcomes.

Level of insight or cognition amongst patients/participants

In assessing the utility of the Kawa model, the participant in question would require a particular level of cognitive ability in order to understand the metaphor and remember the different concepts and components of the model. Creating and completing their actual Kawa maps would also require a level of personal insight on the part of the individual in order to accurately reflect their personal challenges and their circumstances.

In the study by Ostyn (2013) conducted with participants with long term mental health conditions, the researcher highlighted lack of insight and impaired cognitive ability as possible limitations with using the Kawa model and maps. Reduced insight could influence how each participant evaluated and made sense of their progress and the usability of the Kawa model. Owen (2014) noted that occupational therapy clinicians similarly highlighted that if their patients were cognitively impaired or lacked personal insight, the usability of the Kawa model would be more limited. Screening participants for cognitive ability and insight were a pre-requisite in considering the appropriateness of using the Kawa model.

Themes within the Literature Review

Understanding metaphors

The use of metaphor was a theme identified in several of the articles and research studies including (Carmody *et al*., 2007; Cheng, 2010; Renton, 2010; Humbert *et al.*, 2013; Humbert *et al*., 2014; Bai and Paxton, 2015; Gregg *et al.,* 2015). Participants in these studies were able to identify with

the river metaphor, describing how they were able to visualise or imagine a river as representing their life journey. The use of the metaphor of a river to depict one's lived experiences of a past, present and future resonated with many of the participants whether they were clinicians, students or service users. The participants within these studies indicated gained insight into their own life journey from engaging with the metaphor and through creating their personal Kawa maps which represented their lived experiences (Cheng, 2010; Renton, 2010; Humbert *et al.*, 2013; Humbert *et al*., 2014; Bai and Paxton, 2015; Gregg *et al.*, 2015).

Reflective tool

Most of the participants within various studies commented upon the usefulness of the Kawa model as a reflective tool. Participants indicated the ease of use of the Kawa model as conducive to use and the majority indicated that the concepts of the Kawa model were easy to understand (Renton, 2010; Buchan, 2010; Teoh *et al.*, 2013; Humbert *et al.,* 2013; Humbert *et al.,* 2014; Bai and Paxton, 2015; Gregg *et al.*, 2015). Some participants were occasionally confused about the various components within the Kawa model and needed reminding of what they represented (Nelson, 2007; Renton, 2010; Bai and Paxton, 2015). Participants across the research also indicated how the active process of engaging in creating the maps help them to gain clarity and self-awareness (Nelson, 2007; Paxson *et al.*, 2012; Buchan, 2010; Teoh *et al.*, 2013; Ostyn,2013; Humbert *et al.,* 2013; Humbert *et al.,* 2014; Gregg *et al.*, 2015).

New insight and perspectives

Participants indicated that they had developed new insights and perspective of themselves and their personal circumstances through using the Kawa model. They highlighted that they learn aspects about themselves and their lives that they were not aware of previously (Paxson *et al.*, 2009; Richardson *et al.*, 2010; Ostyn, 2013; Humbert *et al.,* 2013; Humbert *et al.,* 2014; Bai and Paxton, 2015) and that these insights

provide them with new perspectives and opportunities to change aspects of their personal circumstances. Some of the studies also indicated that through creating and exploring the maps, new points of discussion arose that were not indicated in earlier interviews (Carmody, 2007; Paxson *et al.,* 2012; Buchan, 2010; Renton, 2010; Ostyn, 2013; Teoh *et al.*, 2013; Humbert *et al.*, 2013; Humbert *et al.,* 2014; Owen, 2014; Bai and Paxton, 2015; Gregg *et al.*, 2015).

Narrative qualities

Clinicians, students and service users reported liking the narrative qualities of the Kawa model. The model had the capacity to help participants to explore their personal stories and elicit narratives associated with their different experiences. They felt that the Kawa model and maps also encouraged an examination of the personal, cultural, social and contextual elements that were part of their lived experiences (Buchan, 2010; Cheng, 2010; Ostyn, 2013; Teoh *et al.,* 2013; Humbert *et al.*, 2013; Humbert *et al.,* 2014; Owen, 2014). Participants indicated through engaging with the Kawa maps that they began to see their own narratives unfold and become more clear (Carmody, 2007; Paxson *et al.*, 2012; Bai and Paxton, 2015; Gregg *et al.*, 2015).

Justification of Current Research Study

Existing research into the Kawa model is relatively limited in quantity but has demonstrated some diversity of perspectives on or responses to it. Research and case studies presented here have included those from Japan, the USA, Canada, Malaysia, Belgium, South Africa, India, Australia and the UK. The studies have also examined a broad collection of areas including student experience, stroke rehabilitation, preceptorship, visual impairment, clinical placements, combat stress, domestic violence and mental health. However the outcome of the literature search indicated that most studies were small scale and involved only a handful of participants or were single case studies. There

were few longitudinal studies which examined the use of the Kawa model over time or involved the examination of a series of Kawa maps created by participants. Most of the research as outlined here to date has been conducted with occupational therapy clinicians or students, with fewer studies involving clients/patients/ service users and the gathering of their perspectives and experiences of the Kawa model.

In the area of mental health, research into the Kawa model has similarly been limited to a handful of research studies (Paxson *et al.*, 2012; Richardson *et al.*, 2010; Ostyn, 2013; Humbert *et al.*, 2013; Humbert *et al.,* 2014; Gregg *et al.*, 2015). However none of these focus on the use of the Kawa model in exploring experiences of mental health recovery from a service user perspective nor have they adopted a longitudinal view of personal recovery or mental illness. Therefore this PhD will focus on establishing the contribution of the Kawa model in exploring the personal journeys of recovery of mental health service users. This is an area which has yet to be explored and so it will contribute new knowledge within the field of mental health recovery. The research will begin to plug the gap in longitudinal study of the Kawa model and examine the contribution and value of Kawa mapping as a visual and narrative tool to promote insight and understanding in personal journeys of recovery.

Summary

This chapter has provided a critical review of current research and literature on the Kawa model. The existing gaps provide scope for applying and researching the Kawa model in mental health and personal recovery. They also justify the use of a longitudinal study examining the contribution of the Kawa 'River' model for exploring the personal journeys of recovery of mental health service users. The next chapter will describe the research methodology and research methods relevant to the research study.

Chapter 3: Methodology

Introduction

Mental health recovery is a deeply personal experience and discovering how each individual perceives and makes sense of their recovery was central to my research. The current research also examines the contribution of the Kawa model as both a narrative and visual tool in exploring personal journeys of recovery.

In this chapter I will indicate my rationale for adopting a qualitative phenomenological approach following an examination of the philosophical concepts of ontology, epistemology, relativism, interpretivism, subjectivity and phenomenology. I will also outline my philosophical position and indicate my tensions within the research. I will further justify my selection of both Interpretative Phenomenological Analysis (IPA) and the Kawa model (KM) within the research.

Ontology

Ontology is viewed as the philosophical study of the nature of being, existence or reality and the fundamental assumptions of what constitutes social reality (Scotland, 2012). It is concerned with questions about what objects exist or can be said to exist, and how they are related. The ontological positions of objectivism and constructivism are considered influential in understanding phenomena. Objectivism postulates that social phenomena exist independently of social actors (Bryman, 2016), and that reality is not influenced by the individual (Grix, 2010). In adopting an objectivist position the individual's relationship with the social world is understood to be one of objective observation (Matthews and Ross, 2010). Constructivism in contrast, asserts that social phenomenon are constantly being constructed and re-examined through the influence of social actors, who create meanings and understandings of social phenomenon (Matthews and Ross, 2010). Klein (2005) suggested that

individuals are influenced by their ontological standpoint, which impacts upon how they make sense of the world around them. As a researcher, I recognised how my ontological position was inextricably linked to the epistemological and methodological approach I adopted within my research and how it influenced my decisions around the research aims, method, choice of data collection and analysis.

Epistemology

Epistemology is recognised as the study of knowledge and justified beliefs, and is concerned with sources of knowledge, its conditions, structure and limits (Klein, 2005; Grix, 2010). Spender (1998, pg. 233) states that epistemology is 'the study of the foundations upon which human knowledge stands and is concerned with the origin, creation and dissemination of knowledge (Burr, 1998; 2015). Modernist epistemology views humans as having the capacity to understand their world through the use of universally valid theories and rational methods of deduction (Moran, 2008). In contrast, postmodern perspectives regard knowledge as socially constructed and expressed through socially crafted language (Moran, 2008). Such a perspective rejects the idea of a universal truth and meta-narrative in favour of local narratives (Alvesson, 2002). Apparent realities are therefore considered to be social constructs that are contingent upon time, context and place (Willig, 2008).

Relativism emphasises the diversity of views, interpretations and understandings of the world around us, with epistemological relativism stating that there is no 'one reality' (Gomm, 2009). Events are experienced, interpreted and understood within the scope of contextual influences and past experiences (Nightingale and Cromby, 1999). In contrast, realism proposes that an external world exists independently and that our perception, thoughts, language and beliefs are symbolic of the world we inhabit (Nightingale and Cromby, 1999). This difference between realism and relativism is most clearly illustrated between the natural sciences and the social sciences and has been regarded as the

interpretivist/positivist divide. Within relativism there is no absolute truth or validity, with points of view having only relative value according to differences in perception (Moran, 2008). The very essence of relativism is that there is no one standard that is valid for everyone and that subjective and interpretive perspectives are valuable and relevant.

Cresswell (2013) indicated that the researcher's beliefs and worldview are reflected within the epistemological and methodological approach they adopt for their research. In reflecting upon my epistemological position, I embraced the doctrines of postmodernism, constructionism and relativism and belief that there is no 'one truth' and that all theory is historically and contextually situated and therefore possesses only relative meaning, value and relevance. This standpoint corresponds with my research enquiry which seeks to identify how each of the participants perceived and made sense of their own recovery within their wider context of experiences.

Subjectivity

Subjectivity is a philosophical concept that is related to notions of personhood, consciousness, truth and reality (Gomm, 2009). The process of being and becoming a person is influenced by personal growth, development and constant interactions with the evolving social context (Silverman, 2014). Appreciation of the concept and impact of subjectivity requires an understanding of how our past experiences may transform our consciousness, identity and view of truth (Gomm, 2009). Burr (2015) highlighted how our knowledge, perspectives and interpretation of experiences are socially situated and constructed through interaction with others. Berger and Luckman (1996) suggested that within a social constructionist perspective, beliefs, cultural understandings, feelings, social values and norms influence our decisions, perspectives and comprehension of truth and reality (Lock and Strong, 2010).

Subjectivity is key to who we are, reflecting the personal constituents and experiences that influence our decisions, views, responses and interactions (Letherby, Scott and Williams, 2013). In the context of scientific research, subjectivity is often associated with personal interpretation, bias and considered counter to science, which seeks an objective basis for truth (Daston and Galison, 2007). Hollway (1989) described how attempts have been made within the field of psychology to 'sanitise' research through excluding subjectivity altogether. However many social researchers regard subjectivity as a valuable and inseparable aspect of the researcher and the research (Ratner, 2002). Our personal values and beliefs are fundamental in defining who we are as individuals and only by recognising such personal attributes can we be mindful of the impact they have upon us as researchers (Hollway, 1989; Finlay, 2006).

Ratner (2002) suggested that all aspects of research are impacted by the subjectivity of the researcher, whereby the researcher and the research are intrinsically linked. The researcher's subjectivity impacts upon how they engage and respond throughout the research process, from deciding upon a research topic, planning the approach and methodology, gathering the data, interpreting results and evaluating the research (Addington-Hall, 2007) Acknowledgement of who we are, what has shaped our experiences, values and beliefs, highlights how we are predisposed to perceive, interpret, relate and evaluate research (Letherby *et al.*, 2013). Within the dimensions of qualitative research, subjectivity is recognised as highly influential, as the researcher is considered to be intimately connected to the research process (Ratner, 2002). The researcher and the research 'feed off' each other, as subjectivity permeates the research at each stage. Being immersed in the research transforms the researcher, impacting upon their thoughts, perceptions and understanding of presenting phenomena (Silverman, 2014).

Personal Views of Subjectivity

I recognised that my values, interests and past experiences have influenced the decisions, actions and interpretations I have made within my PhD research. Cotterill and Letherby (1993, pg. 72) stated that 'conscious subjectivity' evident in feminist research has replaced the 'value-free objectivity' of traditional research and helps to break the power relationship between the researcher and the researched.' Indeed being conscious of my values and perspectives around mental health, recovery, personal choice and empowerment, have helped me to be more aware of my positionality in relation to the participants within the research. In addition being mindful of the power dynamics prevalent within the research, in terms of how the participants might view my previous knowledge and experience as a mental health clinician and role as a researcher, prompted me to be more critically reflective. I continued to examine my values, views and feelings throughout the various stages of the research and kept a personal diary and created my own reflective Kawa maps which supported my reflexivity.

Landridge (2007) suggested that researchers must actively consider their own position in relation to the research topic being investigated, identifying themselves as an 'insiders or outsiders'. Having not experienced mental illness myself, I was not an 'insider' as Landridge would define the term. However having encountered many mental health service users in my previous role as a mental health occupational therapist and knowing several friends who have mental health issues, I wanted to discover more about the personal nature and experience of mental health recovery.

Bhopal (2010) highlighted that the notion of being an 'insiders or outsiders' is not so easily defined and that irrespective of the position the researcher occupies, their impact upon the research process continues to be influential. She highlighted that not having preconceived ideas or experiences about a particular phenomenon would allow the researcher

to be less swayed by their bias and values. However being an 'insider or outsider' may also depend on how the researcher is perceived by the interviewee. Bhopal (2010) described within her own research, a female interviewee who stated that she would not have got involved in the research study, if the interviewer had been male. Here the female interviewee had perceived of gender difference and values between men and women and had felt she would be misunderstood by a male interviewer. This was a concern that I reflected upon myself, as I considered how I perceived of my own position and also how the participants within the research regarded where I stood in terms of being an 'insider or outsider'. Indeed in the research I acknowledge that my position as an 'outsider' was what motivated me to want to uncover the personal stories of recovery and comprehend the different enablers and barriers in supporting mental health recovery.

In selecting an analytical tool to interpret the findings of the study, I chose Interpretative Phenomenological Analysis (IPA) because it acknowledged the importance of the researcher's position and past experience. In IPA the researcher's subjective and personal experiences are regarded as making a valued contribution towards the analysis and interpretation of the findings. This is supported by Smith *et al*. (2006) who highlighted that IPA recognises that the researcher's personal values and experiences influence how they make sense of the participants' views and experiences. This recognition within IPA of the subjective impact of the researcher reinforced my selection of IPA as an appropriate approach.

To keep track of my reflections throughout the research, I recorded my thoughts, views and experiences within a personal diary and created a series of Kawa maps, (Diagrams 24-28). Both the personal diary records and Kawa maps documented my thoughts, decisions and feelings, from deciding on the research topic, interview questions, analysis of the data, to my thoughts and feelings in writing up the thesis. These reflections also helped me to appreciate how my views had changed over time as I

started to better appreciate and understand the various facets of the research study. Below is an excerpt from my diary around my view of the concept of mental health recovery at the start of the research.

"I believe it is possible to achieve personal recovery and that mental health recovery is more than finding a cure especially for those with a long term mental health condition. I think is more about fulfillment, quality of life, hope and how to keep out of hospital. It must be quite traumatic to have to be admitted again and again." (Personal Diary, 21/04/08)

I needed to be aware of my personal opinion about recovery and prevent these views from influencing my interpretation of the participants' perspectives. To ensure that I accounted for my possible biases, during the initial stages of analysing the interview transcripts, I met with my (original) first supervisors to run through my analysis of the first interviews, which enhanced rigour and credibility. I was mindful of my personal views and ensured that the interpretations I derived from the comments made were supported by supporting quotations. By acknowledging my subjectivity, I was also more careful in my synthesis and discussion of the findings in respect of available literature.

My Position

I have approached my PhD from a post-modernist, relativist and social constructionist position. My philosophical standpoint has been influenced by my personal values and professional grounding in the social sciences that recognises the influence of the socio-cultural context in determining perspectives on life and interpretation of events. I do not subscribe to a universal narrative but regard truth to be relative to each individual. Therefore my aim for the research was to explore the personal perspectives of mental health service users as they experience their own recovery, with a focus on what recovery meant to each participant and what factors they regard as contributing or hindering their recovery. Adopting a phenomenological approach allowed me to enquire deeper

into the unique experiences of recovery. Whilst, the Kawa maps provided an additional source of data to the interview responses, contributing visual perspectives of the participants' recovery journeys over time.

I was conscious in distinguishing my specific role within the PhD research, from my previous role as an occupational therapist involved in delivering interventions and therapy. My focus in the research was to come alongside the participants to observe and journey with them through their recovery. I was therefore explicit in explaining to the participants that the research was not an intervention based study and that I would not be delivering any form of therapy. My sole intention was to journey with them as they experienced their recovery over the year.

As a researcher I was explicit with the participants from the outset of the research, from recruitment, to information sheet details, at the start of each interview that they were taking part in a research study and not therapy sessions. I also highlighted there were no right answers to any of the questions and reminded the participants that my role was to gather their narratives of personal recovery through the interviews and visual Kawa maps they created. I reminded all participants that they were engaged in a research study and that as a researcher I was trying to gain further insight into their personal lives and experiences.

I believe that adopting a phenomenological approach with an interpretative stance was appropriate, as it regarded the relationship between the individual and the experience itself as inter-linked (Polgar and Thomas, 2005). This is in contrast to the positivist position of the natural sciences which is deductive and based upon the testing of hypotheses, experiments, measurement, verification and causation (Easterby-Smith *et al.*, 2008). Interpretivist perspectives are in keeping with a qualitative research approaches which are inductive and concerned with understanding the individuals' perception of subjective experiences and the meanings they may hold (Carpenter and Suto,

2008). Researchers undertaking qualitative research seek a deeper level of understanding of personal phenomena, with a desire to interpret and discover personal meanings from the participants' perspectives (Greenhalgh and Taylor, 1997). This is a key aspect of interpretivist methodology, where the researcher is actively involved with the participant in the data collection process and through to the analysis (Polgar and Thomas, 2005).

Qualitative Research

From an epistemological perspective, qualitative research adopts an interpretivist and anti-positivist stance, viewing the 'knower and known' as interdependent (Carpenter and Suto, 2008). The interaction between the researcher and participant is considered fundamental to the process of deriving meaning, insight and understanding (Hicks, 2004). Interpretivist research acknowledges the interaction between the researcher and participant during the data gathering process and how this may impact upon the data collected and the resultant analytical process (Kuhn, 1962; Carpenter and Suto, 2008). This supports the importance of subjectivity and reflexivity where the researcher is constantly aware of their own values and position within the research process. It also holds the view that the social world and experiences of the individual can only be understood by occupying the frame of reference of the participant in question (Cresswell, 2013). The interpretivist researcher can also view the world as a socio-psychological construct where there are multiple realities which form an interconnected whole (Kuhn, 1962; Smith, 2007).

Therefore from the interpretivist perspective, insight and understanding of the participants' values, context and social constructs are essential to the process of analysis (Carpenter and Suto, 2008). The interpretivist research design evolves over time, as features emerge from the research that the initial design may not have accounted for (Polgar and Thomas, 2005). The research design is not as rigid as within quantitative approaches and the researcher is guided by the evolving patterns or

meanings within the research and not structured research frameworks (Hick, 2004). Interpretivism was central to this research, which adopted a longitudinal overview with repeated interviews and the creation of a series of visual recovery maps that reflected how the participants' recovery journeys evolved over the course of a year.

Intrepretivism involves understanding what has influenced or shaped one's perspective. How has the participant's view and understanding of events been constructed and formed? Schwandt (1994) suggested that interpretivism and constructivism are related approaches with complementary philosophical worldviews that steer the researcher towards a particular outlook, in an attempt to appreciate what has impacted upon the participant. Proponents of both approaches seek to understand the reality and lived experience from the viewpoint of those who live it, eliciting personal meaning and value on the part of the participant (Smith, 2007; Harper and Speed, 2012). This was one of the objectives of my research as I wanted to understand how participants understood their world and what socio-cultural and contextual factors were influential. Similar intellectual traditions of hermeneutics, sociology and phenomenology are cornerstones of both the Kawa model and Interpretative Phenomenological Analysis (IPA).

Phenomenology

Phenomenology is a philosophical approach concerned with the study and examination of human experience (Patton, 2002; Langdridge, 2007). Phenomenology is interested in what being human is like, with all the various constituent aspects that make up our individual worlds, and the meanings we attach to them (Moran, 2000; Finlay and Ballinger, 2006; Smith, 2007). Husserl indicated that phenomenology involves the detailed and careful examination of human experience (Husserl, 1927; Zahavi, 2003; Larkin, Watts and Clifton, 2006), unpicking all the elements and essential qualities of each experience and that insight comes through understanding the impact and significance of the event for the individual

concerned. He encouraged stepping away from the phenomenon in order to gain a new appreciation, insight and understanding of the presenting experience (Becker, 1992; Moran, 2000) and the importance of being conscious of what is happening, avoiding preconceptions and suggested that new meaning can be derived from the in-depth process of conscious reflection, personal inquiry and self-examination (Moran, 2000; Smith *et al*., 2009).

Heidegger questioned the possibly of understanding lived experience without an interpretative stance (Langdridge, 2007; Smith *et al*., 2009) and suggested that to fully understand the significance of an event, personal experience, analysis and interpretation of that experience was essential (Inwood, 2000; Larkin *et al*., 2006). He proposed that experiences have both visible and hidden meanings and that phenomenology was concerned with understanding both the latent and disguised meanings as they were brought into awareness and consciousness (Inwood, 2000; Smith *et al.*, 2009). This highlights the impact of social, cultural and relational context and how they influence the meanings we make of our experiences and relationships (Heidegger, 1962; Smith, 2006; Iwama, 2006).

Merleau-Ponty also recognised the importance of context and proposed that our lived experiences are influenced by our situated and physical relationship with the world around us (Inwood, 2000). He suggested that we interpret and give meaning to our experiences subject to our contextual influences and embodied experiences of the world (Merleau-Ponty, 1962; Moran, 2008). Sartre explained that the desire to derive personal meaning is part of becoming ourselves and that as we discover new meaning we also discover who we are (Langdridge, 2007; Smith *et al*., 2009). He also suggested our social and personal relationships contribute to our understanding of experiences and contribute towards our appreciation of our lived experiences (Inwood, 2000, Moran, 2008). These perspectives are embraced within the Kawa model, where the

individual is noted as constructing and understanding their own experiences and meaning of their experiences through their previous social and personal relationship and also their wider socio-cultural context (Iwama, 2006).

The key principles of phenomenology contribute to the philosophy and focus of IPA which seeks to assist the researcher to derive personal perspectives and meanings related to the individuals' lived experience and aims to examine the complexity of person's experience in relation to their situated context (Smith *et al.,* 2009). Adopting a phenomenological perspective in terms of the PhD research is supported by the aim of discovering individual meaning and understanding of the everyday experiences of the participants as they journey through their recovery. The research, in adopting a phenomenological approach, also promotes a process of co-discovery between both the participant and researcher, enabling new interpretation of meanings as they engage in exploring both the verbal interviews and visual maps of recovery.

Hermeneutics

Hermeneutics is the second major theoretical underpinning of IPA and viewed as the branch of knowledge that deals with interpretation (Smith *et al*., 2009). Although the concept of hermeneutics is much older and a separate body of thought than phenomenology, both strands of philosophy meet within the work of Heidegger (Moran, 2000). Hermeneutic theorists are concerned with such questions as; what are the methods and purposes of interpretation? Is it possible to uncover the intentions or original meanings of the author? What is the relationship between the context and production of the written text? The three main hermeneutic theorist's influential in the development of IPA: Schleiermacher, Heidegger and Gadamer (Moran, 2008) are examined next.

Schleiermacher, one of the first proponents of hermeneutics and proposed that all interpretation involved identifying the precise textual meaning and also the subjective view of the author (Moran, 2000; Smith *et al*., 2009). He indicated that without understanding the writer, their context and the essence of their work, it was not possible to fully interpret the text and gain an understanding of the motives and meanings that lay within (Strenski, 2015). From such a perspective interpretation is a craft rather than a mechanical task, which takes time and requires a range of different skills including intuition (Moran, 2000). The purpose of interpretation was not merely to understand the text or spoken word, but to gain understanding of the writer through a comprehensive analysis of the text to derive a deeper meaning, insight and understanding of what is expressed (Moran, 2008; Smith *et al*., 2009; Strenski, 2015).

Heidegger articulated the case for hermeneutic phenomenology and identified the concept of phenomenology as consisting of two parts, the phenomenon 'the event itself' which leads to the understanding of both visible and hidden meanings that may exist, and secondly the concept of 'logos' (Heidegger, 1962; Smith *et al.*, 2009). Heidegger translated this second concept as discourse or judgement which arises through analysis, with the examination of the 'issue' itself as it appears and comes into present focus (Heidegger, 1962; Moran, 2008). He further warned against the danger of preconceived ideas and structures that may impede upon the analytical and interpretative process (Inwood, 2000), indicating that only through detailed analysis and interpretation of the event or text can new meaning and understanding be derived and complexity explained (Heidegger, 1962; Inwood, 2000).

Gadamer (1960) highlighted the influence of history and tradition on the interpretative process and how previous experiences, knowledge, bias or perception affect our perspectives (Moran, 2008; Smith *et al*., 2009) Gadamer indicated that as we undertake a process of interpretative analysis, a dialogue takes place between the past and present (Moran,

2008) where our prior experiences influence how we interpret and understand each situation (Linge, 2008). He felt that the author was not always able to derive personal insight or understanding as they were too close to what was taking place, whereas the interpreter being once removed was able to stand back and see the situation within a different context (Moran, 2008; Linge, 2008). This supports the concept of the Kawa model when through a process of exploration and dialogue the interpreter may highlight his or her own observations and perceptions of the Kawa maps and bring new insights to the individual who has created the maps themselves.

A 'hermeneutic circle' is the dynamic relationship between 'the part and the whole' at several levels (Gadamer, 1960; Linge, 2008) whereby to understand a given part, a person will need to understand the whole and versus versa. For example, the meaning of a word becomes clearer within the context of the whole sentence and that from the whole text, new meaning is derived for each word or sentence (Moran, 2008). This is a particularly helpful view for researchers within IPA who appreciate that the process of interpretation is continuous, dynamic, iterative, circular and far from a linear process (Moran, 2008; Smith *et al.*, 2009). The hermeneutic perspective is an important basis for this study, because it values participants' own interpretation of events and appreciates how past experiences and context may have impacted upon how they interpret their current experiences. Further, drawing upon the concept of the hermeneutic circle, the researcher may become more aware of how their previous social, medical, psychological, familial and emotional experiences may influence their understanding of the present situations.

Idiography

Idiography is the third influence upon IPA and is focused on the specific, rather than establishing general principles of human behaviour or predicting outcomes (Schafer, 1999; Larkin *et al*., 2006). The idiographic perspective emphasises that individuals have individual traits and

psychological structures which are unique to them and that it is not possible to directly compare one person with another, as such traits may differ in influence and importance from person to person (Smith *et al.*, 2009). This differs from a nomothetic view, which emphasises comparability among individuals, whilst accepting that people are unique in their combination of traits (Schafer, 1999). The nomothetic perspective tends to view traits as having the same psychological meaning in everyone and that people differ only in the amount of each trait they possess, which then makes them distinct from the next person (Allport, 1961).

The idiographic perspective seeks to establish the individual's view of their experience and how they relate to and understand phenomena and experiences (Allport, 1961). Ascertaining such idiographic perspectives within the field of research may involve examining individual case studies, bibliographical accounts and personal journals and diaries (Carducci, 2009). Allport (1961) proposed that whilst nomothetic approaches may be appropriate for research aimed at studying and comparing groups, an idiographic approach is more appropriate for studies seeking an in-depth analysis of the specific individual. This perspective is supported by Salvatorie and Valsiner (2010) both of whom suggested that the uniqueness of psychological phenomena makes it unfeasible to rely merely upon experimental evidence to arrive at generalizations on how things are experienced.

Researchers involved in IPA studies are committed to uncovering the detail and therefore strive for a thorough in-depth analysis of experiences and personal narrative (Dickson, Knussen and Flowers, 2008). They seek to establish a personal perspective and understanding of the specific experiences or phenomena within a particular context and through a process of interpretative analysis gain a deeper understanding of its meaning and value (Reynolds, Vivat and Prior, 2008; Smith 2011). Consequently, the majority of IPA studies are small, purposively–selected

and situated samples with a focus on deriving rich in-depth individual perspectives (Knight, Wykes and Hayward, 2003; Dickson *et al*., 2008).

Larkin *et al*., (2006) suggest that to arrive at an understanding of the real world/lived experience of the individual as they encounter the challenges and pleasures that encompass their daily life and existence, more research studies need to adopt a qualitative and in-depth form of inquiry. Knight *et al.,* (2003), in investigating how stigma is experienced by those with schizophrenia, highlights the importance of adopting an idiographical approach to discover the felt impact of stigma on the individual. This study adopted IPA in terms of enquiry and data analysis, highlighting the utility of IPA as an approach in mental health research.

Interpretative Phenomenological Analysis

Interpretative Phenomenological Analysis (IPA) was first introduced in 1996 by Jonathan Smith, who wanted to break free from the traditional constraints of research within psychology and its predominant focus on quantitative and statistical research (Smith, 2007). Smith introduced IPA as a qualitative research approach in the field of health psychology and through a process of refinement and additional research studies by fellow researchers (Larkin *et al.,* 2006; Eatough and Smith, 2008; Dickson *et al*., 2008; Reynolds *et al.,* 2008), established IPA as a credible qualitative research methodology (Brocki and Wearden 2006). The popularity of IPA has however extended beyond the realms of health psychology and has been embraced by a wide spectrum of researchers within the fields of human, social and health sciences who are interested in qualitative inquiry (Eatough and Smith, 2008).

Interpretative Phenomenological Analysis has its theoretical origins within phenomenology, hermeneutics and idiography and is influenced such philosophers and theorists as Husserl, Heidegger, Merleau-Ponty, Sartre, Schleiermacher and Gadamer (Larkin *et al.*, 2006; Smith *et al*., 2009). IPA is both phenomenological and interpretative, with IPA researchers

interested in the lived experiences [phenomenon] and personal meanings [interpretation] that individuals attach to their everyday life (Smith, 2007). This correspondence with the Kawa model which similarly adopts a phenomenological and interpretative stance, with the individual creating visual maps that reflect their own life circumstances and deriving personal meaning from their experience (Iwama, 2006).

Larkin *et al.* (2006) proposed that IPA looks beyond the superficial, to the deeper complexity experiences and involves a process of detailed exploration and reflection to discover the impact that major life and daily events may have upon each individual (Finlay, 1999; Ashworth, 2003). IPA is concerned with what motivates an individual, how they make sense of what has happened, their thoughts, feelings, wishes and actions. IPA also seeks to understand how the individual experience their world as it happens (Smith, 2004), make sense of it (Ashworth, 2003; Dickson *et al.*, 2009) and to explore the attached meanings (Larkin *et al.*, 2006; Reynolds *et al.*, 2008).

Researchers involved in IPA studies as with those focused on the Kawa Model acknowledge that insight into the world of the participant is first and foremost dependent upon the participant privileging the researcher through sharing their stories, revealing their experiences and relating their personal sense of meaning (Larkin *et al*., 2006; Iwama, 2006; Eatough and Smith, 2008; Lim, 2008a). This interaction between the participant and researcher creates an opportunity for a relational dialogue to arise and for the process of interpretive analysis to begin to occur (Flowers, 2006; Smith, 2007; Aresti *et al.*, 2010). This dialogue creates the opportunity for a process of co-construction to take place as both parties examine alternative interpretations and perspectives relating to the phenomenon and jointly gain new insights and understanding of the particular phenomenon (Smith *et al*., 2009).

These exact qualities of IPA make it ideally suited to the research study which is concerned with attaining personal insight and understanding lived experience. IPA adopts an idiographic approach concerned with exploring in–depth participants' experiences and personal meanings in relation to the chosen phenomenon (Biggerstaff and Thompson, 2008; Smith *et al*., 2009) rather than an approach which seeks knowledge about people in general. For professionals and researchers alike the process of beginning to understand what matters to the individual and enhances their health and recovery begins with exploring the complexity of their lived experiences (Allot, *et al*., 2002; Kelly *et al*., 2010; Blank *et al*., 2011). The use of IPA further complements the use of the Kawa maps which provide a pictorial alternate in understanding how the participants visualised their own recovery.

Kawa Model

The Kawa model is rooted within a relativistic, interpretivist and social constructionist paradigm, where the notion of one single truth and interpretation of experience is deemed inadequate in explaining the lived experience of the individual (Iwama, 2006). It adopts a phenomenological and idiographical perspective and reinforces the importance of unravelling the elements within each experience in order to understand their influence and value (Iwama, 2006). The Kawa model proposes that human existence is intricately bound by such contextual elements as culture, society, knowledge and relationship with the wider world. The Kawa model emphasises that our relative perspectives are socially constructed and influence the meanings and values we associate with particular experiences in life (Berger and Luckmann, 1966). Gadamer (1960) highlighted how the broader context can influence how we perceive, interpret and understand each event. Indeed the Kawa Model recognises that all experiences or phenomena are different and how we make sense of our experiences are primarily influenced by our respective socio-cultural influences and context (Iwama, 2006).

The Kawa model further emphasises the importance of an idiographic perspective, seeking to establish the individual's view and interpretation of their experience and how they relate to and understand particular phenomena or experiences. The individual engages with the concepts of the Kawa Model by drawing or constructing a visual representation of their own context, using the respective elements within the model to denote the particular circumstances, issues, strengthens and challenges that are pertinent to them at a particular point in their lives (Lim and Iwama, 2006)

The Kawa maps could be used to represent a point in time by the creation of a single map or to reflect a period of time through the creation of a series of Kawa maps as was the case in the PhD research. Within the research study, all participants created a series of five Kawa maps in total across the research year which provided a visual record of their experiences across the year. The collection of Kawa maps enabled the participant to explore, reflect upon and gain greater insight into their own circumstances and experiences. The Kawa Model does not interpret or explain what is happening or has happened, but encourages the individual to undertake an in-depth exploration of their personal phenomenon to make sense of what has taken place and derive personal meaning (Iwama, 2009).

Like IPA, with its phenomenological, interpretative and idiographic focus, the Kawa model has a comparable emphasis, supporting the importance of identifying the individual's own context of experience, interpretation of events and deriving the meanings they attached to their personal phenomenon. Creating the Kawa maps also provided the opportunity for the participant to construct their maps and then offers the space and time to step back, observe and reflect upon what they have created which enhances further insight and sense of meaning. This perspective corresponds with Husserl's belief that being able to disengage from what occupies one thought and creating a distance in order to gain a new level

of appreciation, insight and understanding of the presenting experiences (Moran, 2000).

Visual Methodologies

The Kawa maps offer a visual tool to aid the participants in their personal exploration and discovery. The use of pictorial images generated through the Kawa maps fall within the scope of visual research methods, an element of qualitative research methodology that involves the use of artistic media to create, represent or indicate knowledge (Emmison and Smith, 2000; Mannay, 2016). Rose, (2016) described how within our current contemporary world, we are surrounded by a host of visual stimuli from movies, photography, videos, digital graphics, which seek our attention, influence our perception, reflect our thoughts or even communicate our feelings. These visual forms can represent our perspectives, express our emotions and provide a way of interpreting our life and social world. Photographs, artwork, sculpture, a You Tube film, a drawing can all represent aspects of who we are or how we understand our lives, the challenges we face or express how we feel (Emmison and Smith, 2000; Radley, 2010).

These visual forms can also be adopted for use within the scope of qualitative research. Rose (2016) highlighted the use of photography and films as the most common visual research methods to date, with digital media and artwork increasingly being considered as possible ways of data collection within research (Reavey, 2012). Hagedorn (1994) in a study she described as a hermeneutic photographic study, requested that all her participants consisting of eight families, take photographs of their experience of caring for a child with chronic illness. These photos provided symbols of their family experiences and prompted ‘spontaneous story telling’ whilst also serving as a way of reflecting upon and interpreting their lived experiences. Within the scope of the current research, the creation of the Kawa maps aimed to fulfil a similar role, where the Kawa maps provided visual and symbolic representations of

the lived experiences and social world of the individual participants. These visual maps also enabled a deeper level of phenomenological exploration and discovery, enhancing personal insight and understanding of how personal recovery was experienced.

Harrison (2002) suggested that using visual methodologies also offers the opportunity of an additional dimension and means of communication between the participant and the researcher. The use of the Kawa maps enhanced this process within the research, by providing an additional means of uncovering the personal perspectives and experiences of the individual participants. Additionally, the creation of the visual maps allowed for comparisons to be made between the participant's interview responses and what was depicted within their own Kawa maps. Any difference that arose between the two could then be discussed and clarified, with the opportunity to promote further exploration and insight. The creation of visual maps within the Kawa model also acted to complement the interview process in confirming the views expressed by the participants and also in clarifying any inconsistencies that occurred.

Summary

In this chapter I have examined and discussed such concepts as epistemology, ontology, hermeneutics, subjectivity and phenomenology. I have also discussed the philosophical and theoretical underpinning of Interpretative Phenomenological Analysis (IPA) and the Kawa Model and their appropriateness for use within my research study. The next chapter to follow will be the Methods chapter which will outline the research design, ethics, recruitment and selection, data collection, analytical approach and the issues of rigour and reflexivity.

Chapter 4 Methods

Introduction

I will describe in this next chapter, how I carried out my PhD addressing the areas of research design, ethics and approval, participant consent, the recruitment and selection process, research sample and participants' demographics, data collection and analysis, research rigor and reflexivity related to the study.

Research Design

I adopted a qualitative phenomenological approach and examined the contribution of the Kawa Model in exploring experiences of personal recovery. The research took the form of a longitudinal study with each participant being involved in five interviews and also the creation of five Kawa maps over the period of one year.

I wanted to involve service users from the initial stages of my research plan, especially as the primary aim of the research was to ascertain service user perspectives of their own recovery. I approached the Brunel University Service User Advisory Group (BUSUAG), which consisted of mental health service users, to review the participant information sheet and interview questions, to ensure that they were suitable for the research. The BUSURG indicated that the information sheet was sufficiently detailed in explaining the research aims, scope, ethical considerations, study involvement and precautions. Also the proposed interview questions were considered to be appropriate in addressing the research aims. This positive feedback from the BUSUAG provided me with reassurance and confidence to proceed with the research.

Research Ethics and Approval Process

Ethical approval is an essential pre-requisite of any research. The Code of Ethics and Professional Conduct (RCOT, 2015) indicates that all occupational therapists and researchers have a duty of care towards service users at all times, and that all reasonable steps must be taken to ensure the health, safety and welfare of any person involved in any activity for which the therapists or researcher is responsible.

Prior to embarking upon the research, I applied for Research Ethics approval from the Research Ethics Committee (REC) of the School of Health Sciences and Social Care of Brunel University London. Upon attaining REC approval in April 2008, (see the letter in Appendix A1), I approached the mental health charity (MHC), which for confidentiality purposes I have decided not to name, to obtain formal agreement to approach their members as potential participants. I met with the Director of the MHC and provided her with a copy of the ethics approval letter, and the participant information sheet (Appendix A1 & A2), to discuss participation in the research. I was then granted permission as confirmed by the MHC letter of the agreement in Appendix A1 which was considered sufficient as the MHC charity did not have its own Research and Ethics Board. As all participants were recruited through the MHC and not through the National Health Service, no further ethical approval was required at the time of the research.

Ethics and Participant Consent

There are several ethical issues to be adhered to when implementing any research and it was my responsibility as the researcher to ensure that these were fully complied with. Hicks (2004) indicated that research participants are to be treated with respect at all times throughout the research process and that the primary concern of the researcher must extend beyond the research outcomes, to ensure that the participants' best interest are considered and addressed. Although I was keen to

progress with the research and start interviewing the participants, it was crucial to ensure that the participants were comfortable with sharing their narratives and experiences with me and also aware of their rights. I explained to all the participants the aims of the research, their personal involvement, their rights to withdraw from the research and that it would not impact upon their continuation in receiving services (Brunel University London Code of Research Ethics, 2013). During the research briefing sessions and at the start of each interview, participants were informed that I was not seeking specific answers, but to get a sense of what their journey and experiences of recovery were like. They were reminded that participation in would be voluntary and that they were free to withdraw from the study at any time without consequences.

I explained to all potential participants during the research briefing sessions the aims of the research and the commitment involved in taking part in a longitudinal study. The research extended across a year and involved each participant in five repeated interviews lasting between 45 minutes to an hour and the creation of five Kawa maps. All participants were provided with the participant information sheet (Appendix A2) and had the opportunity to ask questions about the research during the briefing sessions and also prior to giving their consent to take part. The participants were also assured that although comments made within the interviews may be included in the write up of the research, no individual would be personally identified or named.

Maintaining an ethical relationship between the researcher and the participants required ensuring they would not encounter harm while taking part in the research and that respect towards the participants were upheld (Social Research Association, 2003). I was explicit with the potential participants during the research briefing sessions in highlighting the aims of the research, but also explaining some of the possible levels of psychological and emotional discomfort they might encounter during the interviews when sharing their personal experiences. All participants

provided written consent which was verbally confirmed prior to the start the first interview and continued consent was also obtained at each subsequent interview to allow participants to decide if they wanted to continue with the research.

I was also mindful of the potential power dynamics between participants and researcher. Thapar-Bjorkert and Henry (2004) argued that power can result in those in authority imposing their views, will and having control over those in a subordinate position. This can occur within the power relationship between the researcher and the participants, where the latter might feel pressured to answer or act in a subservient way to satisfy the researcher (Mitchell, 2010). Van Mens-Verhulst (1999) suggested that the researcher's title, role or professional qualification may increase the power differential or create a perception that the researcher knows best or is more knowledgeable. This can lead to the participant deferring to the researcher and critically influence the responses given in the interviews.

The participants within this research were aware of my interest in mental health recovery and my previous role as an occupational therapist and might have felt obliged to respond positively about their own mental health recovery or highlight the value of meaningful engagement in occupations as contributing to their recovery. Similarly being aware of my interest in the Kawa model and its usefulness, the participants might have felt they had to be positive about its value as a tool and been reluctant to critique the model. I tried to manage these potential dilemmas at several levels to ensure that I acted ethically throughout the research. To reduce the power differential, I highlighted to the participants during the briefing sessions and at the start of each interview that I considered them to be the best person and expert of their own lives. During the interviews I reinforced the point that there were no right answers to the interview questions and that I was primarily interested to discover the personal meanings and perspectives they attached to their experiences. I also reiterated that my overall aim was not to interfere or intervene in their

lives over the research year but to come alongside them at various intervals to gather verbal and visual accounts and insights into their personal experiences.

To ensure the participants were clear about the role of the Kawa model within the research, I explained how the Kawa model and maps would be used to elicit personal experiences of recovery overtime. The research study would explore the use of the Kawa model as a visual and narrative tool in exploring recovery and not consist of an evaluation of the Kawa model as a therapeutic measure. My role throughout was that of a researcher and not an occupational therapist and I would not be delivering any form of intervention nor evaluating the model as an intervention tool or procedure. This was to ensure that the participants did not mistake the repeated interviews as therapy sessions.

I had to be mindful that my prior involvement and interest in the Kawa Model did not influence how I explained the purpose of incorporating the Kawa model as part of the research. I spent time additional time in analysing the findings to ensure that my prior interest did not influence my eventual analysis. To ensure that all perspectives were accounted for, I had to listen hard to the interview transcripts and confirm all themes gathered, by including supporting quotations from the participants.

Letherby *et al.* (2013) highlighted how politics, power and emotions are prevalent within research and that the researcher must undertake a process of introspection and reflection in order to be aware of how these influences can impact upon research process. The researcher being in a perceived or actual position of power can exhibit emotions or actions that might both or encourage or dissuade the participants in their responses (Mitchell, 2010). My personal views regarding mental health recovery and my prior interest in the Kawa model meant that I needed to take the necessary precautions to manage my interactions with the participants

within the research especially during the interviews to ensure that I did not unduly influence the participants.

I felt adequately skilled and competent in conducting the research interviews due to my 10 years' experience as a clinician where I had regularly interviewed service users and as an academic where I similarly interviewed students and service users. In addition I felt competent about conducting the research interviews with due care and consideration due to my previous experience of undertaking research interviews. I maintained a reflective diary, keeping a record of any issues that arose in my interviewing of the clients and my own feelings and perspectives in relation to what the participants mentioned during the interviews. An example of this was when I noted down how one of the participants (Stewart) comments on missing out on intimacy and feeling that they he would never have the opportunity to be in an intimate relationship or ever have children, caused an emotional reaction of immense sadness within me and resulted in me thinking more about the importance of intimacy, love and acceptance.

Any potential psychological, physical and emotional distress must be eliminated in the research and I obtained agreement from the MHC that they were willing to offer the necessary support to any of the participants should they be upset after an interview. I then explained this potential support to the participants prior to the interviews. Participants were reminded that they were free to withdraw from the study at any point in time and assured that such a decision would not affect their attendance, membership or participation with the MHC.

Recruitment Setting

The recruitment of participants for the PhD took place at a local MHC for people with mental health (MH) difficulties in greater London. I considered the MHC as appropriate due to it having a large enough membership of 80 members at the time of the research, which made recruiting a total of

8-10 participants for the research a realistic number. I also chose to move away from recruitment through the NHS thereby avoiding the biomedical approach and focus on assessment, treatment, clinical effectiveness, and cost efficiencies (RCOT, 2007b). I hoped that by drawing participants from a non-statutory organisation, participants would be able to more freely explore and express their personal views on recovery and what they felt contributed to their recovery process, rather than feel pressured to respond in ways supportive of the approaches or interventions they received through the NHS.

I was further aware that some of the participants may have received clinical input from occupational therapists in the local NHS Trust and being professionally identified as an occupational therapist might influence how the participants responded in the interviews. I also felt that recruiting participants through the local NHS Trust or undertaking my research within the facilities of the NHS might have resulted in a compromise in terms of clarity of roles, with participants possibly becoming confused as to whether the research was focusing on the contribution of occupational therapy towards recovery.

Recruitment and Selection Process

Following obtaining Brunel University London REC ethical approval and permission from the MHC to proceed, recruitment began with advertising and organising a series of research briefing sessions at the MHC. These briefing sessions were advertised on the information board at the MHC and all interested participants were invited to attend a session. The aims of the PhD, the research process, participant commitment, consent and the right to withdraw were explained and all questions from potential participants answered. The contact details of the researcher were made available and interested parties were invited to contact the researcher to obtain more information about the research and to register their interest to take part. Each individual who expressed an interest to take part was then provided with a participant information sheet (Appendix A2) and any

further questions they had were answered. All potential participants who expressed an interest to be involved were considered against the inclusion and exclusion criteria for the research study (Table 3).

Table 3 Participant Inclusion and Exclusion Criteria

Inclusion Criteria	**Exclusion Criteria**
Have a history of mental health difficulties.	Participants must not be receiving acute inpatient treatment at the time of each interview.
Be member of the specific M H Charity.	Not a member of the specific M H Charity
Have the mental capacity to consent to take part in the research.	Not have the mental capacity to consent to take part in the study.
Be mentally stable at the time of recruitment and at each interview.	Participants must not be floridly psychotic or be in relapse at the point of each interview.

The above three exclusion categories were clarified with the key worker of each potential participant prior to them participating. Ten members of the MHC expressed an interest in being involved. However the figure of ten later reduced to eight, as two individuals subsequently withdrew their interest as they were not able to meet the longer-term time commitment to be involved in this study. This resulted in final number of eight participants agreeing to proceed with the research study.

Research Sample and Participants' Demographics

A key aspect of any research that involves 'human' participants is the study group size. Qualitative research often has a smaller study group than quantitative research where participants might be selected to represent the natural population (Carpenter and Suto, 2008). I adopted a

purposive sampling approach to ensure that individuals who had experienced an enduring mental illness and were interested in their personal recovery would take part in the research. The specific 'sampling' strategy within IPA is one of purposive and homogenous sampling, which enables a more meaningful collection of perspectives and experiences on the chosen topic (Larkin *et al*., 2006). Smith *et al*. (2009) agree on the importance of selecting participants based on the premise that they can provide detailed insight and perspectives related to a particular phenomenon.

Research studies that adopt an IPA approach are noted for having a small number of participants, with Smith *et al*. (2009) indicating 6-8 research participants as a norm within such studies. Recruitment of participants follows a purposive sampling strategy rather than a random selection of participants because people are selected for being 'information rich' and able to provide a germane, detailed and comprehensive perspective of the experience in question and therefore substantially informing the research study (Polkinghorne, 2005: Larkin *et al.*, 2006). In contrast, other qualitative methods such as grounded theory, involve the sampling of large numbers of participants in order to discover common perspectives and generate a theory from the data (Reid, Flowers and Larkin, 2005). Instead, the goal of IPA is to arrive at a detailed and rich representation of a specific phenomenon (Clarke, 2009; Smith *et al*., 2009).

Indeed some IPA studies have essentially been single case studies with an in-depth examination of the experiences and personal meaning of single participant (Smith *et al*., 2009). Such small IPA studies draw on small study groups to enable greater depth of inquiry and analysis (Larkin *et al*., 2006). A previous study by Pitt *et al*. (2009) used IPA to examine personal accounts of mental health recovery and involved small number (n=7) of participants enabling in-depth inquiries using interviews. In discussion with my research supervisor, eight participants was

considered a sufficient number for this research due to each of the participants being interviewed five times throughout the year and therefore accumulating a total of 40 interviews and 40 Kawa maps. In comparison with previous research involving IPA, this study size was considered to be sufficient for the research.

Table 4 Participants' Demographics

Pseudonym	Age	Status	Ethnicity	Diagnosis	Mental Health History
Maggi	58-67	Divorced	White Irish	Schizophrenia	35 years
Kim	48-57	Divorced	White English	Depression	34 years
Peter	48-57	Single	White English	Bipolar	30 years
Anne	48-57	Single	White Italian	Schizophrenia	28 years
Diane	58-67	Married	White English	Depression	36 years
Bert	48-57	Married	White English	Bipolar	32 years
Jill	48-57	Widowed	White English	Schizophrenia	28 years
Stewart	48-57	Single	White English	Schizophrenia	33 years

The participant's demographics shown in Table 4 indicated that of the eight participants, five were women and three were men. Two were within the 58-67 age group and the remaining six in the 48-57 age group. Of the eight participants, three were single, two divorced, one was widowed and two were married. All the participants were of white European ethnicity and this meant there was a lack of cultural diversity in the group, although it enhanced their homogeneity. However, this did not affect the aims of

the research as it was not intended to evaluate the potential differences that might be identified among a culturally diverse group. The participants presented with a range of diagnoses: four had been diagnosed with schizophrenia, two with depression and two with bipolar depression. The participants' mental health histories ranged between 28 and 36 years with the average for the group being 32 years. In summary, the participants represented a mixed gender, older group of participants of diverse marital status. They had long term, enduring mental health histories and presented with a diverse range of diagnoses. All participant names have been changed.

This fairly homogenous sample is a desirable quality for IPA, where groups are selected to enable the research to derive more in-depth detail into the chosen issue (Larkin *et al*., 2006). I did not deliberately select participants within a particular age band or with a specific length of mental health history and the similarities were a consequence of those who volunteered to take part. This level of homogeneity allowed for the findings to be far more valuable for an Interpretive Phenomenological analysis (Smith *et al*., 2009).

Data Collection Process

The data collection for this longitudinal study took place over the period of a year as illustrated by Diagram 4, with a series of 5 interviews in total per participant. All the participants were involved in two complementary processes that took place during each interview and were interviewed at regular three monthly intervals as illustrated below.

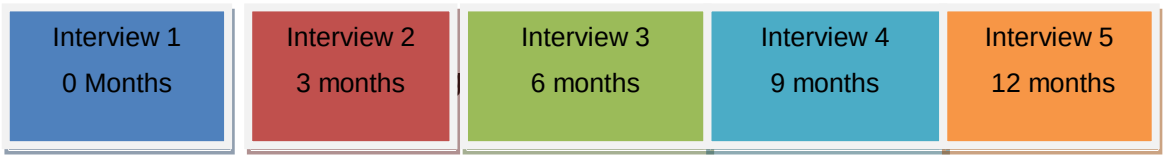


Diagram 4 Interview Series

The first stage involved semi-structured interviews to facilitate the phenomenological exploration of the individual's unique perspective (Domholdt, 2005), whilst the second stage involved the creation of a visual Kawa map that represented the recovery experiences of each participant at a specific point in time, accompanied by an exploratory discussion. The value and use of the interviews will be highlighted next.

The use of interviews promoted the in-depth examination of unique experiences of personal recovery. Britten (1999) suggested that the aim of the interview is to go below the surface of the topic being discussed, explore what people say in as much detail as possible, and uncover new areas or ideas that were not anticipated at the outset of the research. Laliberte-Rudman *et al*., (2000) suggested that the opportunity to be listened to and having the undivided attention of the interviewer may be enriching and cathartic for a participant, providing the space and time for them to express and share their experiences and giving meaning to their life circumstances.

Flowers (2008) suggested that interviews are very adaptable, allowing the skillful interviewer the scope to probe, examine, uncover narratives and explore feelings. Within the interviews, open-ended questions, prompts and requests for clarifications were used to invite in-depth responses, which are also consistent with the features of IPA (Smith and Osborn, 2008). The interviews were beneficial in providing a structure to the questioning process, allowing participants the freedom and opportunity to express their views and share their narratives (Carpenter and Suto, 2008). Qualitative semi-structured interviews were similarly adopted in a previous study involving seven participants about their experiences of recovery from psychosis, where IPA was used (Pitt *et al*., 2009). This reinforced my view that the use of interviews would be appropriate for this research study.

Formulating the Interview Questions and Schedule

The interview questions and schedules were designed in two stages. The first stage involved designing a topic guide to identify key aspects of the participants' experiences based on existing literature and research in the area of mental health recovery (Rubin and Rubin, 2005). The proposed interview questions were presented to the BUSUAG to ensure that they were appropriate and understandable. Obtaining expert advice was in line with the Department of Health 'Expert Patient Initiative' guidelines (DoH, 2001), which encourages the involvement of people with first-hand experience of a chosen area to comment on proposed research. Consulting the BUSUAG met this criterion and the members provided valuable feedback on my research plans. Although the Advisory Group asked several questions of the researcher with regards to the proposed PhD research, no further suggestions in terms of rewording of questions were considered to be necessary to improve the sensitivity and quality of the interview schedule and questions. Copies of the interview schedule (1-5) for all five interviews are located in Appendix 3.

To further refine the interview questions in respect of the actual participants, the first participant interview was a pilot. Piloting the interview process and questions enabled any required changes to be made. However no concerns were indicated at the end of first interview and therefore no changes were made. The questions asked followed the respective interview schedules as noted in Appendix 3.

Management of the End of Data Collection Period

An important aspect of the research was how to ethically manage the completion of the data collection period and the conclusion of the repeated interviews. All the participants had made a personal investment being involved in a series of five interviews over the year and I was conscious that the end in the research interviews could potentially leave a gap. Meeting with me at regular intervals resulted in a level of rapport

being established over time and I wanted to ease the end of the data collection process for the participants and to manage any related emotions they might have with dealing with endings.

I reminded each participant during the fourth interview that we would be meeting a total of five times only, in order to prepare them for the eventual end of the interviews. I openly discussed with the participants at the final interview how they found the interview experiences and also their views about the end of research. I also obtained reassurance from the Mental Health Charity that each of the participants would continue to have access to support from their key workers and be supported when the research ended. Having gained this reassurance I was able to share this information with the participants during the interview sessions. I felt that this was an ethical consideration, reassuring the participants that they would continue to be supported after the end of the research.

I also discussed with the participants if they would like to be involved in future research involving the use of the Kawa model. In addition, I also provided each participant with a personal copy of the Kawa template which they could then take away and use to map they own life journey and recovery following the end of research. Six of the participants accepted a copy of the Kawa template and all the participants indicated that they were agreeable to take part in future research involving the Kawa model.

Kawa Maps and Exploring Recovery

The Kawa model adopts the metaphor of a river to symbolise one's life journey, with each individual having their own unique river which represents their journey through life (Lim and Iwama, 2006). The Kawa maps can also represent an individual's mental health recovery over time 'past, present and future' (Diagram 5). The visual aspects of the Kawa model can assist the individual to identify the wider range of factors that

may impact on the person's health, well-being and recovery (Lim and Iwama, 2006).

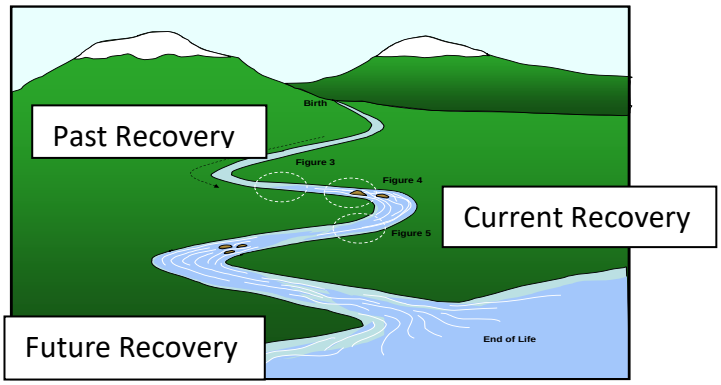


Diagram 5 Recovery journey over time

The Kawa model recognises the importance of individual experience and I felt that it was ideally suited as a research tool, as it promoted the in-depth exploration of phenomena and discovery of meanings. The creation of a series of Kawa maps which represent the lived experiences of each individual over time complemented the use of the in-depth interviews within the research. The use of the Kawa maps also supported the use of IPA as an analytical approach within the study providing an additional visual perspective towards exploring personal recovery.

During the first interview I introduced the KM and its key concepts to each participant (Diagram 6). The participants would use the template and components pieces seen in Diagrams (7-9), to create a cross-sectional Kawa map to represent their personal recovery for that point in time. They would pick up the various component pieces and place them within their own Kawa model template to represent their lived experiences, and label each of the components within their maps. An example of an initial Kawa map created by Jill, one of research participants has been included in Diagram 10. The detailed analysis and exploration of the various Kawa maps created by the various research participants will be highlighted later within the Findings Chapters 5, 6 and 7.

Diagram 6 Basic Concepts of the Kawa Model

Diagram 7 Basic Components of the Kawa Model

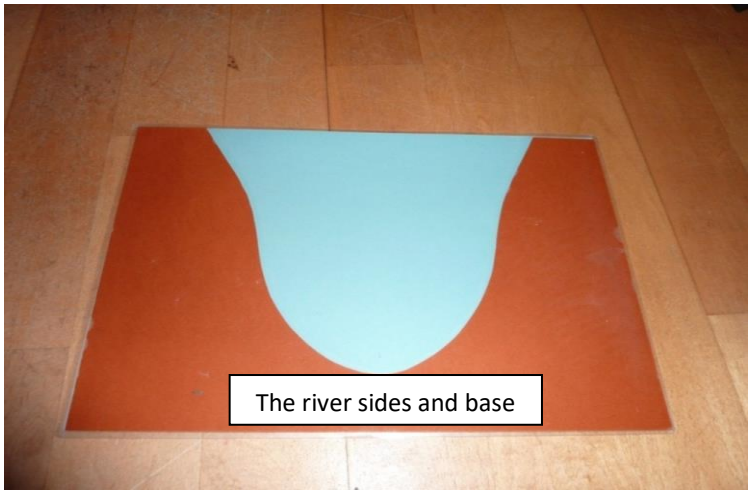


Diagram 8 Template of the Kawa Model

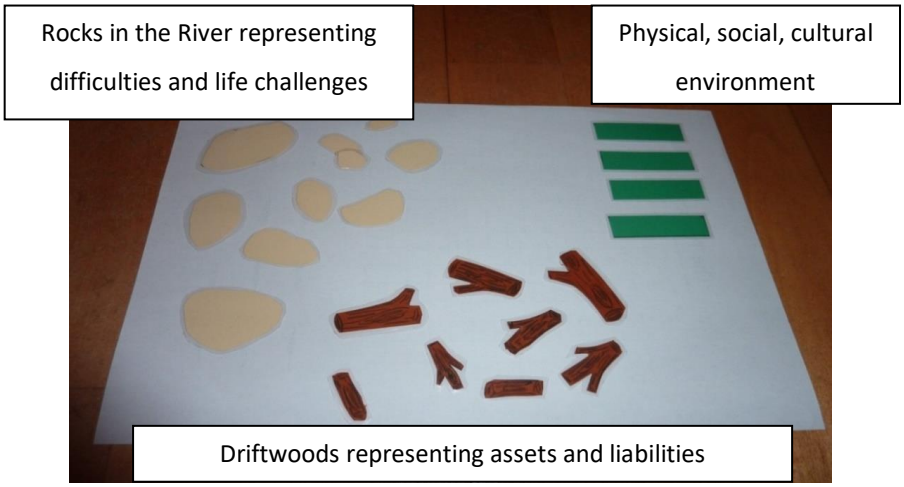


Diagram 9 Component pieces of the Kawa Model

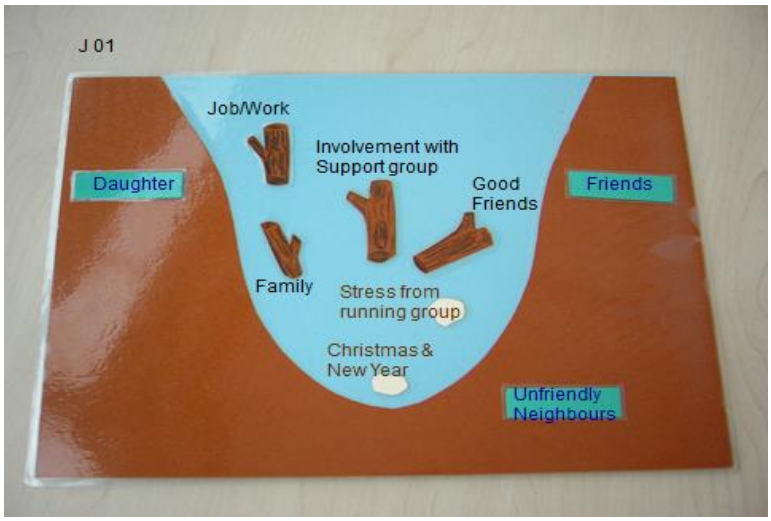


Diagram 10 Example: Use of the Kawa Map

The various components within the Kawa map, represented different elements of the participant's recovery experience: life challenges and difficulties they faced were represented as rocks, the assets or liabilities they possessed as driftwoods and socio-cultural and environmental factors like family, society, health professionals, finances as the river sides and bases. After each participant had created their respective map they were asked to explain what the various elements represented were and to explain why they had placed them within their Kawa maps. They were further asked to elaborate upon how they felt the different elements were influential to their personal recovery and how they felt about using the Kawa maps.

Table 5 Main questions to explore engagement with the Kawa Maps

Kawa Maps Questions
Can you tell me what these various elements are within your Kawa maps?
Why have you included these elements within your Kawa maps?
How are these elements/components influential to your personal recovery?
How have you felt about using the Kawa Maps?

At the end of each interview, I photographed each map and printed a copy for each participant as a visual record of their personal recovery, whilst I retained an additional copy for analysis. The participant was then able to review his/her recovery map in their own time. The 8 participants accumulated a total of five recovery maps each that reflected their recovery journeys through the year.

During the fifth and final interview, alongside asking questions, I also presented the first four Kawa maps created by each participant. I jointly reviewed the series of Kawa maps (01-04) created by each participant to appraise how their felt their recovery journeys had evolved over the period of the year. The Kawa maps in this way provided a useful visual record of the varied journeys that each participant had experienced through the year.

Data Analysis (IPA)

My attempt to transcribe the interviews had limited success as it took far too long and I then employed the services of a professional secretary to transcribe the interviews verbatim. All transcripts were checked carefully by listening again to the audio-recordings. The transcribed interviews were then subject to IPA and I began a detailed analysis of each interview to identify convergent and divergent themes. I also employed

inductive techniques to allow for new and unexpected topics or themes to emerge during the analysis. There are several key stages to the IPA data analysis and these are illustrated in Diagram 11, and further explained in the 6 step process in IPA analysis (Smith *et al*., 2009).

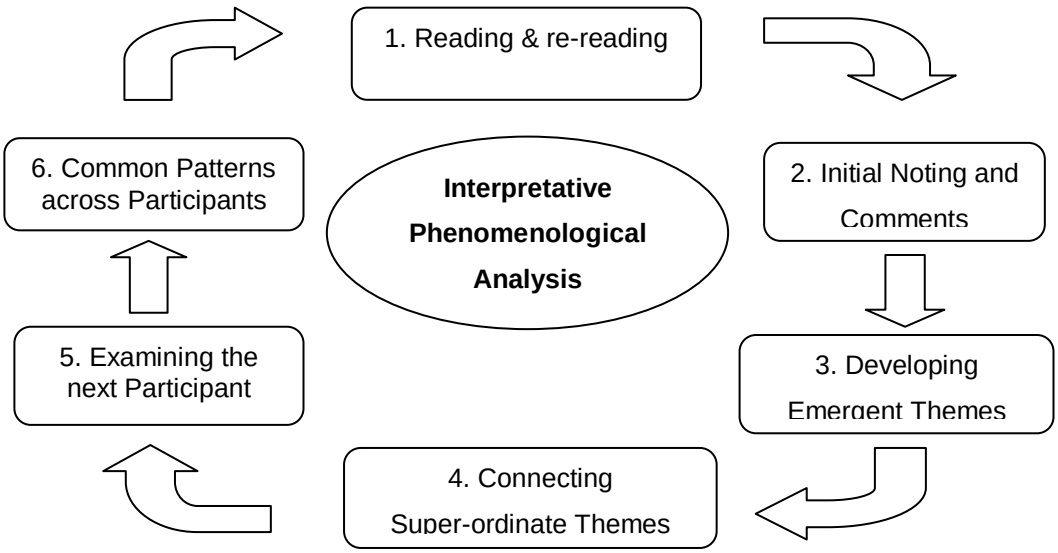


Diagram 11 The Analytical Process for the Research Study

Step 1 - Reading and re-reading

I began the data analysis process by immersing myself in the original data, undertaking a process of reading and re-reading the transcripts and also listening to the audio-recording. Re-reading the transcripts enabled me to absorb and analyses the comments, emotions and expressions of the respective participants and also recall events within the original interviews. I adopted this initial step to prevent summarising all the comments and arriving at the emerging themes too hurriedly. Instead, I invested time to record any preliminary observations, recollections, thoughts, connections, in order to maintain focus on the findings.

Step 2 - Initial noting and comments

This stage involved the exploratory examination of the content and language used within the interviews and I made notes of anything of interest that arose from the transcripts. In practice both Step 1 and Step 2 took place concurrently as I made notes as I read the interview transcripts. Adhering to Smith *et al*., (2009) proposal for IPA analysis, I created a three column table within a word document as illustrated in the Table 6, with the whole interview transcript copied into the central column as shown below.

A hard copy of the whole transcript with wide margins on either side was then printed which enabled me to indicate my observations and make comments as I began analysing the content. The right hand margin was reserved for any initial noting and exploratory comments, whilst the left hand margin was used to note down themes and sub-themes that emerged (Larkin, Eatough and Osborn, 2011). Below is a sample of the transcript analysis of one of the research participants, Kim, to illustrate how the IPA analysis was conducted, with the noting of comments in the right column and the emerging themes in the left column.

Table 6 Sample of Transcript Analysis (Kim)

Emerging Themes	**Original Transcript K02**	**Comments**
Movement and evolving. Feeling positive and increased confidence and	INT. Could you describe your current recovery journey? K. Well it is really good. I feel as if things are shifting. I am sort of going on very steadily. It is a nice easy	There is movement. Sense that things are working out, gradual change. It is going well, feeling positive

sense that all will be okay.	pace and as you say in the context of a river journey very enjoyable, view is good, and the future looks good, optimistic and just a very nice feeling of gentle movement. INT. Can you elaborate a little bit about, I know you said it is good, what things make it good? What is happening that makes it optimistic or good?	and confident. Nice feeling, just enjoying it, nice and good pace.
Personal relationship and intimacy has changed my attitude and view. Improved family relationships. New sense of optimism	K. For me it is relationships because they have always, or seem to have been, in the past, one of my major problems. So family is going well, I have a one to one relationship, that is going well and I think that is a big plus in keeping the whole thing going. INT. I know you talked about feeling optimistic but are there any other feelings that you can identify which you feel maybe relate to how it is at the moment.	How well I get on with people has always being a concern. Also new personal relationship has made a difference in how I appraise my experiences.

Feeling positive about the future. Looking forward and actively planning ahead. Having an aim and focus. Adopting the River metaphor	K. If you are saying about the river model I can see that I want to stay on the journey and I am making short term plans and long term plans so my navigation is to look further into the future more than I thought I would ever dare to do. INT. So it has sort of given you some courage to look beyond. K. Yes definitely. Maybe going a bit into the unknown but with courage. INT. So not with apprehension but being positive about it? Any other factors you think that also have contributed to how you are feeling at this moment in terms of your recovery journey? K. Well the holiday I have just come back from, I went with my family to Italy and then from there I was taken	Feeling optimistic and planning ahead. Setting targets for self to work towards. Using metaphor of the River, navigating my future. Having confidence to venture into the unknown. Family holiday went well, good experience.
Self –confidence and belief. Willing to take a risk.		
Positive experience and encounter.		

New adventure and challenge Time for self. Sense of achievement and boost to confidence and self-belief. New sense of confidence and self-belief Feeling supported and encouraged, people are rooting for me!!	to the railway station and made my way to Rome. So I was in Rome for 3 days on my own with a map and finding my way around and I knew before I went that once I had done it, it would give me a great sense of achievement. I have never done anything like that before on my own and coming from a place where I know what it felt to feel absolutely impossible to get out of bed, so actually do that and come back on my own was a great sense of achievement. A lot of people that I told what I was doing said 'Oh my goodness, I couldn't do that'. As it was coming closer my daughter said to me, 'Are you worried?' and I said 'I am not actually'. I couldn't understand why but I had a lot of people rooting for me. It was if they were on the bank of the river cheering me on. INT. I am assuming you planned beforehand, before	Real sense of achievement and success, feeling very positive about the whole experience. Recognising and acknowledging the improvement made. Look where I have come from, not being able to get out of bed to doing this. I was not worried and people also felt it was a great achievement. Self-belief Support and encouragement from others. Everyone wanted me to do well to get better to succeed. Feeling really supported. Not in it alone.

	you went on holiday that is what you were going to do in terms of spending some time with your family and then going on your own.	
Importance of having dreams and achieving those dreams. Having a focus, doing something I wanted	K. Yes it was all planned. Rome had been a dream of mine in years and it just seemed to be the time was right. I did my own planning.	It was a dream of mine and I always wanted to do it. I achieved one of my dreams.
	INT. So how were those few days?	
Sense of belonging	K. It was incredible, I was very happy with my own company. There was no fear, I felt very at home. I	Comfortable with self. Sense of belonging.
Spiritual renewal and connectedness	really had a feeling of coming home. I don't know whether that was spiritual. I am a practicing Roman	Sense of a spiritual, emotional and physical fulfilment (Pilgrimage). Revitalised, I found
Feeling positive.	Catholic so I was going there for a sort of pilgrimage. It was a spiritual adventure.	myself again.
	INT. So was it intentional that it would be a pilgrimage in some ways or	

	did it just become part of it. K. Yes exactly. INT. But you didn't originally plan to go on a pilgrimage as such? K. No, but I knew I wanted to go to St. Peter's and go to the Vatican that was one of the things I wanted to do but I didn't know what to expect. It was just my daughter had been and said 'Mum you will not be disappointed' but I couldn't know what to expect. So it was the most wonderful surprise, like a gift and I took as many pictures as you like. I kept pinching myself. INT. That is good. I know it is all positive but I was wondering whether any particular things, since I last saw you which might have been obstacles, not necessarily on holiday, but I was just wondering whether there were any obstacles in	
Deserving a reward, sense of a spiritual fulfilment. Surprise at managing to achieve aim.		Planning and achieving a personal goal. Deserving a special present, a reward. Still not quite believing I achieved it.

	the way which might have affected your journey over the last few months.	
Family relationships and dealing with conflicts Using the metaphor of the Kawa model. Being strong enough to deal with upset and disappointment. Reacting positively. Learning to cope and manage.	K. Definitely there have been some rocks. I have got two adult daughters who are married with children and I have grandchildren so I have never been a grandmother before and I did hit a great big rock with my eldest daughter who has twin boys who are 18 months. Her husband has to go away on business fairly regularly and she said will you come and stay and I went one day and thought she just doesn't want me here. But I had to deal with it rather than saying you don't need me, I am going to crash out the door. So I had to deal with that. I had to sit and think. I felt very uncomfortable but it has healed and it has come back better.	Challenges in the relationships with my daughter Using river metaphor to describe the experience. Learning to deal with the disappointment and maybe even rejection from daughter. Managing negative emotions

Step 3 - Developing emergent themes

During this step I identified the emergent themes that arose from the transcripts initially by establishing the themes that were present and then identifying any connections and patterns of themes that were prominent within each interview. I then created a catalogue of the emerging themes, and examined recurring patterns of meaning (ideas, thoughts and feelings) within these themes throughout the text. The focus was to ascertain a range of emergent themes that captured the essences and meanings present in the transcripts. This involved a process of re-reading through the transcripts to ensure that all emergent themes were identified. These themes will be highlighted in the following chapter, chapter 5.

Step 4 – Connecting super-ordinate themes

Throughout this step I was focused upon establishing the super-ordinate themes that connected with the various emergent themes, establishing which of the emergent themes were most relevant to the current research question and aims. I adopted a thematic process, collating and mapping the emergent themes which were then grouped under much broader categories of sub-ordinate and super-ordinate themes which will be identified in the Findings chapter (5).

Step 5 – Examining the next participant

Once an interview transcript had been analysed, the next step was to move to the next interview. Although each of the participants completed five interviews and it was possible to analyses the next interview transcript for that particular participant, I decided to analyses all the first round of interviews before moving onto the second round of interviews. This decision was partly pragmatic and sequential as there was a three month lapse between each round of interviews and I was keen to use the time between the interviews to analyses the available transcripts. In addition, I wanted to collate all data from the whole cohort of participants

who had completed the first round of interviews before moving onto to the next round of interviews. To minimise any bias resulting from the previous transcript analysis, I partitioned off a period of a week between analysing each new transcript. Steps 1-5 were then repeated until all the remaining transcripts were analysed. This approach of analysis also facilitated an understanding of change over time as the participants' evolving lived experiences and patterns of recovery could be observed and noted.

Step 6 - Looking for patterns across cases

This last step involved finding connections and common themes across the whole cohort of participants. I re-examined the convergent, divergent themes as well as super-ordinate themes identified by the whole cohort of participants. This required the renaming of themes or reordering themes in order to establish similarities and differences in the comments expressed. The final set of themes were then summarised and presented alongside supporting quotations from the relevant text as will be indicated in Chapter 5 and Appendix E where the final set of themes are described/shown.

Analysis of the Kawa Maps

I analysed the individual Kawa maps in two main ways following the interviews. Firstly the maps themselves were analysed visually, as the participants created and recounted what they had placed within their individual maps and what each elements represented within their lives. To better assist in the process of analysing the content of each map and also the whole series of maps of each participant, I needed to create some way of cataloguing the different elements within the maps and to capture any common threads across the personal maps. I therefore developed the Kawa model framework index (KFMI) during the research to assist me in the process of gaining insight into commons themes, life world and personal perspectives of each participant.

Secondly, IPA was used to examine for the emergent themes that arose from the participant's discussion with me after they had created they Kawa maps. The participants comments on why the different elements in their map were influential and how they experienced them as impacting upon their personal recovery were analysed to identified their perceived value and specific contribution to their recovery. By tracking through the series of maps created by each participant and examining the corresponding interpretations and meanings attached to their maps I was able to identify recurring patterns and themes and better appreciate their recovery experiences.

The Kawa model framework index assisted me as to better appreciate the elements that mattered in each participant's recovery. The participants were not introduced to the KMFI; instead I used it in my own analysis of their maps. This began with mapping the visual images within the Kawa maps into the respective KMFI of each participant. Below is the Kawa map M04 (Diagram 12) created by Maggi, which I have included to demonstrate how the elements identified by Maggi were mapped onto the KMFI as seen in Table 7.

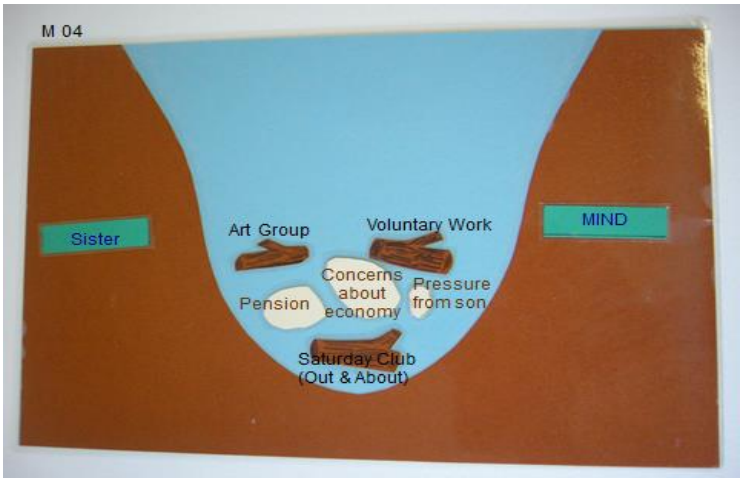


Diagram 12 Kawa Map M04 (Maggi)

Looking at the Kawa map M04 alongside the KMFI in (Table 7), I would make certain that all elements contained in the specific Kawa map were

listed along the left hand column as seen in (Table 7). In Maggi's (KMFI Table 12) all the elements from her Kawa maps were organised under the three respective Kawa Model component categories of *Challenges, life difficulties or concerns* (rocks); *Assets or liabilities* (driftwood) and *Environmental influences* (river sides and base).

Table 7 Maggi's KMFI (Overview of factors within Kawa Maps)

Personal Maps	Map 1	Map 2	Map 3	Map 4	Map 5
Challenges/Life difficulties/ Concerns (Rocks)					
Symptoms of Depression	X				
Struggle to get out of bed	X				
Poor Diet	X				
Pressure from her son		X	X	X	X
Worries about Pension			X	X	
Pressure from sister		X			
Concern about economy				X	
Assets or Liabilities (Driftwood)					
Involvement in art/art group	X	X	X	X	X
Poetry/ writing poetry	X				
Mental Health Charity		X	X		
Voluntary work		X	X	X	X
Pension					X
Outings with MH Charity				X	X
Environmental Factors					

(River sides & base)					
Social Networks	X				
Church	X				
Art Group	X				
Mental Health Charity		X	X	X	X
Support from sister		X	X	X	X

In the case of Maggi's Kawa map M04 for example this meant her rocks; such as pressure from her son, worries about her pension and the world economy were listed within the designated sections of her KMFI. The next step would be to ensure that a corresponding X was indicated in the correct KMFI column to denote which of the series of maps the elements belong to. Therefore in looking at Maggi's Kawa map M04 (Diagram 12) and then her KMFI (Table 7) it was noted that the column highlighted in yellow under section (Map 4) corresponds directly with what was represented within the Kawa map M04. By mapping all the content within all of Maggi's Kawa maps (M01-05) within her KMFI as indicated in Table 7, the range of elements/components indicated by Maggi was clearly identifiable. I could then observe from the KMFI that Maggi faced a range of rocks and identified various driftwoods and environmental factors, that she felt contributed to her health and recovery. Through the use of the Kawa model framework index, several recurring factors were noted as having prominence within the series of personal maps for each participant. These factors would then be examined correspondingly with the respective interview responses to ascertain their perceived value. The data shown in Table 7 also represented the regularity with which each factor may have been highlighted by Maggi within her series of five maps throughout the year.

The perceived value of each of the identified factors within the Kawa map was however dependent upon it satisfying the criteria list highlighted in Table 8, Determining Salient Value, which included regularity of representation, supporting interview responses and emotional conviction.

For an identified factor to be regarded as of salient value (SV), at least two of the three criteria indicated in Table 8, would need to be met. It was therefore important that I identified the value attached to the various components presented in each participants map, as merely being represented within a Kawa map did not immediately indicate that the component had the same level of importance or salient value.

Table 8 Determining Salient Value

Identifying the salient value of each element/component
Regularity of factor being represented within personal maps.
Importance reinforced by supporting interview responses.
Level of emotional conviction when discussing the factor.

Maggi, for example, represented in her Kawa map M04 that her rocks included her concerns about the economy, pressure from her son and worries about her pension. However on further discussion about the specific component highlighted through the Kawa map questions and examining each element/components for its salient value, for example Maggi's concern about the economy was found to not satisfy the criterion of salient value. Each element identified within the personal maps of each participant would need to be verbally or emotionally reinforced or be regularly represented in the Kawa maps to be considered to have salient value.

Through examining and analysing the Kawa model framework index, I was then able to observe an emerging pattern of factors that each individual considered to be instrumental to their recovery and also derive further insight into their personal lived experience. The use of the Kawa maps and KMFI continued to support a phenomenological approach, with an added emphasis on visual data, as interpreted by the participants supported through their verbal narrative. The detailed examination of the Kawa maps and the KMFI will be explored in Chapters 6 and 7.

Rigour, Ethical integrity and Artistry

The credibility and value of a piece of research is determined by several factors inclusive of the ethical integrity, the methodological reasoning and approach, the procedural rigour, trustworthiness and the quality of the research outcomes (Finlay, 2003; 2006). Within the context of quantitative research studies, outcomes are evaluated along such criteria as reliability, validity and generalisability of the research findings (Hicks, 2004; Hoy, 2009). However within qualitative research the importance of such criteria are contested, as qualitative research cannot be measured alongside such quantitative research criteria (Polgar and Thomas, 2005; Sargeant, 2012).

Indeed qualitative research demands a whole range of more compatible criteria, which may encompass such dimensions as 'rigour', 'ethical integrity' and 'artistry' (Finlay, 2006). Rigour is identified by Mays and Pope (1995) as ensuring credibility and trustworthiness, where there is a transparent process of ensuring that the data generated is readily available and the analysis of the data has been thoroughly examined and counterchecked (Finlay and Gough, 2003) to ensure that the interpretations made are credible. Nowell, Norris, White and Moules (2017) suggested that for research to be considered trustworthy, researchers must show that their research, particularly their analysis, was conducted in an exhaustive manner, which was precise and consistent. To ensure for trustworthiness, I was explicit about the research aims and maintained integrity in my record keeping. Further I was transparent in highlighting my methods of analysis and verified the processes I used. Yardley (2008) described several ways in establishing rigour within a research study and described principles of reflexivity and transparency. Being able to establish such dimensions are crucial if the research is to be considered beyond just a source of subjective opinions maintained by unscientific method (Ballinger, 2004; Koch, 2006).

I adopted several approaches and processes to ensure a rigorous approach. These included an overall reflexive attitude and also ensuring a homogenous sample of participants consistent with IPA studies (Reid *et al*., 2005). The longitudinal design of the current research provided me with the opportunity to establish a rapport with the participants over the course of the year and gained unique perspectives and insights into their recovery journeys. I believe the level of trust that was established through the five repeated interviews with each participant enabled me to derive a truthful account of the participants' experiences of their own recovery enhancing the rigour and integrity. The level of trust established could also have contributed to all 8 participants staying with the whole course of the research year and none of the participants dropping out of the research study.

I felt by using the Kawa maps where the participants were able to represent their experiences in a visual format and the corresponding Kawa map questions, allowed for a deeper level of probing and exploration, with the participants able to reflect and gain awareness of their personal circumstances. The use of both a textual and visual format (interviews and Kawa maps) promoted a joint approach to understanding how participants perceived, made sense and interpreted their experiences of recovery.

Thomas and Magilvy (2011) suggested that rigour is the process of being exact, careful and ensuring that all processes are thorough and accurate. Transparency within the analytical process was a key aspect of ensuring rigour and a clear audit trail was kept to ensure that checking of the results could be independently undertaken. I kept a catalogue of all the interviews, records of all the interview transcripts, analysed transcripts, Kawa maps and KMFI for all the participants and a sample of these is presented in Appendix E and F. All procedural details related to the qualitative research process inclusive of the sample of participants, interview questions, responses and of quotations from the participants to

support the identified research themes are available to aid credibility and rigour. Additionally, I also kept a reflective record of my thoughts and feeling regarding my experiences of the research process through my reflective Kawa maps located in the Discussion chapter, in Appendix G and my research diary.

As indicated previously, the use of the BUSUAG to review the research, double check the information sheets and interview questions, helped ensure that the questions asked were not leading or biased towards the Kawa Model being a valuable visual tool in understanding recovery. This enhanced the rigour of the research ensuring that the research process and research questions were appropriate and suited to the research aims. Ethical integrity was also considered an important aspect of promoting research integrity and active adherence to ethical principles and standards which govern responsible research practice are an essential aspect of credible research (Finlay, 2006; Koch, 2006).

Researchers must ensure that throughout all aspects of the research process that they comply with all ethical and moral principles related to implementing the research. I tried to safeguard this integrity by ensuring that the data presented reflected the range of opinions and concerns of the participants and were representative of what they have expressed about their lived experiences. Smith *et al.,* (2009) outlined the concept of double hermeneutics within IPA, which recognises the central role of the analyst/researcher in understanding the experiences of participants. IPA involves a process whereby the researcher attempts to interpret how the participants make sense of their own experience and to report these interpretations (Larkin *et al*., 2006; Clarke, 2009). The voice of participants must however not be compromised in the attempt to enhance the value of the research and I attempted to respect and safeguard the meanings and interpretations of the participants within the process of analysis, by providing clear accounts of what they said within the research study.

Polkinghorne (2005) also highlights the importance of representing the vividness, exactness and richness of the data, with all its weight and emotion, are reflected within the reporting of the findings. Within the current research, I made every attempt to abide by the principles of ethical integrity and artistry in ensuring that the description of the responses from the interviews and the Kawa maps were supported by quotations from the participants that emphasised the specific meanings highlighted. I tried to ensure that the findings presented were authentic reflections of the range of opinions expressed by the participants within the study and that the conviction, vibrancy and richness of data gathered was presented in its entirety. This was supported by highlighting the idiographical accounts of opinions and interpretations expressed by the participants within the research.

Reflections and Reflexivity

An important aspect of the any research is for the researcher to reflect upon their beliefs, perspectives, attitudes and experiences whilst involved in the research (Koch, 2006). The area of reflexivity poses a key influence to being insightful within the research process. Finlay (2006) suggested that reflexivity requires a process of critical self-reflection and awareness that the researcher's background, assumptions, positioning and behaviour can influence and impact up on the research process. The researcher must therefore be mindful of how personal beliefs and opinions may influence how they perceive and respond to the research (Finlay, 2003). Attia and Edge (2016) emphasised the importance of the researcher consciously stepping back from action in order to reflect and be conscious of their own impact within the context of the research.

One key challenge I faced as a researcher was to create a separation between my roles as a researcher from my previous position as a clinical occupational therapist. I refrain from intervening or making suggestions during the interview process when a particular concern was raised by the participant, even if I felt able to offer a possible solution or suggestion due

to my previous clinical experience. I found it difficult at times during the interviews not to offer a solution or to assist with a particular situation when I felt I could offer an answer to a dilemma faced by the participant due to my role as a researcher. I had to decide in such a situation to direct the participant to seek help from their key worker, who they were in contact with at the mental health charity.

Since all the participants were committed to the research process and attended their five interviews, a bond was built between them and me and I was determined to share their unique personal stories. However due to the huge volume of data, this proved a challenge as it was not possible to present within the thesis all the participants' stories and a decision was required. I felt committed to all the participants in equal measures and found it difficult to decide on how to present the findings in a comprehensive way to reflect the narratives and experiences of the respective participants.

Some of the narratives were very personal and reflected the thoughts, feelings and emotions of respective participants. Stewart for example commented on the lack of intimacy in his life and mentioned how he had reluctantly accepted that he might never be in an intimate relationship. This revelation by Stewart led me to reflect upon the importance of intimacy, affection, being valued and loved, aspects of human need which I had overlooked. In my exploration of personal recovery I had somewhat disregarded that experiencing intimacy, affection, acceptance and love were fundamental to deriving a sense of hope and fulfillment in life and contribute to mental health, well-being and personal recovery.

To reduce any possible confusion over my role within the research and the purpose of creating the Kawa maps within the PhD research itself, I reiterated both the focus of the research and the extent of my role as a researcher. Firstly, the research was not an intervention study evaluating the therapeutic use of the Kawa model, but was focused on use of the

Kawa model as a visual and narrative tool to exploring personal journeys of recovery. To this end I made sure at the very beginning of the research both in the recruitment and briefing events and also in the details laid out in the participant information sheet that the primary aim of the research study was explained and the purpose of creating the Kawa maps. This information was repeated during the first interview and every subsequent interview so that the participants were reminded that they were taking part in research and not therapy sessions.

As a researcher I did not offer solutions to challenges indicated by the participants during the interviews, as I would have done in my role as an occupational therapist. At times I was tempted but reminded myself of the primary focus of research and my role as a researcher. I have also been involved in teaching the Kawa model and have also used the Kawa maps in clinical practice and therefore needed to ensure that in analysing the findings and reporting that the views of the participants, that I excluded any potential bias. I needed to be aware of my own subjectivity in the research process.

Due to my involvement in the development of the Kawa model, I was aware that I might be more alert to positive reviews of the Kawa model within the current research. However to ensure that I provided a true account of the participants views of the Kawa Model, I listened hard and re-examined the transcripts to make sure that I did not miss any form of critique of the Kawa model from the participants, even if they might appear to be making a brief review or criticism of the Kawa Model.

To stay true to what the participants actually expressed and not to be swayed by personal interest and to maintain impartiality as far as possible, I ensured that the reporting of the contribution of the Kawa model within all the findings chapters were made and supported by quotations from the participants to ensure trustworthiness and consistency. Also I reported the whole range of opinions both supportive

of and oppose to the usefulness of the Kawa model within the research study.

Summary

The Methods chapter has highlighted the research design, ethical approval process, ethics and consent, recruitment and selection process, research sample and participants' demographics, data collection, and analysis, research rigour, reflections and reflexivity related to the research study. The next chapters (5, 6, and 7), the three Findings chapters, will detail the analysis of the interviews and the Kawa maps in exploring participants' personal experiences of and perspectives on mental health recovery.

Chapter 5 Research Findings

Outline

The results derived from the research are presented within the next three finding chapters. The focus of the research will be indicated next followed by an overview of the three chapters.

Research Question

What is the contribution of the Kawa 'River' Model in exploring the personal journeys of recovery of mental health service users?

Research Aims

- Examining the personal experiences of mental health recovery from a phenomenological perspective.
- Examining the experiences that participants identified as influencing their personal journeys of recovery using the Kawa model.
- Examining the value of the Kawa model as a visual tool in exploring the personal journeys of recovery.

Overview of the Findings Chapters

The first findings chapter will focus on the personal experiences of mental health recovery and explore the diverse influences on personal recovery from a phenomenological perspective, via the use of Interpretative Phenomenological Analysis (IPA). The chapter will then present the convergent and divergent views across the cohort of participants in respect of the super-ordinate and sub-ordinate themes that arose from analysis of the interviews.

The second findings chapter will examine the contribution of the Kawa model and maps in promoting insights into and understandings of personal recovery. The chapter adopts a collective focus highlighting the perspectives of the whole cohort of participants as they experience and reflect upon the use of the Kawa maps across the research year. The Kawa Model Framework Index will be highlighted and its efficacy in examining the Kawa maps indicated. The collective views of the strengths and limitations of the Kawa model and maps will also be highlighted.

The third findings chapter will adopt an idiographical approach, with a detailed examination of the lived experiences and recovery journey of two research participants. The focus involves a thorough analysis of the series of Kawa maps created by each of the participant in addition to responses to the semi-structured interviews, establishing an insightful perspective of their personal recovery through the year. The Kawa Model Framework Index will be employed in examining the Kawa maps.

First Findings Chapter (Phenomenological Approach)

Introduction

This chapter will present the themes that emerged from whole cohort of research participants in respect of their perspectives and perceptions of mental health recovery. The super-ordinate, sub-ordinate, convergent and divergent themes derived from the multiple interviews via the use of Interpretative Phenomenological Analysis (IPA) will be highlighted. The use of IPA facilitated a detailed examination of the participants' life world, capturing personal phenomena and meanings associated with their experiences of personal recovery.

Themes

Several super-ordinate themes were noted in the analysis, highlighting convergent and divergent perspectives and experiences of recovery.

Supporting extracts from the participants will be included and my interpretations will also be indicated, with emphasis on the co-constructed nature of the research process.

The initial research focus was to establish a personal perspective of what mental health recovery meant for each participant. Personal interpretations, experiences and meanings associated with recovery and the corresponding factors that the participants felt were influential to their personal recovery were identified. The various themes identified by the whole cohort of participants are presented in Table 9 below, which provides an overview of the perspectives regarding personal recovery via the use of IPA. An X in each box in Table 9 represents the participant identifying with the specific theme.

Table 9 The lived experience of recovery over one year: an interpretative phenomenological analysis: Cohort Themes: sub-ordinate and superordinate themes

Themes and Quotations	Anne	Bert	Diane	Jill	Kim	Maggi	Peter	Stewart	Themes
Perspectives on recovery: *"What I understand that there are different degrees of recovery for different people."*									Super-ordinate theme
Staying out of hospital: *"We measure our recovery by how long we have been out of hospital since our last admission"*	X	X	X	X	X		X	X	Sub-ordinate theme
Learning to cope with the illness: *"Learning to cope with your*	X	X	X	X	X	X	X	X	Sub-ordinate

illness and to live as normal a life as you can"									theme
Feeling more socially connected: *"Socially I am getting on better"*									Super-ordinate theme
Enjoying an increasing network of relationships: *"They provide me with activities and the opportunity to socialise to a degree with other people, so I won't get too lonely."*	X	X	X	X	X	X	X	X	Sub-ordinate theme
Appreciating the value of professional support: *"Support is very important. I have a care co-ordinator, support worker and a psychologist who are looking after me."*	X	X	X	X	X	X	X	X	Sub-ordinate theme
Feeling listen to and accepted: *"Well I draw upon my relationship with my mother. I speak to her every day. We discuss what I'm worried about and she gives me her opinion."*	X	X	X	X	X	X	X	X	Sub-ordinate theme
Experiencing a stronger sense of belonging: *"It makes me feel that I am a part of the community"*	X	X	X	X	X	X	X	X	Sub-ordinate theme
Looking outwards and getting									Super-ordinate

involved: *"You feel a sense of self-esteem that you've got something to contribute"*									theme
Expressing self and developing confidence through valued activities: *"I love writing poetry and I felt if I can do that I can put it to lyrics in a song. Well I was quite over the moon actually and when I got the song recorded and I realised how it turned out."*	X	X	X	X	X	X	X	X	Sub-ordinate theme
Gaining positive feedback from voluntary work and community groups: *"The other occupational therapist treats me as an equal and they say 'You are part of the team'. They treat me as part of the team and that is so important in my recovery, you know"*	X	X	X	X	X	X	X		Sub-ordinate theme
Increasing self-esteem from making a contribution to others: *"Sharing our experiences at the lecture, that was such a great opportunity, and there are people that were saying, that it had been so valuable for students*	X	X	X	X	X		X		Sub-ordinate theme

to hear"									
Enjoying flow and transcendence (e.g. walking, singing, reading): *"Singing is a great thing for me. I mean I sing in the choir at Church because I find it physically very good for me and very uplifting"*		X	X	X	X	X	X	X	Sub-ordinate theme
Feeling more committed to looking after own health and well-being: *"I know what it felt to feel absolutely impossible to get out of bed, so actually to do that and come back on my own was a great sense of achievement."*	X	X	X	X	X	X	X	X	Sub-ordinate theme
Coping with life's challenges: *"I have been through the rapids and survived"*									Super-ordinate theme
Reappraising obstacles and stressful aspects of life: *"Yes because I am exploring with you by asking questions, making me think deeply about what these things mean to me and how important they are."*	X		X	X	X		X	X	Sub-ordinate theme

Surviving the rapids - feeling more confident to cope with the unknown: *"Well I think it is very relevant because it is a period of my life where it has become a bit like a gently meandering river in a sense, rather than in flying around rocks and problems."*	X	X	X	X	X	X	X	X	Sub-ordinate theme
An Evolving Journey: *"Life travels like a river...it moves*									Super-ordinate theme
Feeling different: *"I just feel as well I feel more confident that I can do things you know."*	X	X	X	X	X	X	X	X	Sub-ordinate theme
Defining a new sense of self: *"Oh I do feel a lot different. I mean I have accepted the changes that have been going on in my life."*	X		X	X	X		X	X	Sub-ordinate theme
Feeling able now to express hopes and aspirations: *"I am actually starting to move forward which is a real big step, you know, in the direction I need to go because I have been ill for so long."*	X	X	X	X	X	X	X	X	Sub-ordinate theme

The next section will examine each of the super-ordinate and sub-ordinate themes as highlighted in Table 9, drawing upon relevant quotations from the participants and offering further commentary and interpretation. Convergent and divergent views around the various themes will also be scrutinised.

Perspectives on Recovery

The participant's perceived view of mental health recovery was a helpful starting point within the research, with the various interpretations of recovery. The theme perspectives on recovery, although broad in its scope, encapsulates the diverse ways the research participants interpreted and understood mental health recovery. All the participants reflected upon different aspects of their lived experiences when attempting to comprehend what mental health recovery meant to them. They collectively spoke of mental health recovery as an ongoing and deeply personal experience, indicating how difficult it was to pin point if and when they had recovered. All the participants also perceived their own mental health recovery in slightly different ways, indicating a personal interpretation of recovery.

> *"What I understand is that there are different degrees of recovery for different people."(Anne Interview 1)*

Anne described recovery as multifaceted and personal to each individual, highlighting that recovery was not the same for each person nor perceived in an identical way. For Anne recovery appeared as a continuous journey of discovery, as she tried to find a solution to her life challenges.

Peter similarly described his recovery as a continuous process of deriving personal insight and discovery and he was less concerned about arriving at a precise point where he could say for certain that he had fully recovered.

> *"I think one of the aspects of my recovery is that there hasn't been a single event or a single day that I can say that is a breakthrough and I'm recovered." (Peter Interview 1)*

In his comments above, Peter seemed to doubt he would ever discover a 'cure' which would lead him to be 'fully recovered'. Peter may have held this view due to having a history of manic depression for over 30 years and not having discovered a 'solution'. Indeed Peter described in his later interviews how there had been much fluctuation in the earlier periods of his mental illness and despite remaining well and free from hospital admissions for 11 years, Peter's continued to be cautious about expecting full recovery.

Staying out of hospital and avoiding a relapse

The majority of participants were fearful of having a relapse and being admitted to hospital. The participants highlighted how traumatic and disruptive it was to be hospitalized and indicated that being in recovery in their view, meant being well enough to avoid an admission to hospital.

> *"We measure our recovery by how long we have been out of hospital since our last admission" (Peter Interview 1)*

Here Peter describes how he equates his own recovery, by the length of time he managed to remain out of hospital. Peter explained how the frequency with which he was admitted to hospital, was for him a good indicator of his level of personal recovery. This perspective of associating recovery with managing to stay out of hospital resonated with several of the other participants too. Kim described how not having a relapse or needing to be hospitalised was for her an indicator of the progress she was making with her recovery. Kim felt that her ability to continue in recovery was measured by the length of time she remained out of hospital.

> *"The only thing I would like to add, this applies not just to me but to other people that I speak to, is that we measure our recovery by how long we have been out of hospital since our last admission. People say I haven't been in for 2 years or 3 years or whatever and that is a great signpost for us which is a good indicator of how well we are recovering and coping." (Kim Interview 1)*

Diane had a different understanding of how a relapse impacts upon recovery. Diane describes that becoming ill in her view, does not equate to not making progress with her recovery. Diane seemed to acknowledge that as there are fluctuations in people lives so there are fluctuations in people's mental health and that part of the process of recovery was learning to manage with such changes and fluctuations as they happen.

> *"Well recovery that doesn't mean to say you can't have a relapse and another recovery. A recovery doesn't necessarily mean a full recovery, forever, permanently, although we all hope to have a permanent recovery, but it can be a recovery and then a lapse and then you have a relapse. It is possible; you can go up and down for all your life." (Diane Interview 1)*

Diane described how she saw recovery as a continuous and changing process. Diane felt that recovery did not mean a total restoration of her health and seemed to accept that her recovery journey would be characterised both by periods of relapse and good health. Indeed Diane's extended mental health history of over 30 years with several relapses may have influenced her perspective of recovery as a continuous fluctuating journey.

Learning to cope and manage with mental illness

For the majority of the participants recognising that they would continue to experience fluctuations in their mental health throughout their journey of recovery, inspired them to learn how best to cope and manage their mental health.

Jill described her understanding of mental health recovery as a process of carrying on and coping with life despite becoming ill. Jill seemed to acknowledge that having a relapse was a probable occurrence and this was confirmed when she experienced a brief relapse of her mental health between her third and fourth interview. Jill described recovery as a process of applying the skills she acquired in order to more successfully manage with her life challenges and to carry on despite the occasional relapse. Jill seemed less concerned about frequency of admissions or the duration of her stay in hospital, but more about learning to manage her own health and having as regular a lifestyle as possible.

> *"Mental health recovery, I think it is a way of being able after you have had one breakdown or two breakdowns or ten breakdowns of learning to cope with your illness and to live as normal a life as you can." (Jill Interview 1)*

Jill seemed to be more focused upon achieving some level of normality and enjoyment in her everyday life and felt that from her own perspective this was an indication that she was experiencing recovery. Perhaps Jill's long history of mental illness influenced how she understood and perceived recovery, that is was more about finding a measure of normality and satisfaction within her everyday life than eliminating it altogether.

Part of coping and managing with one's mental illness was feeling some measure of control, and the majority of participants indicated that attaining recovery meant having more control over their own lives and enjoying some level of freedom and independence. Stewart who also had a mental health history of over 30 years and been in regular contact with mental health services throughout this time, seemed to equate recovery with achieving personal autonomy.

> *"Recovery means being able to have a reasonable degree of autonomy in life. Being able to live with many similarities to most other people." (Stewart Interview 1)*

Stewart described a desire to have the same level of independence that he felt everybody else was accustomed too. Stewart seemed to associate being in recovery with having freedom and not being constrained by his mental health condition. He seemed to also associate making progress in his recovery with needing less support from health professionals and being more self-reliant. Stewart expressed a desire to be less dependent on others and to regain some measure of control over his own life.

Summary

The research participants identified unique and personal interpretations of what mental health recovery meant to them. They also collectively highlighted the importance of staying out of hospital; avoiding a relapse and learning to cope with their mental illness as essential aspects of achieving recovery. The next section will examine the super-ordinate and sub-ordinate themes that participants' viewed as influential to their recovery throughout the research year.

Feeling more Socially Connected

All the participants indicated that they felt more socially connected with others through the research year, describing improvements in the quality of their social interactions and relationships with others. These relationships range from those with family members, friends, relatives and health professionals.

> *"I am more positive. Socially I am getting on better" (Diane Interview 2)*

Diane who lived with depression for a long period of time mentioned that she had always found it difficult to relate and interact with others. Here she seemed to recognise some level of personal improvement within herself as she indicating feeling more positive and getting on better with others, which enhanced her overall outlook and recovery.

The sub-ordinate themes in support of the super-ordinate theme of feeling more socially connected were: Enjoying an increased network of relationships, Feeling listened to and accepted, appreciating the value of professional support and experiencing a stronger sense of belonging.

Enjoying an increasing network of relationships

> *"The mental health charity provided me with activities and the opportunity to socialise to a degree with other people, so I won't get too lonely." (Maggi Interview 2)*

All the participants inclusive of Maggi indicated improved social networks and relationships as essential in supporting their recovery. They described how they valued the opportunity to get involved in different activities and benefitted from additional interactions. Jill highlighted that the friendships and relationships she had established with other mental health service users were instrumental to her recovery. Jill felt having wider social networks and increased support were influential in her maintaining her health and well-being.

> *"I think that those people from mental health have helped me, the friendship side I've made, are very important to me in my recovery." (Jill Interview 1)*

Kim, likewise, identified having friends and social networks as important to her remaining well. Her friendships seemed to motivate her to be active and engaged, providing her with a sense of purpose. However Kim seemed to acknowledge that just keeping busy did not take away the sense of isolation nor provide a guarantee that she would remain well.

> *"I have friends that I go to dancing with. Yes I feel quite supported socially. I feel I can pick up the phone and say would you like to do something not that that takes away the feeling of isolation." (Kim Interview 1)*

Stewart highlighted a strong and dependent relationship with his mother who lived in Scotland. Stewart explained how their close relationship meant he had daily contact with her and was able to discuss his thoughts and gather her opinion. However Stewart acknowledged he had limited social network and relationships beyond his mother, which was something he wished to change.

> *"Well I draw upon my relationship with my mother. I speak to her every day. We discuss what I'm worried about and she gives me her opinion, she helps me." (Stewart Interview 3)*

There was a sense that Stewart felt he was missing out and not experiencing much quality of life, as noted from his comments below. This realisation encouraged him to seek other forms of support and develop new relationships. Stewart highlighted how he subsequently got more involved in his local church during the year and eventually added this new involvement to his support networks.

> *"I worry about that fact that I live a solitary life. I wish I had more people in my life. I think I would have a much higher quality of life if I had more people in my support network." (Stewart Interview 4)*

Anne indicated the importance of having social support and a network of friends, where she could benefit from the input of others around her. She further explained how her difficulties with trusting others impacted upon the relationships she made. Anne acknowledged how this was a challenge when she was not well and her instinct would be to avoid other people during those moments.

> *"It helps to have a social life, be supported. It helps to have friends and people caring about me. People I can trust. Immediately I need to overcome some of my fears to be able to trust people. So there are two sides to this because I think in the past, when I was more ill it was more difficult to maybe have a social network. (Anne Interview 1)*

Anne also indicated how she had been motivated to set up a self-help group for women over the last couple of years. This desire was inspired by her own past experience of not being able to find support for herself. Anne mentioned the level of commitment she invested in the self-help group and a drive to contribute in other ways. She also acknowledged the sense of achievement and pride she derived from the positive comments she received for her work with the self-help group which enhanced her self-esteem and confidence.

> *"I have set up a core of support for people, a self-help group for service user and that is quite a bit of commitment on my part. And I do other things and they give me a good feedback about myself." (Anne Interview 1)*

Appreciating the value of professional support

All the participants highlighted the importance they attributed to the professional support they received, indicating it as influential in promoting or curtailing their recovery. For over half of the participants, Jill, Stewart, Kim, Anne and Diane, professional support was noted to be of equal importance as support from their friends and family. These five participants specifically highlighted the value of having an allocated time and place to be listened to by a professional. In contrast Peter, Bert and Maggi, viewed the professional support they received as less influential than support from close family members.

> *"What has helped is that my psychologist is very good. I can't wait to see her on Thursday, she has been away for two weeks, she is my confidant and she deals with the trauma and puts things in perspective for me." (Jill Interview 5)*

Jill felt her psychologist was instrumental in helping her to keep things in perspective. Jill indicated feeling supported and accepted by her psychologist and had developed a very trusting relationship, regarding her psychologist as more than just a professional, but actually as a

'confidant' to whom she could perhaps reveal her secrets. The lack of family support available to Jill, with her daughter as her only remaining family may have reinforced the desire for more closeness that Jill attached to this relationship with her psychologist. This deeper connection that Jill felt towards her psychologist seemed to enable her to more fully explore her emotions, work through her past experiences and gain greater insight. There was however a sense from the above statement that Jill may have become overly dependent upon her psychologist. With Jill seemingly counting down to the exact day when she would be seeing her psychologist again.

Stewart similarly described how the relationship, help and support he received from a range of health professionals enabled him to remain well. Stewart appeared to highlight the importance he placed on having regular support as well as the value of established relationships grounded in consistency, familiarity and trust.

> *"Well I am supported in the community by a team of mental health professionals. A psychiatrist, I see a clinical psychologist. I have seen the same psychiatrist for fifteen years and I have seen the clinical psychologist for about fourteen years, the same man. I see the clinical psychologist every 2 to 5 weeks and I see the psychiatrist every 6 weeks, I see a social worker every 6 weeks and I see a community psychiatric nurse every 5 weeks. So these are the mental health professionals that are involved in my care." (Stewart Interview 1)*

Stewart seemed to benefit from the structured professional input and support he received with the opportunity to have time and space for himself to discuss his concerns and receive help. There was a rhythmic sense of continuity in his professional support and Stewart was quite specific in emphasising the length of his relationships with both his psychiatrist and psychologist. Stewart had also previously indicated that he did not cope well with change and desired a level of certainty and continuity in his life which he felt promoted his health and recovery.

Stewart subsequently identified, as noted in the quotation below, an upcoming change (during the research year) with his psychiatrist retiring, as a substantial change in his circumstances and an area of clear concern in terms of the professional support available.

> *"In fact when we come to decide which boulder is on the river, it is the time with my psychiatrist. I just thought of that as a boulder, my psychiatrist is retiring at the end of September and I have known him since 1993." (Stewart Interview 4)*

Kim similarly stated how the professional help and support she received was important in helping her to manage her mental state. Kim highlighted the struggle she faced in overcoming her depression and the demands of trying to restore her health and recovery. In Kim case, she indicated how her supportive, nurturing and patient support worker, was essential in her personal recovery.

> *"I have some very good support from my support worker, lots of encouragement and she is very gentle and had a great understanding of what it was like just to find it difficult to get out of bed and rebuild my life because that's how it feels." (Kim Interview 1)*

In contrast, Bert did not receive any form of counselling or psychological input and described how he was reliant on his wife and regarded her as the primary influence in him remaining mentally stable. Bert did however acknowledged that his wife needed her own space and was not able to meet all his needs which prompted Bert to get involved in other groups to expand upon his range of social support networks. This led to Bert getting involved in a research and self-help group the year before, where he felt supported and continuing with his appointments with his support worker and psychiatrist.

> *"L coming into my life and agreeing to be my wife, who helped for stabilisation, she has been the one who has been there." (Bert Interview 1)*

Feeling listened to and accepted

All the participants indicated at different levels, the importance of being regarded and listened to. This seemed to represent a need to be taken seriously and was a form of being acknowledged for their views and contribution. At times this involved interactions with health professionals or with their peers.

> *"Well I draw upon my relationship with my mother. I speak to her every day. We discuss what I'm worried about and she gives me her opinion." (Stewart Interview 3)*

Peter mentioned how much he valued being taken seriously by the mental health unit and his psychiatrist when he noticed a relapse in his health. Peter described having his opinion considered and valued by health professionals as important for his self-confidence. Peter also felt the timely help from his psychiatrist, the medication and available support were crucial to him recovering quickly from his relapse.

> *"He fitted me in, that was really pretty good because it is unusual to get to see the psychiatrist on the day you actually make contact. Anyway he put me on a drug that I have been on before when I was high and it brought me down again from the high very quickly." (Peter Interview 4)*

Peter also acknowledged the importance of accepting the treatment offered and described a trust in his psychiatrist to prescribe him the right medication to get better. There seemed to be a mutual trust and respect between Peter and his psychiatrist which led to mutual regard for each other's judgement and decision.

Kim similarly indicated a trusting relationship with her counsellor and how she valued the opportunity to discuss her thoughts and concerns with someone she considered trustworthy, who was accepting of what she said. This respectful relationship seemed to enable Kim to be more open in examining her past emotional and psychological issues. Perhaps Kim's

previous experience of being judged by others led to her to being cautious about sharing her thoughts, and feelings. These past experiences may have reinforced the value Kim apportioned to having the professional support and the unconditional regard she experienced with her counsellor, encouraged her to be more genuine with her emotions.

> *"I have got someone I can trust;…..I don't feel judged. I can actually be honest with the way I'm feeling." (Kim Interview 3)*

Jill described the increased self-confidence and esteem she felt when she was regarded as an equal member of the team by the occupational therapist on the ward, even though she was only doing voluntary work. Jill indicated that her contribution during the year had been well received and this enhanced her overall self-belief and confidence.

> *"The other occupational therapist treats me as an equal and they say to me. 'You are part of the team'. They treat me as part of the team and that is so important in my recovery, you know." (Jill Interview 5)*

Maggi highlighted how the accepting atmosphere and supportive relationships she experienced within her church helped her feel regarded and accepted. The supportive environment coupled with feeling able to speak freely and be listened to, encouraged Maggi to take on new roles within her church including working as a volunteer, which enhanced her feelings of being accepted by the church community.

> *"Well you know they are always very open and very friendly and lots of people to chat to. You get to know all the people here. I went to my church and I attend church three times a week and I am a volunteer in the soup kitchen." (Maggi Interview 1)*

Experiencing a stronger sense of belonging

> *"It makes me feel that I am a part of the community. Yes. Well I suppose I feel part of the community because if you participate in the culture of your community. That's what I'm doing I'm participating in the culture of the community in which I live. (Stewart Interview 3)*

For all the participants there was a clear desire to belong, to feel part of a group or community. This could take several forms, from belonging to a peer-group, to a social group, a church community or even a football club as with Stewart. Stewart explained that being a member of his local football club brought him much enjoyment, especially when he was attending matches. Stewart expressed how in those moments of watching the game, he could just forget his worries and be totally immersed in the game. Additionally, the excitement and energy of watching the game seemed to be a notable contrast to the more mundane aspects of Stewart's lifestyle and this might have been a reason that he identified watching the football games as enhancing his quality of life.

> *"It is the nicest part of my life. It's really exciting watching a football match, a live football match. I find the whole experience is just something that gives me a great quality of life." (Stewart Interview 3)*

Stewart further highlighted how he derived a sense of belonging by being a supporter and felt more connected with his local community. Stewart indicated watching the game with other fans around him as a time where he could blend in and be like everyone else. He was accepted as a fan, had something in common with everyone else, developed a bond of friendship with those around him and shared in the collective experience of enjoying the football match. By being a member of his local club, Stewart was able to participate, feel connected, engaged in the cultural norm and expanded upon his social networks and friendships.

Bert described how being part of their local church provided him the opportunity to widen their social network, support and spend time with others. This sense of community of being part of a church group was also highlighted by Kim, Maggi, Anne and Stewart who similarly mentioned their faith and belonging to a church community as important to their own health and recovery.

> *"Yes, it is the body of the church and the bible describes it by having people, different people, people with different experiences and all wanting to help each other. Obviously you gravitate towards certain individuals more than others. It a sort of self-support group within that small body of the Church." (Bert Interview 1)*

Bert seemed to indicate that he had formed some supportive relationships and felt a sense of acceptance and belonging within the church community. Feeling accepted and a sense of belonging to a community outside of his mental health peers was an important step forward for Bert as he had being reluctant to make new friends, due to his fears of how others might react to him having a mental illness.

Maggi described a level of solidarity amongst those that attended the mental health charity and attributed the bond between members to the fact that they had all experienced mental health issues, which she felt strengthen their acceptance of each other. She also described not feeling judged and everyone seeming to understand and support each other despite their differences as essential to her feeling a sense of belonging within the group.

> *"Yes because everybody is suffering from their mental health, so it makes you appreciate it, you know, that we can meet together like this and no prejudice, you know? People with all different backgrounds." (Maggi Interview 1)*

In contrast, Anne spoke of adopting a much more individual approach to her life in general. Although she was involved in the self-help group and

also a research group, Anne did not feel comfortable to share her personal concerns and issues with others. Anne acknowledged how she found it particularly difficult to speak about her personal trauma and described selecting a solitary journey of self-analysis in working through her own difficulties. Anne's difficulties seemed to stem from a level of mistrust of others, which she spoke of in her previous interviews. This made it particularly challenging for her to feel assured enough to confide in others or feel that she could belong to a group. There was a level of anguish in Anne's comments below around her inability to share her past experiences with others and having to choose a solitary approach in making sense of her own circumstances.

> *"Well it has been a very lonely journey and a lot of the time I wished there was someone I could talk to. I wish there was someone that could see, could share with me the joy of seeing the progress. There is no doubt about it, it is very painful but it is also exhilarating." (Anne Interview 5)*

Looking Outwards and Getting Involved

> *"You feel a sense of self-esteem that you've got something to contribute" (Jill Interview 4)*

A positive sign of improved personal recovery was an ability to move beyond being pre-occupied and concerned about one's own circumstances and being more interested in aspects external to the self. Several of the participants including Jill above seemed to feel that they had more to offer as their self-esteem and confidence increased.

Expressing self and developing confidence through valued activities

The majority of participants within the research were involved in some form of creative activities both for enjoyment but also as a form of self-expression. Some of the participants did so more publicly, whilst others would do so privately for their personal benefit.

> *"I love writing poetry and I felt if I can do that I can put it to lyrics in a song. Well I was quite over the moon actually and when I got the song recorded and I realised how it turned out." (Diane Interview 4)*

Diane described feeling increasingly more confident as she progressed through the year and this increased self-confidence, enabled her to explore new challenges in her life. Diane commented on combining two of the activities she enjoyed doing, writing poetry and music into a form of self-expression and highlighted her surprise when she had a song recorded. This success eventually encouraged Diane to attempt more and led to her reading her poetry over the radio and also singing in public as part of a music group.

Maggi similarly mentioned how she had got involved in art as it was a form of self-expression and also a leisure interest. Maggi indicated her surprise and pleasure at finding one of her pieces of art being exhibited on the Healing and Mind internet site. This resulted in a boost to Maggi's confidence as she expressed a sense of pride and gratification that her artwork had been displayed and had drawn appreciation from others.

> *"They put one of my pictures on the Healing and Mind internet site. Well you get satisfaction don't you? Seeing your work and people enjoying your work" (Maggi Interview 5)*

For Stewart engaging in the artwork was more private and he spoke of the enjoyment he derived from being involved in art and attending the art group. He acknowledged the group support and ability to express his creative skills as a benefit of being involved in art. Stewart also indicated that through his art involvement, he was able to look outwards beyond himself and gain appreciation of beauty that surrounded him. Stewart appeared to gain satisfaction with completing a piece of sculpture, which enhanced his confidence and self-esteem.

"I find it very rewarding. Actually it gives me an insight to something beautiful. It gives me an insight to what it is to see how something beautiful can come about. I have just finished a sculpture actually, which has worked out. It is quite a good one." (Stewart Interview 2)

Gaining positive feedback from voluntary work and community groups

"The occupational therapist treats me as an equal and they say 'You are part of the team'. They treat me as part of the team and that is so important in my recovery, you know" (Jill interview 5)

All the participants within the research apart from Stewart were involved in voluntary work. This included organising and running activities on the acute psychiatric ward (Jill, Diane), to making tea at the mental health charity or providing peer support (Kim, Anne, Peter, Maggi, Bert). Engaging in these activities seemed to provide a sense of purpose, focus and fulfilment as the participants indicated a desire to 'give something back' and contribute towards supporting their peers, especially as they had previously also received help.

In her role as a volunteer on the acute hospital, Diane described drawing upon her previous experiences to support those in hospital. Diane derived a sense of satisfaction in being available for other service users, supporting them in their time of need or just empathising with their circumstances. Diane also described the trust she received in carrying out tasks on her own as approval of her contribution, and mentioned feeling her confidence multiplying as a consequence. Her positive experiences as a volunteer over the past year seemed to help Diane to realise her own potential capabilities.

"I am also a volunteer at R and in the Internet Café; I make teas and coffees and work with friends at the Internet Café at the hospital."(Diane Interview 1)

Bert mentioned how his involvement in the research and self–help group provided him with the opportunity to contribute and widen his social circle. Bert highlighted the boost in his self-esteem as a result of being approached to be involved in this capacity. Bert also described how the time spent building relationships, getting to know other people more, helped to cement the bond between members within the group. Bert's specific involvement in the self-help group and research group seemed to provide him with a reciprocally supportive and accepting relationships with others, where he could discuss his thoughts, express how he felt and be himself outside of his secure home environment.

> *"I've been involved with the research project and other meetings I've been asked on. You meet lots of people and you also feel a sense of self-esteem that you've got something to contribute." (Bert Interview 1)*

Stewart chose not to volunteer, describing how he struggled with many different aspects of his daily life and that trying to remain mentally stable was more than enough of a challenge. Stewart seemed worried that by doing more, he would struggle to manage and described how the task of looking after his flat was more than enough for him to cope with.

> *"Yes in some ways. I don't want to have anything more to deal with that is stressful than managing the flat really." (Stewart Interview 1)*

Perhaps Stewart's previous experiences of not managing with his daily tasks and routines, led him to doubt his ability to cope and manage. Stewart may have been conscious of how not managing his stress levels could potentially lead to him having a relapse of his mental health, which he was keen to avoid.

Increasing self-esteem from making a contribution to others

The majority of participants indicated how their increased self-esteem made them more confident in contributing in different areas of their

interest and conversely that the positive outcomes from such contribution promoted their confidence and self-esteem to continue with contributing in additional ways.

> *"Sharing our experiences at the lecture, that was such a great opportunity, and there are people that were saying, that it had been so valuable for students to hear" (Kim Interview 5)*

Kim indicated her involvement in delivering lectures and sharing details about her conditions with students over the past year. Despite feeling nervous, Kim appeared to see it as an opportunity to share her own story and help others to understand what it was like to have a mental health condition. This experience seemed to have a very positive impact on Kim as she described how her input was well received and regarded by the students, which enhanced her view of her own contribution.

Peter described how involvement in the service user movement and the work he undertook had contributed to keeping him mental stable as he has had something to focus on and contribute towards. In the first interview, Peter described how he felt the need to get involved as he was aware that many of his peers were less stable and needed help. Peter subsequently decided he would represent their interest and became chair of the service user group.

> *"Because the service user work I do has helped to keep me stable, it has given me something to do." (Peter Interview 2)*

In contrast, both Maggi and Stewart felt less able to contribute in this respect. Maggi mentioned that she was involved in the mental health charity and had helped in the basic task of making tea and coffee for the group but did not feel she could contribute in other ways. There seemed to be a lack of confidence in Maggi's that she would be capable of contributing in other ways or what she had to offer would be good enough. Stewart on the other hand did not feel able to contribute because

he was reluctant to be affected by changes within his set routine. Stewart therefore chose to be involved in areas where there would not be too much disruption to his regular lifestyle.

Enjoying flow and transcendence (e.g. walking, singing, artwork)

The majority of participants indicated that they derived a sense of 'flow' and fulfilment in the activities that they were engaged in. Diane described a sense of being in the 'flow of the moment', being meaningfully involved and gaining pleasure in the chosen activities. Peter indicated feeling 'in flow' whenever he went walking, describing how he was able to be free from his stresses when he was walking and would be so immersed in the experience that he would forget about his problems. Peter also identified by the end of the year that alongside spending time with his brother, that walking was the most important contributor to him remaining well and in recovery. Peter clearly felt that his walking and overall recovery were interrelated and expressed a deep desire to remain well enough to continue with his walking.

> *"That is the other thing I hope, I will be in good health to do the walking. That is important. I hope that my recovery will continue for as long as possible." (Peter Interview 1)*

Kim mentioned a similar experience with singing and explained how 'in that moment' she would be totally 'caught up' in the experience of singing. Kim felt that for her, singing was cathartic, emotional and uplifting, and she seemed to be energized by it. The enjoyment Kim derived from singing subsequently persuaded her to join the church choir.

> *"Singing is a great thing for me. I mean I sing in the choir at Church because I find it physically very good for me and very uplifting" (Kim Interview 4)*

This view about singing was also shared by Diane who felt that singing brought her much enjoyment and she identified with Kim in feeling that she was almost in 'a world of her own' when she was singing. Diane was so 'caught up in the flow' of singing that she seemed to be lifted above her concerns in life. Diane enjoyed singing to such an extent that she eventually started having singing classes and like Kim started to perform in public when she joined a music band during the research year.

Anne, in contrast to the other participants, did not describe getting so involved in any activity where she enjoyed flow and transcendence. Although Anne was involved in the self-help group, exercise group and mental health charity, the majority of Anne's time was spent trying to find a solution to her mental health concerns, which were around her fears, guilt and self-recrimination. This seemed to be a constant pre-occupation of Anne's as she was determined to find an answer to overcoming her mental health difficulties.

Feeling more committed to looking after own health and well-being

All the participants were keen to ensure they remained well and made progress in their overall health and recovery. For some participants this involved pursuing activities that they felt would directly contribute to their overall health, whilst other participants chose to avoid situations or circumstances they felt were detrimental to sustaining their recovery. At times the respective participants would feel in control of such events, however at other times they felt powerless.

> *"I know what it felt to feel absolutely impossible to get out of bed, so actually to do that and come back on my own was a great sense of achievement." (Kim Interview 2)*

Kim highlighted above how she had felt so much more confident within herself over the year that she decided she would plan a trip to Rome on her own as she had always wanted to visit the Vatican. For Kim this was a substantial plan and she acknowledged that succeeding in doing so

would be a huge boost to her self-esteem and belief. During the course of the research year, Kim did manage this and mentioned in latter interviews how she struggled to believe that she achieved such a feat, especially when she looked back at how unwell she had been previously, struggling to even get out of bed.

Diane, like Kim, mentioned how her self-esteem and confidence had improved over the year due to her taking on new challenges in her life. Although Diane described being a little worried about facing the unknown and taking on new experiences, however her successes and sense of achievement helped her to see herself quite differently and enhanced her overall well-being. Diane also recounted how she had decided to get involved with planning the Mental Health Day, which was not something she would have done before. Although she was nervous about meeting new people and making suggestions, Diane felt that the positive experience she had gained before helped her to feel confident in offering her input.

> *"I have done quite a lot of things. An awful lot of positive things actually. I do feel that I am kind of moving forward now." (Diane Interview 5)*

Stewart described a different set of events when his plans to remain well were impacted by actions outside of his control as highlighted by a change of his psychiatrist. Stewart felt aggrieved about not having any notice of such a change happening especially as he had established a long-term and trusting relationship with his present psychiatrist. The possible consequences of such a change seemed to be lost on the professionals involved in his care, where they failed to realise the impact their actions would have on him.

> *"I don't know if she is going to be reliable or not. I have been someone who has mental illness, a chronic illness." (Stewart Interview 5)*

Stewart might have reasonably felt anxious about his new psychiatrist; being concerned if they would get on together; if she would be understanding and would his health and recovery continue to be stable or improve despite such a change. There was a sense of Stewart seeking certainty and reassurance that his professional care would not be adversely affected, especially as he was focused on ensuring his health and recovery would continue without interruption.

Peter similarly spoke of not liking change and indicated that having consistency and predictability in his life was, he felt, important for his overall health and well-being. Peter described how he had been reproached by health professionals for being resistant to change. However, Peter highlighted that this reluctance to embrace change was not only an issue for him personally, but a view he felt was shared by other service users too.

> *"I suppose I didn't like idea of change which is something I am still accused of by mental health professionals. The thing I've been saying that people have reacted positively to is that mental health managers need change more than mental health users" (Peter Interview 1)*

Additionally, Peter seemed to express annoyance at how such decisions being made would impact on his health and recovery, despite him trying to do all things to ensure a smooth passage of recovery.

Coping with Life's Challenges

> *"I have been through the rapids and survived" (Peter Interview 5)*

All the participants indicated that a sign of them making progress and getting better was the ability to cope with both predictable and unpredictable life challenges. Several of the participants' highlighted instances where they had managed to draw upon personal resources and

resilience to overcome their life difficulties, as highlighted by Peter's comments above, or had succeeded in facing a new challenge, which enhanced their self-confidence and belief.

Bert adopted the metaphor of the Kawa 'River' model, just like Peter, and mentioned the importance of feeling more in control of his life. Bert felt that the image and analogy of a river were reflective of his life journey at the present moment. Bert described how he had been relatively stable in his mental health for some time and felt the gentle meander of the river was reflective of his current life stage. Bert seemed to be pleased that things were more predictable and settled and he felt more able to deal with his life circumstances due to his increased self-confidence and achievements.

> *"Well I think it is very relevant because it is a period of my life where it has become a bit like a gently meandering river in a sense, rather than in flying around rocks and problems." (Bert Interview 5)*

Peter highlighted a determination to regain control of his life circumstances and spoke of taking the initiative in his comments below. Peter appeared compelled to represent both his own interests and those of his peers, and explained how a situation had arisen around the housing charity that had encouraged him to get involved as he felt he was in a position to help those less able than himself. Peter's confidence and experience helped him to cope with the uncertainty and manage the situation to the best of his ability.

> *"What spurs me to fight these battles is that there are people out there who are back where I was 20 years ago. They really need this support and it worries me that they might not be getting it." (Peter Interview 1)*

All the participants also highlighted how the confidence they had developed through involvement in a variety of activities including being a

volunteer, creative activities, social groups and public performances, had helped them to develop their self–belief, resilience and self-esteem to feel able to meet new challenges in their life..

> *"I am feeling much more positive. The problems seem to be shrinking or I am coping with them better or I am looking at them in a more positive light. I am much more optimistic." (Diane Interview 4)*

Diane explained how the confidence and skills she gained from singing and reciting her poetry, being part of the self-help group and through volunteering gave her the belief and positive attitude that she could overcome and manage her challenges in life. This new confidence and self-esteem was crucial in supporting Diane sense of achievement and personal recovery.

Reappraising obstacles and stressful aspects of life

Several of the participants also commented on how they had started to reappraise different aspect of their lives and the situations they were in, during the research year. They indicated gaining new insights as they reflected upon their recovery journey through using the Kawa maps and also by talking things through during the interviews with me being the researcher.

> *"Yes because I am exploring with you by asking questions, making me think deeply about what these things mean to me and how important they are." (Jill Interview 5)*

Jill describes in her comments above the process of exploring her own circumstances as she both looked at the Kawa maps she had created and also reflecting upon her experiences. She also indicated how being asked to examine different elements in her Kawa maps led her to reassess the important aspects of her own life and recovery. This aspect of the interviews will be further explored in the next chapters.

"I feel having talked to you about these two events in my life, I feel happier about having had the chance to think it through talking to you." (Peter Interview 2)

Peter similarly highlighted the opportunity to talk things through during the interviews and that examining his Kawa maps helped him to gain additional insight and understanding about his relationship with his mother and his flatmate. Peter seemed to also feel that the interview sessions provided the space for him to think through and explore his thoughts and views rather than merely talk about his experience with regards to recovery. In fact Peter described in a later interview how he viewed the interview session as almost like a form of therapy.

"Well as you say you get everything in the picture and you can see where you can improve on it you know?" (Maggi Interview 5)

Maggi similarly mentioned how she developed new insights from using the Kawa maps and reflecting upon what she had created. Maggi appeared to benefit from being able to visualise her recovery experiences, deriving an additional perspective of her life. The ability to reappraise life circumstances with a new perspective appeared to help the participants evaluate different aspects of their life and enhance their overall perspective on personal recovery.

An Evolving Journey

"Life travels like a river…it moves (Kim Interview 5)

All the participants acknowledged that their lives were not static during the year and evolved and changed in different ways. Some participants felt different about themselves and seemed to rediscover parts of their former self that they seemed to have forgotten, whilst others developed new identities due to different interests and involvement during the year.

Feeling different

> *"I just feel more confident that I can do things you know." (Peter Interview 5)*

The majority of participants spoke of perceiving or understanding themselves differently by the end of the research year. Some of the participants like Peter above attributed this to a new level of self-confidence and belief, however others described a reappraisal of who they were, i.e. feeling different about themselves or noticing aspects they were unaware of previously. Maggi explained how she felt differently about herself as she gained a new perspective of who she was. She also felt more able to articulate what she wanted and what she felt was important to her due to a new level of personal insight and understanding.

> *"Well you get things in the right perspective you know what I mean? What's important and what's not so important" (Maggi Interview 5)*

Jill described how she felt different about herself and what she was capable of, linking this with being actively involved in volunteering and also her role in the self-help group. By undertaking a new role as a peer support and working with service users on the acute wards, Jill seemed to feel more confident and assured. This new self-belief seemed to assist Jill in managing the various changes she had to face in her recovery journey.

> *"Oh I do feel a lot different. I mean I have accepted the changes that have been going on in my life." (Jill Interview 4)*

Diane spoke of wanting to move onto something new, finding a way forward in her life. Diane described how being ill for such a long time had held her back and now that she felt different about herself, she was able embrace a side of herself that had remained almost concealed due to her long-term health condition. In a sense Diane seemed to be breaking away

from being stigmatised by her diagnosis and seeking a new direction for herself.

> *"I am actually starting to move forward which is a real big step, you know, in the direction I need to go because I have been ill for so long." (Diane Interview 5)*

This ability to self-evaluate and reflect was a crucial element of recovery and feeling better or more confident was an indicator of increased self-belief. Participants highlighted how their self-perception had changed over the year as they felt more positive and optimistic.

Defining a new sense of self

The majority of participants, apart from Maggi and Bert, seemed to indicate that through the research year they had discovered a new sense of self. They attributed this change to new interests and involvement in aspects they had previously not been engaged in or a consequence of feeling more confident or perceiving themselves differently than before.

Diane similarly described how she had started to inhabit a new world that she was unfamiliar with, one that she did not know existed or was opened to her. Diane's experiences through the whole year had shifted and changed so substantially that she seemed almost unable to recognise her former self. In her year Diane had starting both singing and reciting her poetry in public, been on the local radio and started a new music group on the ward and was, adopting new roles and responsibilities.

> *"Well I've moved to this kind of new world in a way. It is a kind of new world. I am in a different set up completely." (Diane/03/09)*

Anne described a journey of looking inwards and discovering hidden aspects of herself. She used the analogy of peeling an onion to signify the layers of personal discovery she had gained through using the Kawa

maps and interview sessions. Anne described reaching what she felt was a decisive point in her life and used the analogy of unpeeling an onion to symbolise her journey of discovery and recovery.

> *"I have managed to reach the core if you like. You know people compare it with an onion. I am the centre of the onion. All the layers have been pulled back and then starting to see the end of the tunnel. I find areas where emotions were distorted by lies and I am able to slowly undo them and in reality to feel the truth and emotion to feel the truth. That is where I am at." (Anne Interview 5)*

Perhaps Anne felt that she was emerging from the tunnel of her 'fear and confusion' as she mentioned in her comments below and gaining enlightenment over her life circumstances, a sense of being able to discern the truth from the lies that had preoccupied her thinking. Anne seemed to describe reaching a turning point where she was rediscovering aspects of herself and gradually locating an identity that had been loss.

Anne further used the metaphor of the river and the concepts within the Kawa model to describe her life journey and experiences. Anne used the image of rocks 'floating to the surface' to describe how she felt her perception of her past traumatic experiences and difficulties had started to shift. Anne seemed to identify with these 'rocks' as problems emerging from the hidden depths of her river and beginning to float up to the surface and then floating away. Anne seemed to indicate that if her problems were capable of rising to the surface and floating away, they could not then be so heavily entrenched or insurmountable for her to be able to deal with and overcome.

> *"They are kind of floating to the surface so they can go away. What was deep in the unconscious emerges. This cannot be heavy because it is floating and that is the reality. Yes they are weighing less on me. I didn't mean it but it worked out that way. I didn't do it consciously but it makes sense." (Anne Interview 5)*

In contrast both Maggi and Bert, who did not experience many fluctuations throughout the year, did not note much change in their own identity or self-image across the year. They seemed to consolidate who they were, by spending time engaged in their previous interest and carrying out the same occupations. Further exploration of the functions of the Kawa mapping will be provided in the next chapter.

Feeling able now to express hopes and aspirations

All the participants expressed a desire to move forward and felt positive about making progress in their personal recovery. Diane described a new sense of hope and optimism that she was heading the direction she wanted to go. Diane expressed confidence that she would be able to move beyond her illness to aim for new path in her life, with prospects for new opportunities.

> *"I am actually starting to move forward which is a real big step, you know, in the direction I need to go because I have been ill for so long." (Diane Interview 5)*

Kim was similarly determined to move away from being seen a sick or dependent person, to one focused on contributing to the welfare of others. Kim expressed a desire to acquire a new identity beyond her previous perceived status as a mental health service user, being determined to put everything in perspective. As her recovery progressed Kim recognised that her illness did not fully defined who she was as a person and she expressed a sense of hopefulness for her future.

> *"Being ill was a tiny bit of my life, look at me I am actually not a psychiatric patient."(Kim Interview 4)*

Anne noticed an improvement in her recovery through her views about intimate relationships. Anne had indicated that due to her previous trauma, she had difficulties in trusting men, however from the comments below during her final interview that Anne's attitude seemed to have

changed. Anne seemed to have made a breakthrough where she had reached a point where she had developed the courage and confidence to contemplate being in a relationship, which was a considerable step forward for her.

> *"Thinking about having a partner is something I had forgotten about. Well it turned out quite recently that the person I was interested in, he mentioned he would just like to be friends with me, so that is a bit of a setback." (Anne Interview 5)*

The new sense of hope and aspiration was evident in the way the participants evaluated their lives and their attitude to the challenges they were to face in the future. In having increased self-confidence and belief the participants seemed to feel more positive and optimistic and were willing to engage in new opportunities and interest which promoted their health and recovery.

Summary

This chapter has focused on the personal experiences of mental health recovery and examined factors considered influential to personal recovery from a phenomenological perspective, via the use of Interpretative Phenomenological Analysis. The chapter has presented the convergent and divergent views across the cohort of participants in respect of the super-ordinate and sub-ordinate themes that arose from analysis of the interviews.

All the participants were able to engage in the interviews and explore their own interpretation and experiences of personal recovery. As the research year progressed they seem to become more immersed and conscious about their personal journeys of recovery over the year. Despite their long history of mental health problems the participants as a whole seem to be able to make their own progress in their health and recovery.

The next chapter to follow will examine the contribution of the Kawa model and maps, and adopt a collective focus highlighting the perspectives of the whole cohort of participants as they experienced and reflected upon the use of their Kawa maps across the research year.

Chapter 6 Second Findings Chapter (Collective perspectives of the Kawa model)

Introduction

This chapter will present the views, thoughts and experiences of all the research participants with relation to how they perceived the Kawa Model (KM) in assisting them to explore and understand their own mental health recovery. The chapter will respond to the research question: What is the contribution of the Kawa 'River' Model in exploring the personal journeys of recovery of mental health service users? The chapter will first provide an overview of the use of the Kawa maps; examine the analysis of the Kawa maps through the use of the Kawa Model Framework Index; explore the contribution of the Kawa maps and river metaphor in assisting participants to derive personal insights and discoveries; examine the perspectives and reflections of the participants in using the Kawa maps and outline the perceived strengths and limitations of the Kawa model.

Throughout the chapter the term Kawa model will be used to describe the overall framework whilst Kawa maps will describe the visual representations made by the participants. Where appropriate, examples of the Kawa maps created by the research participants will be included to illustrate its use and value.

Overview

All eight participants attended their interviews throughout the research period, with each creating a Kawa map at each interview, resulting in a total of forty Kawa maps across the eight participants. I further engaged the participants in a process of exploration and discussion following the creation of their Kawa maps. Kim's series of five Kawa maps (Diagram 13, Maps K01-05), created at three monthly intervals, have been included below to demonstrate their composition and form. These maps illustrate Kim's lived experience and recovery through the year and present in

visual form, the circumstances and elements she deemed influential during the period.

These Kawa maps provided both a snapshot in time (an individual map) and also a longitudinal perspective (series of maps) unique to each participant, and enabled both the participant and I to attain a visual record of lived experience and recovery of each individual. For Kim and the rest of the participants, the Kawa maps featured a combination of **Challenges and Life Difficulties (Rocks), Assets & Liabilities (Driftwoods) and Environmental Factors (River sides and base)** that they perceived as instrumental to their personal recovery.

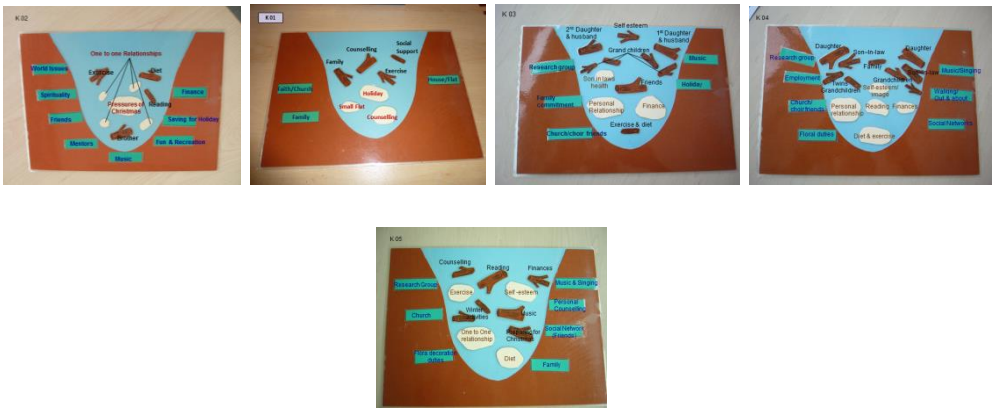


Diagram 13 Kim's Series of 5 Kawa maps (K01-K05)

Analysing the Kawa Maps

The visual representations within the Kawa maps were analysed by means of the Kawa Model Framework Index (KMFI), which I developed specifically to analyse the series of Kawa maps created by each participant. With IPA used to explore the verbal accounts and meaning assigned to the objects represented in the maps. Through the use of the Kawa Model Framework Index, I was able to observe an emerging pattern of factors considered by each participant as instrumental in their

recovery. By examining the Kawa Model Framework Index illustrated in Table 10, and looking vertically down the respective columns I was able to ascertain what each participant highlighted as contributory elements in their recovery. Further through examining these elements alongside the participant within the final interview, I was able to establish the perceived impact that each element or experience had upon each individual's recovery.

Collective Perspectives

The Kawa Model Framework Index could be used to analyse both the individual and also the collective Kawa maps created by all eight participants. The collective perspective provided a detailed view of what the cohort of participants considered as influential in supporting or hindering their mental health recovery. Although the findings derived from the eight participants could not be generalized to draw conclusions for all individuals with mental health issues, it did promote a greater awareness and understanding about what was mutually perceived as influential across the cohort. The Kawa Model Framework Index presented in Table 10 indicates the different elements highlighted within the Kawa maps of all the eight research participants. Within Table 10, the X represents challenges/ life difficulties (Rocks); E represents environmental factors (River sides and base) and A represents Assets and L represents Liabilities (Driftwoods).

Table 10 Kawa Model Framework Index (Factors highlighted by all Participants)

Personal Kawa Maps	Anne	Bert	Diane	Jill	Kim	Maggi	Peter	Stewart
Challenges/Life difficulties/ Concerns (Rocks)								
Marriage Issues			X					
Lack of confidence			X					
General Relationships & Interactions			X	X	X			X
Family relationships (Partner, Siblings, Children)			X	X	X	X	X	
Concerns about brother							X	

Concerns about flatmate							X	
Running out of meaningful occupation/ activities (Walking)							X	
Coping with change				X			X	X
Change in Health Professionals				X			X	X
Mental Health Condition and Related symptoms	X					X		X
Health, Exercise and Diet		X		X	X	X		X
Benefits/ Pension/ Finances					X			X
World Events						X		
Counselling					X			
Accommodation					X			X
Seasonal pressures (Christmas)				X	X			
Poor Self-esteem/Image					X			
Concentration					X			
Stress	X			X				X
Trauma	X							
Guilt	X							
Assets (A) or Liabilities (L) (Driftwood)								
Creative Engagement/ Occupations:								
Singing/ singing lessons			A					
Music /guitar			A					
Poetry/ writing poetry			A			A		
Music & drama group		A	A					
Art/ Art Group						A		A
Watching football								A
Being on the Radio			A					
Walking							A	
Outings			A			A		
Self-esteem/ positive attitude	A	A			A			
Relating and relationships (Partner, Sibling, Children)			A	A	A		A	
Involvement in Sports			L		A			
General Health			L		A			
Friends	A		A	A	A			
Mental health support/ user involvement		A		A		A	A	
Welfare Benefits & Finances					L	L	L	
Housing							A	
Knowledge & Information	A							
Medication		A					A	A
Professional help		A		A	A		A	
Social support	A				A			A
Family				A	A			A
World Events					L			
Positive Experiences		A						A
Determination	A							
Mental Health & Insight	A	A						
Resilience and perseverance	A							
Faith		A						A
Voluntary work	A	A	A	A	A	A		
Environmental Factors (River sides & base)								
Social Networks	E	E	E	E	E	E		E
Noisy/stressful environment			E					

Family	E	E	E	E	E	E		E
Holiday			E		E			
Finance	E	E	E		E			
Supportive Relationships	E	E		E	E		E	E
Mental Health charity	E				E	E	E	
Housing					E		E	E
Freedom Pass							E	
Professional Support/ Help	E			E	E		E	E
Beliefs & Faith groups	E	E			E	E		E
Employment/ Work					E			

Examining the Kawa Model Framework Index (KMFI) in Table 10 provided me with a collective assessment of the respective factors that the participants identified as influential in their lived experiences and recovery across the research year, as visualised in their Kawa maps.

In terms of **Challenges and Life Difficulties (Rocks)** which were influential to their recovery journeys, more than half the participants identified Family Relationships (encompassing those with partners, siblings and children), General relationships and Interaction (with a wider range of individuals), Health, Exercise & Diet as challenges they encountered. Less common but still indicated by three of the eight participants, were the issues of Dealing with Stress, Related symptoms of Mental Health condition, Coping with Change and New Health Professionals.

In terms of **Assets & Liabilities (Driftwoods)**, represented by the letters A & L respectively within Table 10, Friendships, Help from Mental Health Professionals, Relationships and Relating (to partners, siblings and children), Self–esteem and Positive attitude, Voluntary work and Service User involvement were all areas highlighted by more than half of the participants as Assets in supporting their mental health recovery. Additionally, the participants also identified a whole range of Creative activities and occupations which they engaged in, such as Singing, Art, Music, and Poetry as assets too in supporting their health and recovery. Whilst the major Liability identified by the participants within their Kawa maps as having a negative impact was, Welfare Benefits and Finances,

with the concerned participants highlighting the insufficient amount of benefits they received and limited finances as a definitive concern.

In the area **Environmental Factors (River sides and base),** the key features of influence were Social Networks, Family, Beliefs and Faith Groups, Mental Health Charity, Professional Help and Support, Finances and Supportive Relationships. Some overlaps were noted with certain factors such as Family, Support, Relationships, and Health professionals featuring across several of the Kawa component areas. This was within the workings of the Kawa model and maps, where participants could indicate each factor as being influential in different ways, for example Family could be viewed by the individual as an Asset but also an Environmental factor or even as a Rock. What was important was determining how the individual perceived and understood the impact of the different factors/elements within their lives and how these were represented within their Kawa maps.

The KM as mentioned previously does not dictate what each element must be, nor is it concerned with how each element is perceived by the individual. Instead what is more important within the KM is appreciating how each person makes sense of their own world and spectrum of lived experiences. Indeed the Kawa Model Framework Index provided a unique record of the recovery journeys of the participants over time and I was able to appreciate how the participants might value and prioritise their future involvement amongst their various interests.

Contribution of the Kawa maps towards Understanding Recovery

An alternative perspective of recovery

All the participants within the current research expressed how engaging with the Kawa maps provided them with an alternate perspective of their recovery. Kim mentioned how the Kawa maps represented a vivid visual

record of her recovery journey and described how conceptualising her life and recovery as a river journey resonated with her. Kim felt that her personal journey seemed to alter and change just like a river flowing through its course and equated the natural flow and changes in a river as representative of the fluctuations in her own life, as noted in her quotation below. Creating her Kawa maps, working with the river metaphor and evaluating the elements in her Kawa maps, for example (Diagram 14, Map K04) below, appeared to enhance Kim's appreciation of her life circumstances and journey through recovery.

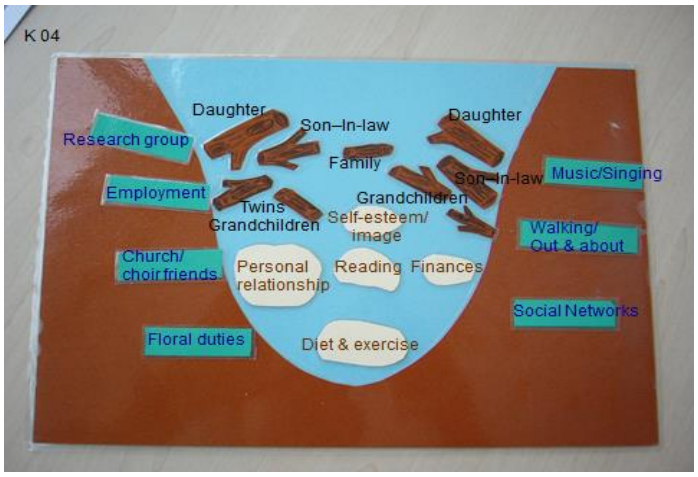


Diagram 14 Kim's Kawa Map 04

> *"Looking at recovery as a river is quite wonderful for me because we know a river is moving, it ebbs and flows with the current and I think that is what our lives do. If you look at a river, it's flowing fast, we've had a lot of rain and it's bursting and it's quite…you can see the turmoil but when it has been calm, you've had a calm period, the river is calm." (Kim Interview 4)*

Kim's views were echoed by the majority of the participants, who similarly mentioned they were able to identify with the river metaphor as symbolising their journey through life. They acknowledged that relating to the concept of a river representing their lives helped them to better comprehend their own recovery experiences and all agreed that working

with the visual maps generated a clearer perspective of their recovery experience promoting new insights.

Jill similarly described how she was able to identify with the metaphor of a river representing her life journey and highlighted that the Kawa maps helped her to examine both her past experiences and future plans. Jill also felt the Kawa maps were all-encompassing, enabling her to represent and explore all the different aspects of her lived experience, enhancing her personal understanding and evaluation of her own recovery.

> *"Well it is a metaphor isn't it? It is a sign showing you how your life has gone and if you really think about it, you could put every little event on it. Most rivers meander along and that is what life is like? I understand myself far better now than I did." (Jill interview 5)*

All the participants also described how the opportunity to explore their Kawa maps assisted them in a more objective way to examine the differing impact and influence that specific factors had upon their lives. Creating the series of Kawa maps seemed to have the effect of helping the participants to reassess how their lived experiences and recovery journey had changed and evolved over the past year and enabled them to work towards making plans to sustain their health and well-being.

Reflecting and considering what is influential to recovery

The process of engaging with the Kawa maps, required dedicated time and space, with participants investing in a process of reflecting upon their own lives as they constructed their maps and in later interviews, as they reviewed earlier maps. All the participants acknowledged that having time to think and reflect was an experience they associated with using the Kawa maps and which they valued. Additionally, constructing the Kawa maps required the participants to consider the wider contextual and

interrelated aspects of their daily lives, for example their relationships with church friends or anxieties around going on holiday.

Peter commented about the value of moving beyond the obvious and considering the contribution of the inter-related aspects of his recovery. There was a sense that achieving recovery was more than just feeling better or getting '*your life in order'*, but involved addressing a wider range of areas for example relationship with flatmate and accommodation, to achieve health and well-being. In the quotation below and in Diagram 15, Kawa Map P03, Peter indicates how he took the time to consider, and ponder what he would place within his map. In deliberating on constructing his map, Peter seemed to be creating his own sense of meaning through categorizing his experiences within the images available within the model. Peter engaged in a careful process of labelling his experiences and in so doing, seemed to derive more clarity about what influenced his health and recovery.

> *"I'm wondering if brother shouldn't be an environmental factor rather than one of the logs because if the logs are things that help me to keep going and my brother is definitely one of those. Then I would definitely do another log for the walking. And I will do another log for being involved with the User Movement. I am still fairly involved in that." (Peter Interview 3)*

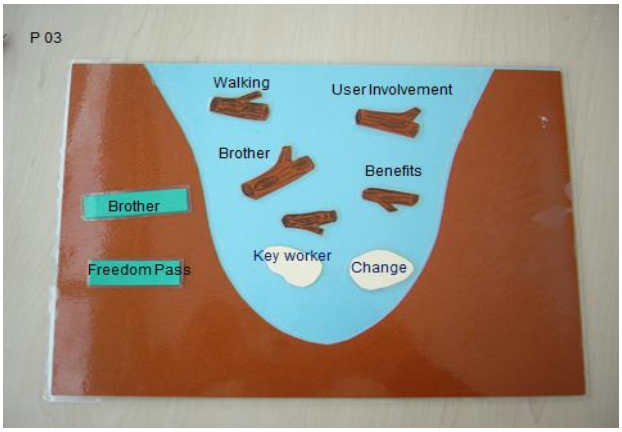


Diagram 15 Peter's Kawa Map 03

Stewart similarly described how creating the maps enabled him to derive a deeper level of understanding of the wider range of issues that had an impact on his life. The structure provided through the Kawa model in looking systematically at the different components (challenges, assets, liabilities and environmental factors) provided Stewart with a systematic way of analysing how each element had contributed to his lived experience and recovery.

> *"Well it has prompted me to think about the issues that I have to deal with in my life. It sort of prompted me to think in a structured way; I think, about the problems, the issues that I have to manage actually. It has been a good thing." (Stewart Interview 5)*

All the participants also acknowledged that the period of exploration, reflection, dialogue and questioning following the construction of their Kawa maps was a feature which they found both insightful and revealing. This aspect of talking through, explaining the representations and reflecting upon their maps was regarded by all the participants as a key benefit of working with the Kawa model and maps.

> *"Yes because I am exploring with you by asking questions or making me think deeply about what these things mean to me and how important they are now and how important they have been to my recovery. Everything so it is good." (Jill Interview 4)*

Jill highlighted the value of this unique aspect of working with the Kawa maps in the above quotation, identifying how the process offered the opportunity for self-examination, interrogation and personal scrutiny as positives. By looking at the Kawa maps together and engaging in the subsequent dialogue, Jill seemed to move towards a process of self-evaluation, investing her efforts to better understand herself and arrive at a solution to her circumstances.

Strengths of the Kawa Model, according to Participants

All the research participants expressed a range of opinions about the Kawa model and its potential in helping them to map and examine their own lived experience and recovery journey. These included differing perspectives of the strengths and limitations of the Kawa model and maps. Table 11 provides a summary of perceived strengths and limitations of the Kawa Maps as indicated by all the participants.

Table 11 Summary of the participants' view of the value of the Kawa Model/ Maps

	Anne	Bert	Diane	Jill	Kim	Maggi	Peter	Stewart
Strengths								
Clarity & empowerment	X	X	X	X	X	X	X	X
Reviewing changes in life and recovery	X	X	X	X	X	X	X	X
Self-discovery & personal growth	X	X	X	X	X	X	X	X
Ease with identifying with the Kawa concepts	X	X	X	X	X	X		X
Limitations								
Not remembering the components				X		X		
Jargon & Terminology							X	

The participants as a whole were positive about the Kawa model and saw the strengths as: Clarity and empowerment; Reviewing changes in life and recovery; Promoting self-discovery and personal growth, and Ease with identifying with the Kawa model. In terms of limitations only Jill and Maggi mentioned having difficulty at times remembering the respective Kawa components for example the meaning of 'rocks', whilst Peter described some reservations early on in the interview sequence about the river metaphor and terminology related to the Kawa model. The rest of

the participants did not voice any perceived limitations about the Kawa model and maps.

Clarity and empowerment through creating the Kawa maps

All the participants describe gaining clarity in creating and examining their personal maps as a particular strength of the Kawa model. They indicated how the process of contemplating, visualizing and assigning pieces within the Kawa template, promoted insight and better understanding of their own life journey. Kim described how she derived a greater sense of personal awareness and understanding through the creation of her maps. She also felt that it was important to get fully involved in the process of creating, revising and engaging with the Kawa maps in order to arrive at a fresh perspective. Being able to move the component pieces around the map and to shape the image meaningfully, whilst also exploring how things could be different was an aspect that all the participants valued, highlighting the benefits of examining different scenarios and possible solutions.

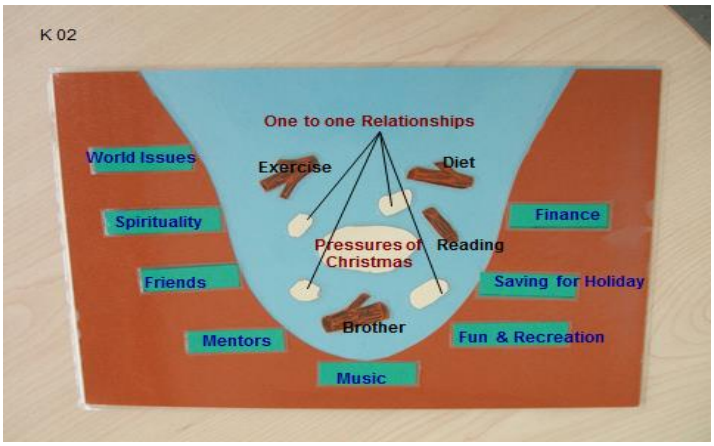


Diagram 16 Kim's Kawa Map 02

> *"I never saw it that way but I can see it in the way of a river, now that I have actually fiddled about with all this little bits and pieces, it is a different situation. (Kim Interview 2)*

The opportunity for manoeuvring the different elements within her river map and exploring alternative solutions and outcomes seemed to helped Kim feel more empowered and in control of her life circumstances. In creating Map K02 Diagram 16, Kim took time moving the different components around before she felt satisfied with where they were placed, to best reflect her circumstances. The ability to change different aspects of her life within her maps might have helped Kim feel more able to dictate her own recovery journey.

Anne similarly described feeling enlightened and empowered through engaging with the Kawa maps. The process of spending time creating, examining and then talking about the different elements in her Kawa maps, appeared to provide Anne with an added sense of clarity and she appeared to better understand what she needed to do to improve upon her present situation. Anne also mentioned the word 'reality' in her quotation below underlining the importance of verifying her own thoughts and perception of events in her life: a need to perceive circumstances as they actually are rather than a biased view of the progress she had made in her recovery. Creating the Kawa maps seemed to lay bare her own multi-faceted life and Anne began to accept the positives and also the contributions she had made, which she had struggled to acknowledge in the past.

> *"It helps me to focus with one glance on reality. It helps me to remember and therefore, you know, to be aware of what I have achieved. I can't fool myself and make it go away. It is there. I can't cheat myself. It also helps me to see what good things I have in life. To see the positives." (Anne Interview 5)*

Reviewing changes in life and recovery

Another distinct strength of the Kawa maps highlighted by all the participants was that it provided both a visual representation and record of their current life circumstances and enhanced the opportunity for

further exploration. This unique quality of Kawa maps and the opportunity to review previous maps created was universally identified by all the participants as something which they felt was beneficial and of importance.

Bert described how the Kawa maps provided a clear visual way of seeing what was happening in his life and helped reduce his confusion. Bert could observe the challenges he faced, view his assets and draw upon the environmental factors he had available to manage the challenges in his life as seen in Map B03 Diagram 17. Bert was then able to prioritise and ensure that he focused on the specific elements in his life, such as keeping mentally stable, taking his medication, engaging in meaningful activities (computer skills and using the library), involvement in the service user group and church, family relationships and keeping in contact with health professionals to promote and sustain his health and recovery.

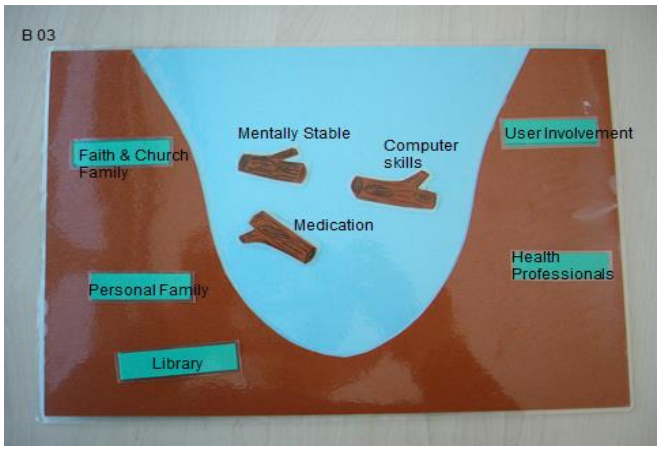


Diagram 17 Bert's Kawa Map 03

> *"Everything becomes much clearer as I look at this. I can see what is helping and what I need to do to stay well."(Bert Interview 3)*

Maggi similarly valued the visual aspects of the Kawa maps and felt it enabled her to understand how different elements in her life had impacted upon her health and recovery. Examining her own map revealed what

factors were particularly influential and by externalising or objectifying her concerns and representing them within her personal map, Maggi was able to step away, reflect and gain an appreciation of her changing life circumstances.

"Yes it is very helpful. You can see things, where you can improve." (Maggi Interview 5)

Similarly, Jill highlighted the benefits she gained from examining the earlier Kawa maps J02 Diagram 18; she had created as she noticed some recurring patterns within her life. Jill described how health professionals seemed to feature prominently within all her visual maps and this triggered her to reflect upon her dependency for such support. Jill was then able to redress the balance and decide upon getting more involved in self-help groups and to draw upon peer support. The ability of participants to draw upon such a feature of the Kawa maps seemed to highlight its therapeutic potential. Jill appeared enlightened by this process of exploration and concluded that to be freed from the 'sick role' she might need to reduce her over dependence upon professional help and support.

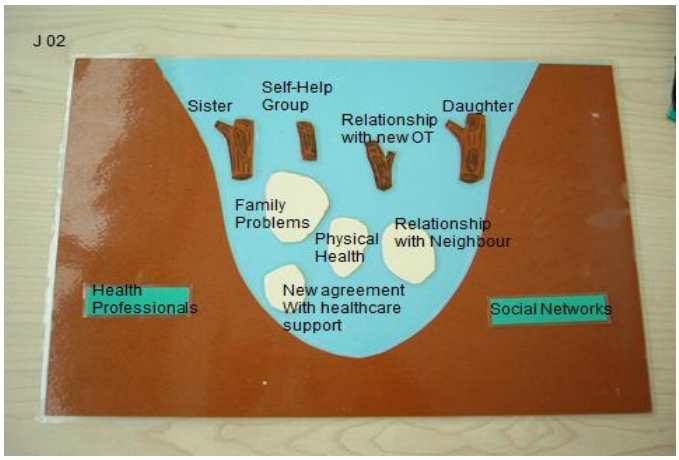


Diagram 18 Jill's Kawa Map 02

"Now the self-help group is very important. I am trying to make the Health Professionals a bit less important in my life than they have been for the past 20 odd years, but I am beginning to see there is life away from hospital and illness and you can enjoy. You can't enjoy illness." (Jill Interview 4)

Stewart described how the Kawa maps provided what he regarded as a more accurate record of the circumstances within his life. This might be particularly important to Stewart who experienced psychotic thoughts as part of his mental health condition and was susceptible to imagining situations that might not have actually happened. Stewart explained in the quotation below how the visual maps seem to provide him with a visual record of his past situation and a clearer understanding of his current circumstances. The Kawa maps seemed to reflect changes over the course of time and provided Stewart with a level of predictability about how things might evolve in the future should his life continue along the same trajectory.

"My first thoughts are that this gives a record of facts that relate to my life. It gives snap shots of my life from one time to another. Perhaps it can help me if I can see how things have gone in the past I can see how things might go in the future, you know?" (Stewart Interview 5)

Anne described how placing each component element within her river as symbolic of how she had managed her own recovery. Anne seemed to acknowledge the impact she could have in determining the outcomes in her own life, a sense of having some control over events in her life and being able to dictate how a situation might evolve. Below in her comments, Anne mentioned how the rocks (Difficulties) in her river seem to be flowing up towards the surface as she worked tirelessly at trying to resolve her difficulties and that the rock floating to the surface were symbolic of her achieving some form of resolution.

"Yes the rocks at the bottom. They are kind of floating to the surface so they can go away. I mean it doesn't make sense but somehow I made it strong. What was deep in the unconscious emerged. I find that quite good because that is the reality. I made it emerge. It has been demolished." (Anne Interview 5)

Self-discovery and personal growth

The creation of the series of personal maps that reflected how each participant's life and recovery journey had evolved over time was highlighted by all participants as strength of the Kawa model and maps. All the participants felt that engaging with the maps over the course of several interviews, help support their self-discovery and development as they progressively gained more insight and understanding of how to influence their own recovery.

Anne explained how through examining her maps (A01& A04) Diagrams 19, she derived her own sense of meaning and associations with the images she has created. As described above, Anne described the 'Rocks' within her maps as floating and made the connection that the rocks could not be too heavy or weighing her down too much if they were floating to the surface of her river. Anne seemed to undergo a process of self-discovery, evaluating and reflecting upon her maps and deriving new insights into how the position and size of the different components were symbolic of how she both perceived and felt about their influence in contributing to her health and recovery. This symbolic representation of the size and position of the rocks in Anne's Kawa map A04 might indicate that Anne felt less 'weighed down' by her challenges and difficulties, personal trauma, fear and guilt (all rocks) in her life at that specific time. In fact examining the quotation below from Anne appears to verify this particular view point.

Diagrams 19 Anne's Kawa Maps 01 and 04

> *"This cannot be heavy because it is floating and that is the reality. It is not as heavy here as it is here. Here it was sinking to the bottom of my psyche. Hurting a lot! Here it cannot hurt as much because it is much smaller. Smaller and lighter." (Anne Interview 4)*

Stewart, like Anne, seemed to reflect upon how the size and position of the rocks within his map symbolically represented the restricted flow within his river. In his Kawa map S02 Diagram 20, Stewart highlighted a congested river flow, with disruptive neighbours, problems at the barge where he did his art, benefits review and his physical health as large rocks restricting his 'river flow' and recovery. However, Stewart also represented the art group, church and watching football as assets in his current map and his social networks, health professionals, church, stable accommodation and mother as his environmental factors. The process of exploring his Kawa maps aided Stewart's self-discovery and personal

growth as he was able to understand where the barriers were and what elements he could draw upon to overcome the challenges he faced.

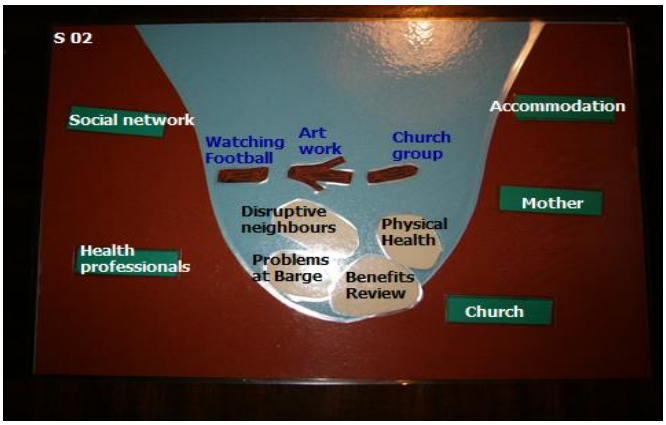


Diagram 20 Stewart's Kawa Map 02

Maggi, similarly described how looking at her series of Kawa maps enhanced her self-discovery and provided her with a valuable snapshot of her recovery. It reminded Maggi of the different activities she had found meaningful and had been involved in throughout the year. Maggi also indicated a level of disbelief at the many meaningful activities she had been involved in over the year and used the term 'You' rather than 'I' in her quotation below perhaps to emphasise the surprise she felt.

> *"It is amazing the amount of things I did that you don't realise. You think my life has a meaning and getting involved in things is very important isn't it." (Maggi Interview 5)*

There appeared to be a pattern of each Kawa map building upon the one before and providing a progressive picture of her recovery. Maggi described how the series of images provided an overview of what she found meaningful and enhanced the development of her personal goals to work actively towards her health and recovery.

Identifying with the River Metaphor

A further strength of the Kawa model highlighted by all the participants was the ability to identify with the river metaphor as symbolising their journey through life. Jill explained how she related to the river metaphor, describing her life like a meander of events as with a flowing river. She felt the Kawa maps seem to appropriately reflect the circumstances in her life both at a particular point in time and across the research year.

> *"Most rivers meander along and that is what life is like? It is a sign showing you how your life has gone and if you really think about it you could put every little event on the map." (Jill Interview 4)*

Kim also identified with the natural features and characteristics of rivers and drew parallels between the changing flow of a river and the shifting patterns in her own life and recovery. In her Kawa map K04 Diagram 21, Kim created a map full of different features reflecting the whole complement of experiences and elements that she deemed relevant to her recovery at the time. Kim also indicated the overwhelming waters in her river as reflective of the fluctuating nature of her own lived experience. Kim explained how in her view that life in general was unpredictable and described in her quotation below how a heavy downpour was like experiencing a traumatic change of events within her life journey.

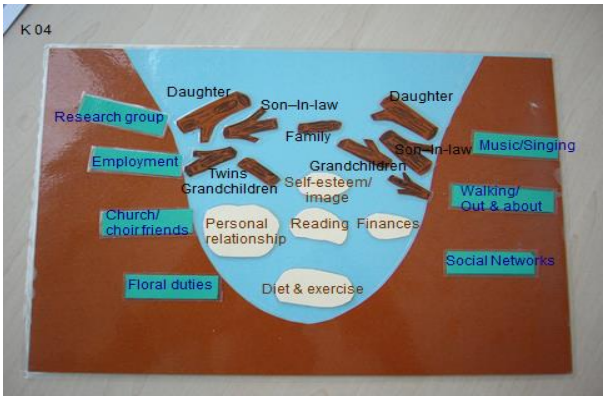


Diagram 21 Kim's Kawa Map 04

> *"I think that is a great reflection of our lives and we can't predict when we are going to have a heavy pour of rain and the next day it's going to be traumatic." (Kim Interview 4)*

Kim similarly described how creating the personal maps helped her sharpen her focus. In her comments below, Kim provided her own analogy of 'looking through a book', comparing the experience of looking at her series of maps, like looking through a book, being able to note what had happened before and what her life was currently like, observing the journey she had travelled and gaining a better understanding of her recovery. Kim also described as strength the simplicity of being able to see and recognise like a child could what she would need to do to improve her circumstances. Indeed Kim felt that the visual qualities of the Kawa maps helped her to reassess her lived experiences and gained an extra level of comprehension as noted for the quotation below.

> *"I think it's brilliant because it has given me a visual, tangible form and being able to reflect where you were. It is almost like being with the children and looking at a book and saying 'What can you see there?' and obviously you are looking and pointing things out and developing what you see in a picture form, so for me it has been very useful to look back." (Kim Interview 5)*

In contrast, Maggi took on quite a different metaphorical perspective and described in her final interview how she viewed the pictorial image of the Kawa map as almost representing a 'womb'. How the river walls seem to form the shape of a womb, an image she might have associated with being enclosed and protected as illustrated below in her last Kawa map M05 Diagram 22. Maggi also mentioned in her comments below '*a baby feeling safe in the womb'* and acknowledged when questioned further that she found it a safe experience in creating her own Kawa maps. Maggi might have similarly felt safe and protected within the interviews to speak freely about her lived experiences and recovery.

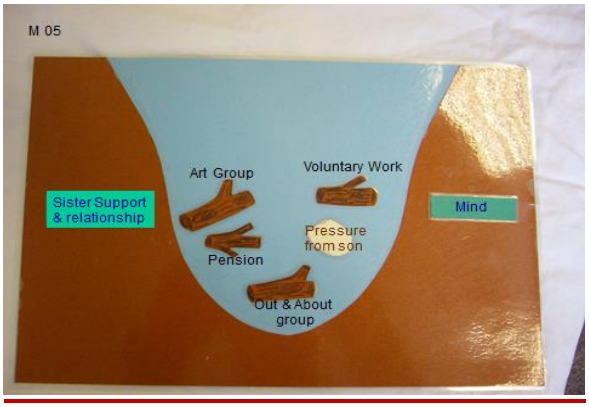


Diagram 22 Maggi's Kawa Map 05

> *"It is like a womb isn't it? The safety of a baby in the mother's womb." (Maggi Interview 5)*

Like Maggi, Peter adopted a variation of analogy in thinking about his Kawa map and mentioned that choosing the term 'a tumble in the darkness or emerging through the tunnel' was, he felt, a more representative way of explaining his experience of breaking out of his previous relapse into his current recovery. Although this might have highlighted a limitation of the Kawa Model with participants not selecting the exact terms, it reinforced one of the key purposes of the Kawa model, to not confine individuals to just one fixed means of explaining or making sense of their personal experiences and valuing the use of different metaphors and analogies to describe everyday experiences.

> *"I think what I've just said about the rapids and difficult times in my life and now getting through that. I must admit a better metaphor to me would be a tumble in the darkness and now I feel I have emerged from the darkness through the tunnel. That is slightly more meaningful metaphor for me than the river thing." (Peter Interview 4)*

Kim indicated a link between the condition of her 'river', with the quality of her life and recovery. Kim used the analogy of a river to explain the relationship between taking care of her own river, keeping it flowing

freely, as representing her own health and well-being. She explained in her comments below how by polluting her personal river, she would effectively clog up her own life and described the importance of nurturing her river/life and ensuring that it was nourished and healthy. Although Kim described a river as a living being and one of potential beauty, she might also been describing how life was fragile and needed to be looked after so that it would blossom into something special.

> *"Yes because we know for a fact that if we don't take care of the river it will die. If we put lots of rubbish into the river, you know, it's going to get polluted and horrible. So we have to look after the actual river and respect it. Yes it is a living thing. It can be a thing of beauty which can very easily be destroyed." (Kim Interview 4)*

Limitations of the Kawa Model according to Participants

The majority of participants did not voice any limitations regarding their experience of using the KM and maps and in fact most of the participants were able to almost immediately construct their maps with minimal or no help during the interviews. The few limitations identified by some of the participants are highlighted next.

Difficulties remembering the respective components

A couple of participants did, on occasion, need a reminder of what the different Kawa components represented as they engaged in creating their maps. I provided such a reminder, for example the 'rocks' representing difficulties and challenges in one's life or the 'driftwoods' representing assets or liabilities, and the respective participants were then able to continue with creating their Kawa maps. However, this could be a potential weakness of the KM, with participants at times not remembering what each component or symbol represented. Both Jill and Maggi, for example, required reassurance about what the 'driftwoods' represented and although it took a moment to be reminded, this created a marginal

delay might have restricted the fluidity/spontaneity in creating their respective maps.

> *"I can't remember what these driftwoods are for?" (Jill Interview 4)*

> *"I've forgotten what forms part of the environment?" (Maggi Interview 3)*

Jargon and Terminology

One of the original reasons for the conception of the KM was to limit the use of professional jargon and, to an extent; the KM had been successful especially in its adoption of natural concepts. Kim acknowledged this aspect of the KM in her comments below, indicating the simplicity of the Kawa concepts as promoting ease of use of the KM.

> *"I think my recovery is very good and actually to look and reflect on the map I did originally and it is a very simplistic analogy I guess, but it is also very clever and easy to understand and it is a good visual thing to reflect on." (Kim Interview 2)*

However even the use of common terms such as rocks, driftwoods and riversides and base that were conceptual terms related to the KM, did created some confusion as they might a different meaning and could lead to a misunderstanding. Peter indicated that he viewed rocks and what they represent as being different from what they represented within the KM. Whilst 'rocks' within the KM were identified as 'difficulties or challenges' that people may experience in their lives, Peter highlighted that he initially perceived rocks as objects that were solid, steady and something quite secure as noted in his comments below. This was not a major concern as Peter was able to explain what each element meant within his Kawa maps. This also illustrated the flexibility of the KM as individuals did not have to strictly adhere to one fixed definition of representation of their experience and were free to interpret the concepts and experiences as they perceive them to be.

"I don't like calling them rocks because you use rocks for something else, but those are the points of stability in my life style." (Peter Interview 2)

Summary

The KM is based on a fluid construction of the individual participant's experiences and life world. The pictorial and symbolic representations enabled the individual to visually examine and verbally discuss how the different component/elements indicated within their personal Kawa maps influenced and contributed to their lived experiences. Participants were also able to look beyond their presenting challenges and difficulties (rocks) and consider the wider range of contextual and environmental influences like family, social support, physical environment and cultural norms that may determine aspects of their lives in positive and negative ways. In addition, the KM also encouraged participants to consider the different personal assets within their lives which they were drawing upon to positively and proactively enhance their lived experiences and recovery.

Within the current research all the participants seemed to indicate positive experiences in using the KM as a means of representing their life and recovery journey through the research year. All the participants identified with the concept and metaphor of a river journey representing their own recovery journey and described the strengths of the KM as providing clarity and empowerment, promoting a review of changes in life and recovery, enhancing self-discovery and personal growth, and all noting the ease with identifying with the KM and concepts. In terms of limitations of the KM, a few participants had difficulty at times remembering the designated meaning of the respective Kawa components and one participant adopted different metaphors and terminologies to relay some of their experiences. On the whole, all the participants were positive about the KM and maps as they felt it was a

dynamic and responsive process and enabled them to reflect the changes in their lives in a tangible way.

In conclusion, this chapter has provided an overview of the use of the Kawa maps, examined the analysis of the participants' Kawa maps through the use of the Kawa Model Framework Index. It has also explored the participant's views of the contribution of the Kawa maps and river metaphor and outlined the perceived strengths and limitations of the KM, as identified by the participants. The next chapter will adopt an idiographical approach, focusing on two specific participants Peter and Diane. The chapter will examine in depth participants' experiences of recovery over the course of one year.

Chapter 7 Third Findings Chapter (Peter and Diane's Kawa Maps, an Idiographical Perspective)

Introduction

This chapter will provide a detailed examination of the Kawa maps created by two participants, Diane and Peter. The biographical perspectives and in-depth examination of the two participants' experiences in relation to the Kawa model/ maps will be highlighted. The representations within the Kawa maps were analysed using the KMFI whilst IPA was used to explore the verbal accounts and give meaning to the maps and objects therein.

The chapter will indicate the reasoning in relation to the two specific participants chosen; outline the KMFI, Kawa maps and analysis process with Peter and then with Diane; Examining the similarities and difference between the participants in terms of contribution and value of the Kawa model/maps in aiding their own understanding and communication about the recovery process over the year will be highlighted. The chapter will build on the findings from the previous findings chapter and contribute towards fulfilling the aim of examining the value of the Kawa model as a visual and narrative tool in exploring the personal journeys of recovery.

Decision on Selecting Participants

Through the extended process of analysis it became apparent that it was impossible to include in the Findings chapters the full analysis of 40 personal maps and 40 interviews from the eight participants, due to the overwhelming volume of data generated. Therefore a decision was made on what aspects of the data would be presented within each of the Findings chapters, with the first and second chapters presenting the whole cohort of participants. Whilst third chapter presented would concentrate on two participants only, but with a more detailed focus on the contribution and value of the KM on an individual level to clarify the

recovery process and explore the associated verbal narratives. This would equate to the analysis and examination of ten personal maps and ten interviews for the two participants selected.

Selection Criteria

The selection of the two participants was based on ensuring a balance in terms of gender, status, diagnosis, stage of recovery and their affinity with the KM during the research period. The two participants selected do not provide representative views of all the participants, as the focus here was on the recovery journeys of the two specific participants. The participants selected were Peter and Diane, Peter was male and single, having a diagnosis of manic depression, in relatively stable recovery and was initially saw less value in using the Kawa model/maps, whilst Diane was female, married, diagnosed with depression, less stable in her recovery and saw more value in using the Kawa model/maps.

Analysis Process

The personal maps for both participants would be scrutinised using the KMFI providing a clearer insight into the perspectives and meanings that each individual attached to the elements they considered as influential within their life journey. The series of five personal maps for each of the two individuals (Peter and Diane) were also analysed for similarities and differences in terms of elements that each participant identified as influential to their life and recovery journey throughout the year. The personal Kawa maps would then be examined in tandem with their interviews responses to gain a more detailed account of the participants' experiences and the value and meaning they attached to the elements highlighted. The analysis using Kawa Model Framework Index would adopt an idiographic approach and be focused on gaining insight into the life world and personal perspectives of each participant. Tracking through the series of maps created by each participant through the year enabled

the exploration and examination of influential patterns and themes within their individual recovery journey.

Peter's Kawa Maps

Introduction

This section offers an overview of Peter's *five* personal maps, which he created as part of his interviews within the research year. Included below are the series of Peter's five personal maps (P01-05) Diagrams 23-27, which were created at regular three monthly intervals.

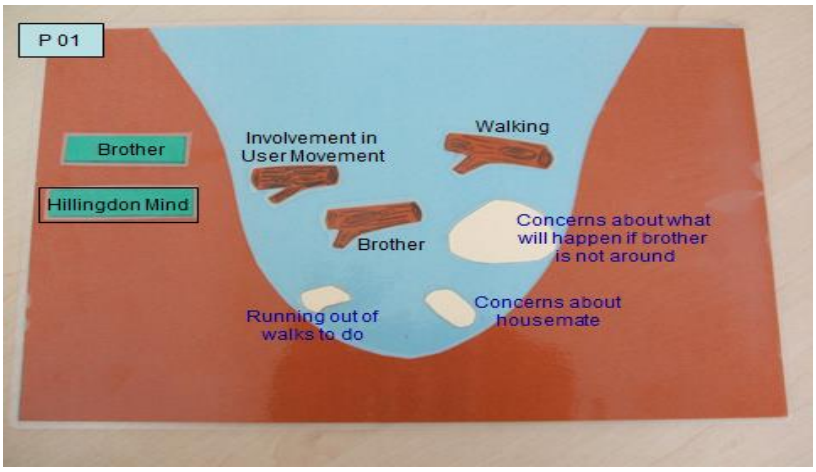


Diagram 23 Peter's First Personal Map (P01)

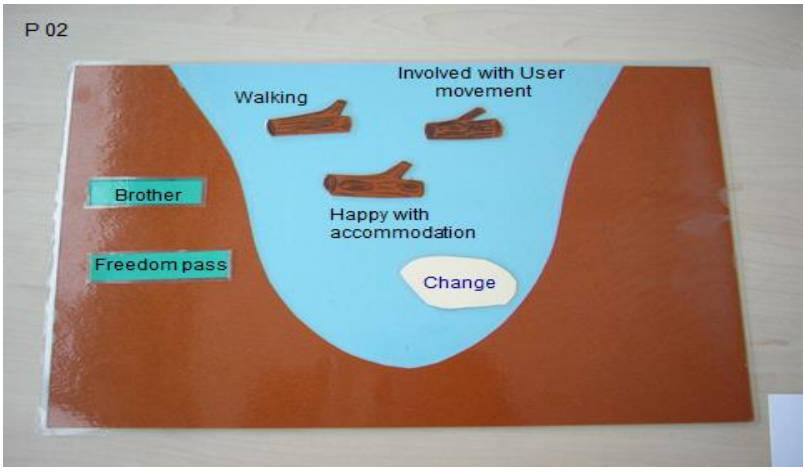


Diagram 24 Peter's Second Personal Map at 3 Months (P02)

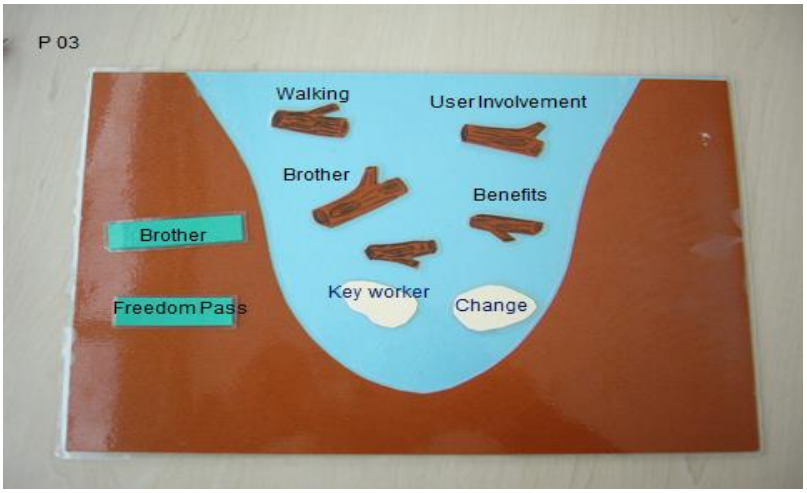


Diagram 25 Peter's Third Personal Map at 6 Months (P03)

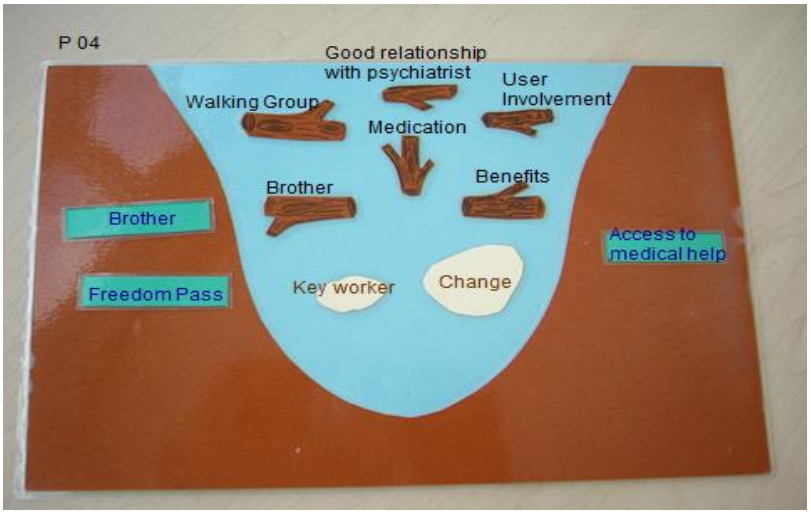


Diagram 26 Peter's Fourth Personal Map at 9 Months (P04)

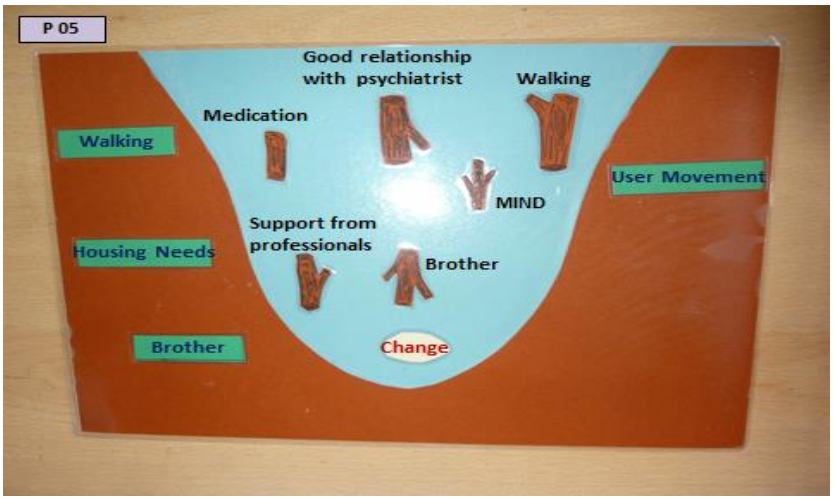


Diagram 27 Peter's Fifth Personal Map at 12 Months (P05)

The series of *five* personal maps (P01-P05) Diagrams 23-27, indicate the elements that Peter perceived as influential to his lived experience at different points throughout the year. Through the use of the Kawa Model Framework Index (Table 12), several recurring elements were noted as having prominence within Peter's series of personal maps. These were examined alongside Peter's interview responses to ascertain their perceived value. The elements highlighted by Peter within his personal maps, were then collated in Table 12, where a (X) denoted Peter identifying a specific element as contributing to his lived experience at that precise time.

Table 12 Peter's Kawa Model Framework Index (Overview of Elements within Personal Maps)

Personal Maps	**Map 1**	**Map 2**	**Map 3**	**Map 4**	**Map 5**
Challenges/Life difficulties/ Concerns (Rocks)					
Concern about brother	X				
Concern about flatmate	X				
Running out of walks	X				
Cope with Change		X	X	X	X
Change of Keyworker			X	X	
Assets or Liabilities (Driftwood)					
Involvement with User movement	X	X	X	X	X
Relationship with Brother	X		X	X	X
Enjoyment from Walking	X	X	X	X	X
Stable Housing Situation		X			
Welfare Benefits			X	X	
Medication for condition				X	X
Relationship with psychiatrist				X	X
Environmental Influences (River sides & base)					
Relationship & support of	X	X	X	X	X

Brother					
Mental Health Charity	X				X
Freedom Pass		X	X	X	
Access to medical help				X	
Housing situation					X

All the elements in Table 12 were organised under the three Kawa Model component categories, which were challenges, life difficulties or concerns (rock); Assets or liabilities (driftwood) and Environmental influences (river sides and base). The data shown in Table 12 also represents the regularity with which each element/component was highlighted by Peter within his series of maps over the year. The examination of the data in Table 12 also highlighted several prominent elements/components that Peter indicated as contributing to his life journey through the year. The perceived value of each element was however dependent upon it satisfying the criteria listed in Table 12 (Determining Salient Value), which included regularity of representation, supporting interview responses and emotional conviction. For an element to be regarded as of salient value, at least two of the three criteria indicated in Table 12 must be met. For example a definitive element that Peter indicated within all his five maps was his interest and enjoyment with walking (see Table 12).

> *"The thing that helped me a lot is my passion for walking."*
> *(Peter Interview 1)*

The salient and perceived value of walking in contributing to Peter life journey and recovery was reconfirmed by Peter verbal reinforcement within his interview response and emotional conviction, as observed in the quotation above when Peter spoke of the importance and passion he felt about walking and how it supported his overall health and well-being .

Table 13 Determining Salient Value

Identifying the value of each element
• Regularity of factor being represented within personal maps.
• Importance reinforced by supporting interview responses.
• Level of emotional conviction when discussing the factor.

Therefore each element that Peter identified within his personal maps would need to be verbally or emotionally reinforced in the corresponding interview to establish it as a salient value. Through re-examining Peter's personal maps and interviews responses, several factors were identified as of salient value and indicated with a black **X**, in Table 12**.** Whilst, those highlighted with a **red X** for example **(his Freedom Pass)** were factors considered to have less salient value even though they were highlighted within his Kawa maps. A fuller examination and scrutiny of several of the salient factors will occur next, beginning with a brief overview of Peter's life and recovery journey through the research year.

Overview

Peter described minor fluctuations in his personal circumstances over the research year. He also mentioned that his mental health had been relatively stable for around a decade and that he felt much more able to deal with the life issues and concerns he had to face. Peter also indicated within his Kawa maps several factors he deemed influential to his mental health recovery and these factors including walking, service user involvement, his brother, managing change and health professionals which will be discussed in the next section. Indeed Peter specifically identified the first three, walking, relationship with his brother and engagement with the Service User movement as key factors in supporting his own recovery.

"I suppose the three things, the walking, the User Movement and the relationship that I have with my brother. Those are the three most important things in my life." (Peter Interview 1)

Walking

From the outset, Peter described his engagement in walking as an important aspect of his recovery. Peter highlighted the many benefits he derived from both walking and being part of a walking group within all his interviews and identified walking as a positive influence (asset) or (environmental support) within all his personal maps (P01-05). In the discussions that followed Peter would often speak with emotional conviction of the importance and value he attached to going for walks and being part of the walking group.

"A group of us go walking once a week and that has been going really well." (Peter Interview 4)

In fact in the conversation that followed the creation of the Kawa map, Peter indicated that not only had he gained additional walking companions, but he had overcome his previous anxiety of relating with others and had made some new friends through the walking group. Peter described below a change in his own personality as he revealed how instead of being content to be on his own, he had begun to enjoy the company of others through the walking group. There was a sense that spending time with others may have given Peter the confidence to socialise more and also consider that others might value his company too. Indeed Peter described during his later interview how he felt much less isolated as he was able to extend his social circle beyond his own brother whom he was reliant upon for the majority of his social contact and companionship.

"I've been a fairly solitary person for a long time. I used to walk a lot on my own but that is less true now."(Peter Interview 1)

In fact for Peter walking was more than just an activity he engaged in but was perceived as essential to his physical and psychological well-being. In describing walking as an asset in his Kawa map (P01), Peter mentioned previously having a heart attack and attributed his involvement in walking as one of the key reasons he had not suffered a relapse and had improved upon his overall physical health. Peter seemed to attribute how he could regulate his own mental and physical health through both walking and staying fit as indicated below.

> *"I was 47 when I had the heart attack and that is a bit young to be having heart problems.*
>
> *I put down to the walking why I have had such a good recovery." (Peter Interview 1)*

Peter further described feeling more relaxed and sleeping better as a direct result of going for regular walks. Peter felt sufficient rest, sleep and not feeling stressed was fundamental to him remaining mentally stable, emotionally well, curbing fluctuations in his mood and limiting relapses. Peter acknowledged that walking provided regular exercise, fresh air and company, which were all essential to him remaining well. Through creating and exploring his Kawa maps and examining what was represented, Peter appeared to gain more insight and personal realisation around how he could influence his own health and recovery.

> *"One of the reasons I took it up was that it helped me sleep because I still find if there is any aspect of my mental health that still gives me trouble sometimes is not a very good sleeping pattern." (Peter Interview 1)*

Peter expressed how over time he had developed a deeper level of self-awareness around managing his manic depression. Indeed Peter described how he had developed a strategy to control the fluctuations in his mental state and mood. Peter recounted in his fourth interview below, how he had utilised walking to manage a recent potential relapse. Peter described how he felt that he was 'getting high' and decided to go on long

walks to curb his excess energy and tire himself enough to be able to sleep. This action that Peter had taken seemed to have been effective in curtailing his mania and keeping him well.

> *"Basically it was okay; it brought me down really quickly. The high energy levels and the lack of sleep. I was self-medicating as well, in that the next two evenings I went for long walks and that helped me sleep. So I came down off my high." (Peter Interview 4)*

Peter clearly felt that his walking and overall recovery were interrelated and expressed a deep desire to remain well enough to continue with his walking. Peter indicated how being able to go for walks meant a lot to him and he was keen to remain mentally and physically well, just to be able to continue with his walks as seen in the next quotation below.

> *"That is the other thing I hope, I will be in good health to do the walking. That is important.*
>
> *I hope that my recovery will continue for as long as possible." (Peter Interview 1)*

A minor concern Peter indicated in his recovery map (P01) represented by a small rock was not having new walks to undertake. However this was a passing concern as Peter mentioned acquiring a book of guided walks. Indeed in the subsequent interviews and his Kawa maps Peter represented walking as positive assets that enhanced his recovery. Peter was also able through examining his series of Kawa maps at his last interview, to note that walking was a meaningful occupation that he valued which also formed part of his 'self-treatment'.

> *"Yes, walking is the most obvious one, in supporting my health and recovery." (Peter Interview 5)*

The enjoyment Peter derived from walking was reinforced by the statement below, where he indicated that if he had to choose between his

walking and his involvement in the Service User Movement which were equally important to him, he would choose to continue with the walking.

> *"If I had a choice and somebody said I had to give up the walking or the stuff I do in the User Movement I would probably give [up] the stuff I do in the User Movement and keep doing the walking." (Peter Interview 1)*

This seemed to emphasise how meaningful an activity walking was for Peter and how much he valued the opportunity to continue with this meaningful activity. In examining the series of Kawa maps that Peter created, his overriding interest and desire to engage in walking was confirmed by it being present throughout all his Kawa maps during the year.

User involvement

Another important influence that Peter identified as contributing to his life and recovery journey was his involvement with the local Mental Health Charity and Service User Movement. Throughout all his personal maps (P01-05), Peter represented his involvement as an asset as noted in Table 12. The valued position of the Mental Health Charity and Service User Movement was reinforced throughout Peter's interviews where he spoke of the commitment, role, responsibilities and benefits of being involved.

> *"I got involved in the User Movement and that was a fairly gradual thing. Some people at the hostel were quite upset. I became a sort of spokesman for them, something I took the lead in and that was really good, because it was the first time I acted as a voice for other people, some of whom were more ill than I was." (Peter Interview 1)*

Peter described above how his initial involvement happened quite by chance due to events occurring where he previously lived. Peter was unhappy with his housing situation and felt a need to represent his views

and those who shared the same hostel accommodation. Peter was stirred to voice their objections and to represent their collective concerns. Peter also appeared to be motivated by a desire to give something back and help others who he felt were less able to voice their own concerns.

> *"We didn't like what was happening, again we formed a committee and I was the chair of the committee. I led it again; I was chair for three years" (Peter Interview 1)*

Peter seemed to indicate a sense of purpose and personal satisfaction in leading and representing the views of others. Peter appeared to develop a new passion and confidence to stand up and be heard, discovering a new ambition and focus within the Service User movement. Through looking at his Kawa map and talking about his experiences, Peter was able to appreciate the level of involvement and commitment he invested in supporting others and also gained insight in how this role and responsibility had made him more confident, empowered and contributed to his self-esteem.

> *"The user work I do, it has helped to keep me stable. I think it has given me something to do." (Peter Interview 2)*

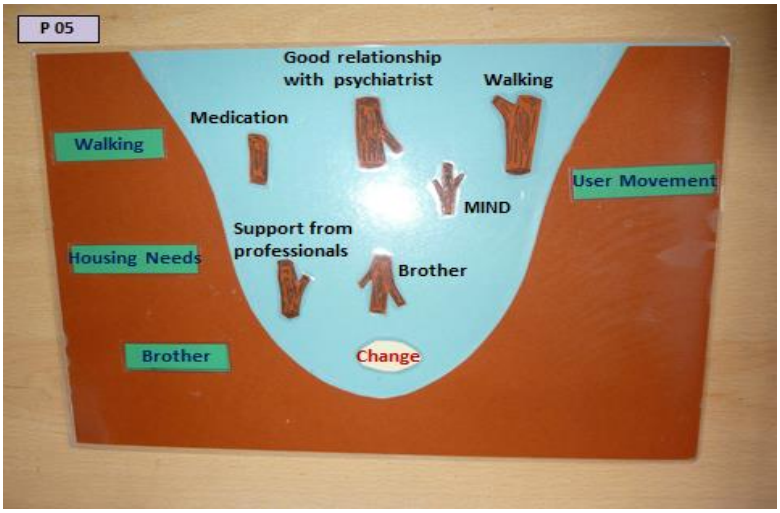
Peter also described above how by being involved in many aspects of the Service User movement, chairing meeting, discussing issues and leading groups, helped him keep focused and occupied. It further instilled a sense of achievement, purpose and recognition, enhancing his confidence and self–esteem. Peter, through his involvement in the User Movement, appeared to take back some control over his own life, which was a positive contrast to the unpredictable nature of his mental health condition, which he had less control of or was able to dictate.

Peter appeared to acquire a new identity through his involvement, where he was not just a mental health service user, but someone with an important role and responsibility. This new identity and purpose appeared

to provide Peter with a new insights and perspectives. In reviewing his series of Kawa maps during the last interview Peter recognised the important he felt about being involved in the Service User movement and representing the views of his peers. Peter seemed to draw satisfaction from the influence he had in improving the welfare of other, highlighting an understanding of what it felt like to be 'powerless' and drawing on his own experience to motivate him to continue his involvement.

> *"What spurs me to fight these battles is that there are people out there who are back where I was 20 years ago. They really need this support and it worries me that they might not be getting it." (Peter Interview 5)*

However, there was a change in Peter's motivation later in the year where he described wishing to take a less prominent role in the Service User movement. Peter expressed in his statement below a desire to be less involved and to have a break. In examining his Kawa maps (P01-05) it can be observed that Peter had continually identified his involvement with the User movement and Mental Health Charity an (asset).



> *"My ambition is to spend less time on the user issues which I have done for years and I'm running out of steam a bit and more time to do these fabulous walks. (Peter Interview 3)*

However in his last Kawa map (P05), Peter for the first time represented his involvement in the Service User Movement not as an asset but as an environmental support for his own recovery. This might have indicated that Peter's involvement with the Service User Movement which he had identified as an asset in his previous four maps (P01-04), had now shifted in its' importance and Peter had now ceased to view it as an asset but just as an environmental influence. Indeed Peter seemed to reach a defining moment in terms of his involvement with the Service User movement as he expressed a desire to have a change and to devote more of his time to his own interest in walking.

Relationship with brother

Peter described his twin brother as the most influential person in his life and represented him as a constant asset and environmental support throughout all his personal maps (P01-05). In his first personal map (P01), Peter identified their relationship as unique and central to his life and recovery journey. This was reinforced within all his subsequent personal Kawa maps (P01-05), where Peter repeatedly identified his brother as a valued asset and vital source of support. The perceived importance of this relationship was reinforced by Peter's comments as he described the infinite bond they had and his hope that the closeness they shared would continue in the future. This valued relationship they shared may have been reinforced by Peter's brother being his sole remaining family member.

> *"It is the most important relationship in my life and always has been." (Peter Interview 1)*

Peter also indicated the unique understanding he had with his brother and described how they had shared a lifetime together, living together, going to the same university, sharing identical interest and sharing a joint history that he felt was impossible to explain. In fact Peter indicated it was impossible to describe the complexity of their interconnectedness as

twins within the space of an interview. Peter also described the relationship with his brother as typical of any close relationship, with its share of highlights and disagreements.

> *"The relationship with my brother you can't do in an interview like this, because it would take a day probably to explain the ups and downs of that." (Peter Interview 1)*

Peter appeared keen to emphasise that he got on well with his brother despite their potential differences. Peter seemed to reinforce this in the quotation below by de-emphasising the friction that existed between them, using the term 'occasionally' to underplay any potential conflict. Peter may have felt a need to create an impression that they continued to have a strong bond and not reveal too much about their relationship in the earlier interviews, keeping the interview content relatively ambiguous for the moment.

> *"I continue to have a very close relationship with my twin brother. There has occasionally been friction in that relationship in the past, there isn't at the moment." (Peter Interview 2)*

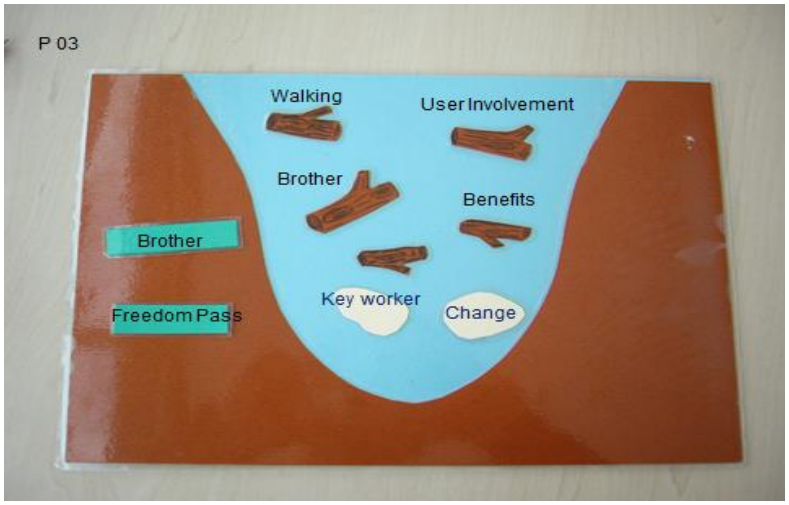
Peter also described that on an emotional level, his brother understood him better than anyone else due to their likeness in character and personality as twins. Peter described how they were almost like one person, mentioning that as identical twins their thoughts, views and feelings were often indistinguishable. Peter also explained how he was prone at times to forget the importance his brother signified and this was reflected in some of the research interviews, where despite highlighting his brother as an important asset and influence within all his Kawa maps (P01-05), Peter neglected to mention this impact in the initial stage of the interviews. It was only through creating Kawa maps and subsequent examination that Peter seemed prompted to highlight the impact his brother represented as noted below

"He is so much part of my life; I sometimes sort of forget the fact." (Peter Interview 3)

The depth of closeness Peter felt towards his brother was supported by Peter's comments in his last interview, where he described his relationship with his brother like that between a husband and wife or child. Peter described how he could not imagine being separated from his brother, reinforcing the intimate and supportive bond they shared together. Additionally with the absence of any other family members and with Peter and his brother both being single, the bond they had together proved even more critical. In fact Peter described how it felt like they were a 'married couple', due to their level of their intimacy and closeness.

"Just in terms of having someone so close. He is probably like wife and children to me." (Peter Interview 5)

Peter also mentioned the importance he placed in spending regular time with his brother and indicated how he would make compromises in order to share time together. Peter described having to accommodate his brother's interest, which was a sacrifice that Peter was willing to make. As keeping in contact with his brother provided Peter with a valuable continued source of support and companionship.



In his personal map (P03) Peter continue to identify his brother as an asset in his life, but also represented his brother as part of his environmental support, something which he felt was essential to his health and a constant source of support. This might have been symbolic of how Peter identified the influence and impact of his brother as he saw his brother as a constant support, something that did not change within his life. In this way Peter recognised his brother as an asset but also as a value unchanging part of his wider environment, being part of his social network, family, social support, friendship and integrate to his continue interest in walking too.

> *"We are still seeing quite a lot of each other, most weekends. What we tend to do is something that he wants to do. I kind of indulge him a bit because he is working. That is his only chance." (Peter Interview 3)*

Peter also indicated that his mental health and mood was influenced by the events that affected his brother. Peter described in his third interview how he felt extremely worried and concern when his brother became ill. He used the term 'debit' rather than 'asset' to denote the emotional and psychological change he felt when his brother became unwell. This seemed to reinforce the closeness of their relationship and illustrate how instrumental Peter's brother was in influencing Peter's emotional state and recovery.

> *"The last couple of times he's been ill it's been debit rather than an asset because I tend to get upset as well, when he gets ill." (Peter Interview 3)*

In his interview below, Peter also explained that his brother suffered with manic depression, a condition that Peter was also similarly diagnosed with. However Peter's described how his brother seemed to be much less affected by his condition, having experienced far fewer episodes of illness than Peter himself. Peter indicated with both of them being twins and affected by manic depression, this seemed to reinforce the notion of a

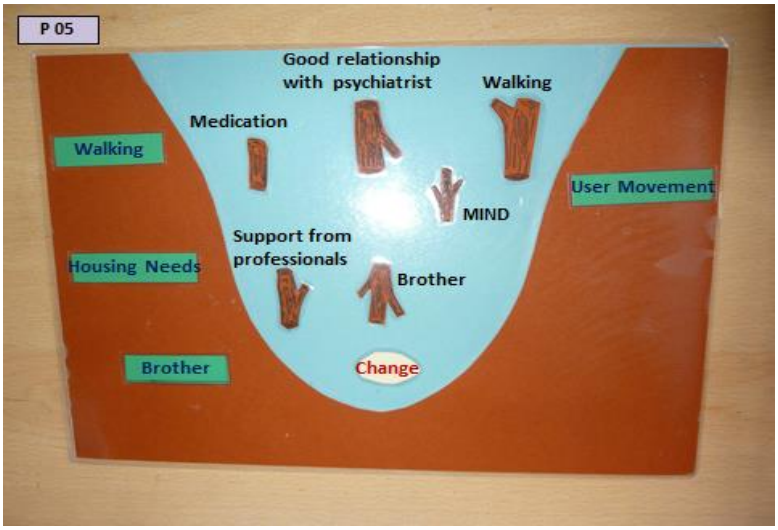
genetic link with the condition. However what seemed to be much less predictable was how the manic depression had affected them quite differently.

> *"It has happened, only a couple of times. He also suffers from manic depression as well which is an argument for it being a genetic disorder. My brother has far fewer episodes than me, whereas, I was in and out" (Peter Interview 3)*

Peter's described how he felt his manic depression had affected him much more severely in comparison to his brother, with Peter experiencing numerous hospital admissions in the past, not being able to hold down a job and having to live in supported housing. In contrast Peter described how his brother had only relapsed twice, had achieved a PhD, was still in employment, had acquired some level of success in his career and had his own property. There was a sense of Peter feeling some level of injustice with how his manic depression had cost him much more personally than his brother.

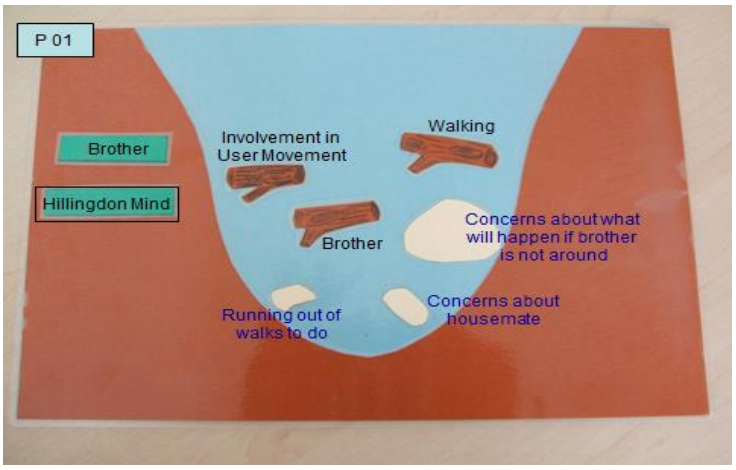
> *"He has now worked his way up. He now works for a University. He is the Careers Officer." (Peter Interview 1)*

Peter's brothers 'relative successes could have served as a reminder of the disparity in their lives where his brother seemed to have acquired opportunities and achievements that had eluded Peter. Being identical twins it may have seemed somewhat paradoxical for Peter, as his brother not only represented the main support, companionship and trust that Peter valued, but also signified the inequalities in their respective lives. This distinct difference seemed to serve as an explicit reminder for Peter of how disruptive his own mental illness had been and how it had restricted his personal achievements in life. This difference in both his and his brother situation was highlighted in the narrative discussion that arose from the creation of the Kawa maps, with Peter reflecting on how his recovery journey could have evolved differently.



Despite Peter indicating frustration with how things had evolved within their individual lives, Peter continued to describe his brother as central to him sustaining stability within his own life. Peter felt that meeting up regularly with his brother provided him with a structure, routine and purpose. Indeed as seen in Kawa map (P05) above, Peter continued to identify his brother as a crucial support and asset in his life. Peter described the time spend with his brother as both meaningful, enjoyable and something he looked forward too. Indeed Peter's whole social focus seemed to be primarily centred on his brother and led Peter to feel much less concern about meeting others socially. However such a position could prove to be detrimental to Peter's mental health and social functioning if anything untoward should happen to his brother or impact upon their relationship in the future.

> *"We always meet up in town for a drink on a Wednesday night; there are also sort of Friday, Saturday and Sunday with him, which are part of my routine."(Peter Interview 5)*



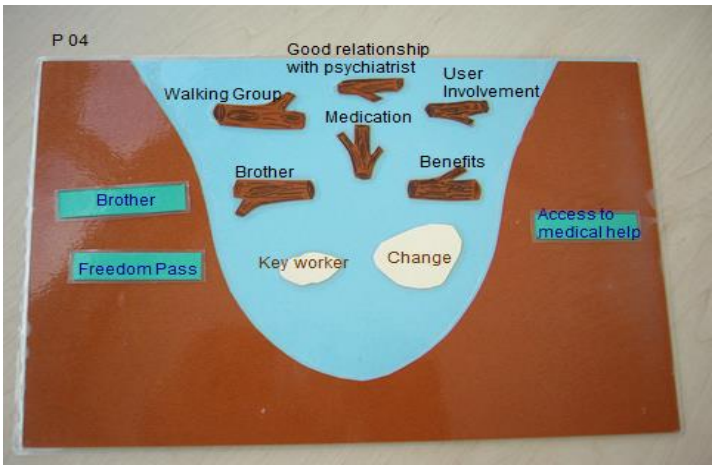
"I've mentioned this before, I cannot imagine what it would be like not to have a twin brother. It is something that has just made my life exceptional in some ways I think." (Peter Interview 5)

On reflecting upon his life and recovery journey over the year, Peter also noted within his personal maps (P01-05) how much he considered his brother not only as an asset but also as a valued environmental support in all aspects of his live from familial to social and emotional. Similarly throughout the interviews, Peter continued to identify his brother as a crucial support and companion, fundamental to his life and recovery journey.

Change

Peter described 'change' as something that he struggled with and mentioned that he wanted everything to be constant and predictable. He indicated change as his biggest and most frequent concern within four of his personal maps (P02-05). Indeed change was the only area of concern (rock) that Peter identified as his primary concern and which remained as an issue throughout the year. Peter clearly identified in the Kawa map (P04) below, how he struggled with change, indicating as a huge concern

(rock) within his river, symbolising the scale of his concern about how trying to deal with change was stressful.



Peter readily admitted finding change a challenge, as he felt out of control and did not know if he would manage with new situations. This sense of being out of control may have mirrored his anxieties around his manic depression, which he described as being unpredictable and uncertain. Throughout his Kawa maps, Peter continued in representing change as a substantial concern (rock), which he felt affected his mental state and recovery.

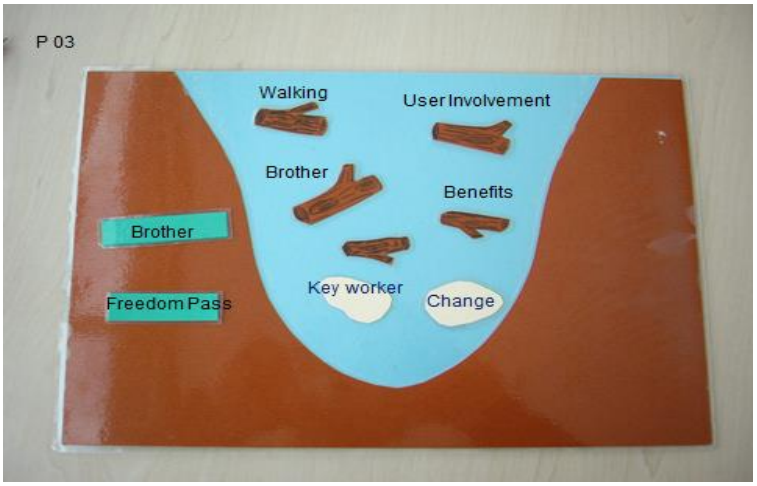
> *Change is something I don't like very much. If I look back over all the years I have been in the User Involvement, I have usually been fighting the change on one level or another. (Peter Interview 4)*

Peter also highlighted previous occasions when he had challenged the need for change as he was not convinced of the possible benefit. Peter felt that change should only be implemented to bring about improvement, rather than to merely introduce something new. Peter described how he felt that the changes instigated by health professionals and those in authority were often implemented to fulfil a vested interest which did not always benefit those it was meant to benefit.

"I don't like changes. The couple of changes I've been through have been unwelcome changes. I sometimes say at meetings that mental health managers like change but users don't. I think that is really true." (Peter Interview 2)

To illustrate his particular point, Peter indicated in how a recent change he felt had a detrimental impact on his own recovery. Peter described seeing the same key worker over several years and this had provided him with stability and support. However at his third interview, Peter mentioned how he had been informed that he was to have a new keyworker. This proved a huge concern for Peter and he represented this change of his Keyworker as a (rock) within his third to fifth (P03-05) Kawa maps. Here in Kawa map (P03) below, Peter illustrates the change in his key worker as a concern (rock), which he felt would adversely affect his health and recovery. Indeed Peter's were realised when he later described the relationship with his new key worker as problematic and difficult.

"Yes well the new key worker is a bit of a problem at the moment. Yes, I still don't like change." (Peter Interview 3)



Peter also expressed his annoyance at not having a say or choice about a new key worker and there was a sense of Peter feeling powerless to influence what he considered to be an extremely important change in his personal circumstances. Peter explained he could not understand the

purpose behind the decision and felt imposed upon. This whole situation seemed to be made worse especially with Peter's struggles with his new key worker.

> *"I got given a new key worker who I am finding quite difficult to get on with. I found it a bit of a struggle." (Peter Interview 3)*

Indeed Peter highlighted the importance of having trust and a good rapport with the people who had helped him and described struggling to understand the reasons for him needing a new key worker. Peter described in his fourth interview how unsettled and stressed he felt about having to start the whole process of building a new relationship, telling his whole medical history and sharing his experiences to someone new. Peter felt that the situation represented a total lack of awareness and understanding amongst those in authority, who failed to appreciate the importance of long established and trusting relationship.

> *"It is ludicrous people with these problems how they are expected to see somebody new each time they go. It is not helpful." (Peter Interview 4)*

Peter further described how he often found change to be highly stressful and felt increasingly anxious about situations that were out of his control. He stated how he viewed change as the major hurdle in his life, which he needed to overcome and manage. Peter expressed his concern about not letting the stress and anxiety overcome him to such a level that it might bring about a relapse in his mental state. Looking at his Kawa map (P04), Peter was to describe change as the 'major' rock in his river which was to be the main obstacle in his river flow.

> *"Change is the big one because that it is the rock I hit." (Peter Interview 4)*

Despite describing mainly negative experiences of change, Peter did acknowledge that there were a few times in his life when change was positive. One example that Peter discussed when reviewing his series of maps was making the decision to move out of his family home to live in a group home and subsequently into his current flat. Peter described in reviewing his Kawa maps that he could now see the benefits of embracing this change and agreed that despite feeling nervous about both moves at the time, he did now recognise the importance of taking those steps toward change and a new challenge.

> *"It should have been blindly obvious that it was the change I needed to make but there you go." (Peter Interview 5)*

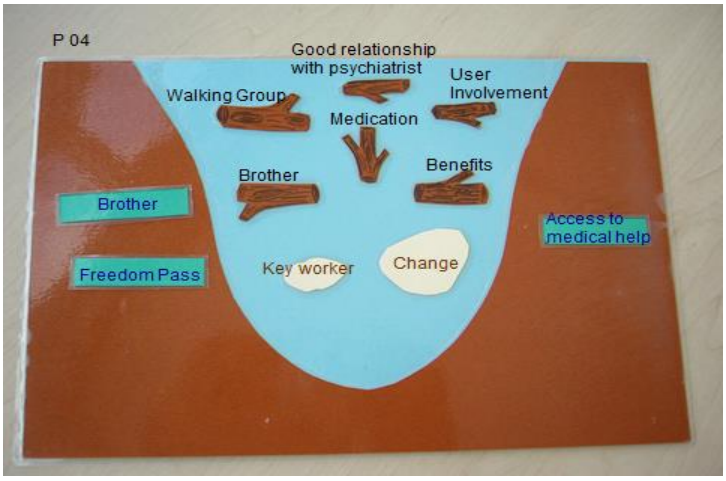
For Peter is appeared that it was not change in itself that he objected too, but that he did not have control of many aspects of his own life. Peter explained the feeling of not knowing, being powerless and not being in control as his key objections to change. For Peter the need for predictability and certainty was something he strived towards, as his experiences of change had often led to immense stress, which led to a relapse into his illness. Peter described needing to know what would happen next in order to manage his condition and be able to shape his life circumstances and recovery.

Professional help

Another important aspect of Peter's recovery seemed to be the established relationship that he had with his psychiatrist. In his personal map (P04) Peter described this relationship as a positive asset and attributed the medical help he received as instrumental in preventing him from having a relapse. Peter described how he had sought help and support from his psychiatrist when he suffered a slight deterioration in his mental state and had noted the beginning signs of a relapse. Peter

concluded that his psychiatrist had been good to take his concerns seriously and had agreed to see him on the day.

> *"The symptoms were there and my psychiatrist had always told me that if I thought I was going high I should contact him and not wait for my next appointment. I asked if I could speak to him and he was very good because he offered to see me on the same day" (Peter Interview 4)*



Indeed by examining his Kawa map (P04) above Peter was able to identify that having ready access to medical help, the good relationship with his psychiatrist and taking his medication, support from his brother as influential factors in maintaining his mental health. Peter further explained how over time he has been able to read the signals that indicated he was becoming unwell. Having such an extended mental health history gave him insight and made Peter familiar with some of the common signs of mania.

> *"I've had the illness for so long, that I recognised what was happening." I began to have the symptoms of going high, my energy level shot up. I wasn't sleeping well which is a classic sign. (Peter Interview 4)*

However, Peter also described the contradictory nature of manic depression, where becoming high can itself mask the signs of a relapse. Peter explained that he could feel so positive about himself and so

energised during his mania that it becomes difficult to tell that things were not as they should be. Additionally, Peter highlighted how it could be tempting to delay getting help as the sense of confident, being excitable and elated could lead to a false sense of wellness and could delay one seeking appropriate professional help.

> *"Yes I recognised it myself, I was getting high. You don't always because you get very exuberant and sometimes when you are high you can think everything is going swimmingly well, but I knew I was going high." (Peter Interview 4)*

Peter also described being taken seriously and having his opinion regarded as valid as important to his self-confidence. Peter felt grateful that he was regarded seriously by his psychiatrist and health workers and described the timely help from his psychiatrist, the medication and available support as crucial to him recovering so quickly from his relapse.

> *"He fitted me in, that was really pretty good because it is unusual to get to see the psychiatrist on the day you actual make contact. Anyway he put me on a drug that I have been on before when I was high and it brought me down again from the high very quickly." (Peter Interview 4)*

Peter also acknowledged the importance of accepting the treatment offered and also the value of medication in controlling his condition. He described trusting his psychiatrist to prescribe him the right kind of medication that would help him to get better. There seemed to be a mutual trust and respect between Peter and his psychiatrist which led to mutual regard for each other's judgement and decision. In fact in reviewing his Kawa maps at the final interview noted how he had represented his good relationship with his psychiatrist and the medication as assets within his maps, which felt helped him in stabilising his mental state and sustaining his recovery.

Summary of Peter's Kawa Maps

The use of the Kawa maps provided a visual dimension to understanding the perspectives and interpretations of Peter's experiences of recovery. The opportunity of mapping his recovery seemed to enhance Peter's awareness and insight regarding how different elements within his life influenced his recovery. The use of the Kawa maps alongside IPA enriched the data collected throughout the repeated interviews as each participant was able to visualise, reflect back, analyse and appreciate where they were along their personal journey of recovery over the course of the year.

Diane's Kawa Maps

Overview

This section will focus on the exploration of Diane's Kawa maps and examine the added value of the Kawa maps in enhancing the information gathered within the interview process. Each of Diane's Kawa maps (D01-05) Diagrams 24 will be highlighted next with an overview of the elements/components that were represented in Diane's personal maps indicated in Table 14. Each factor highlighted will be scrutinised alongside the respective interviews to ascertain their perceived value in supporting Diane's recovery journey.

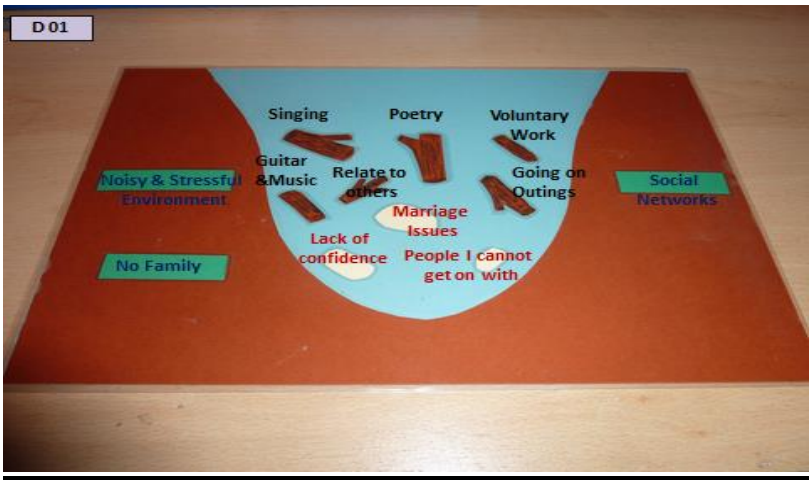


Diagram 28 Diane's First Personal Map (D01)

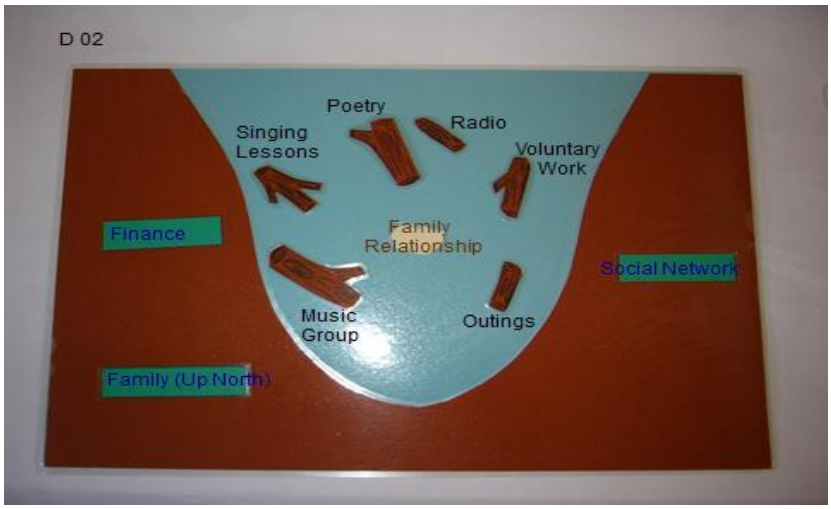


Diagram 29 Diane Second Recovery Map (D02)

Diagram 30 Diane's Third Recovery Map (D03)

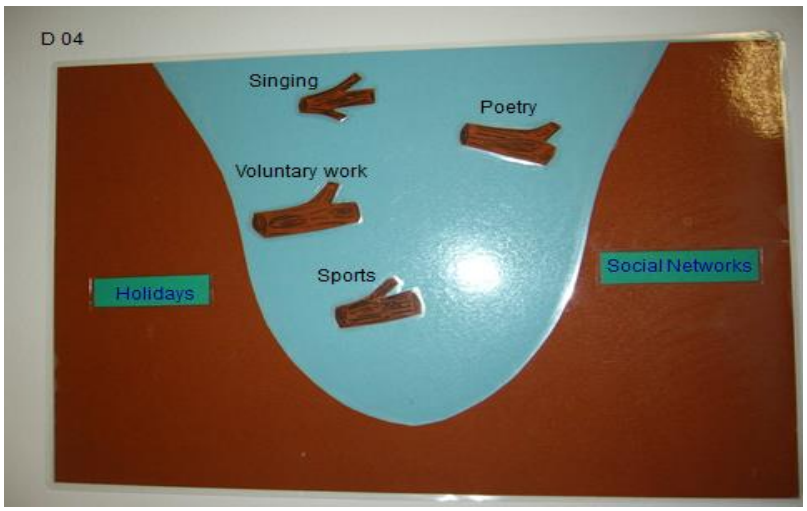


Diagram 31 Diane's Fourth Recovery Map (D04)

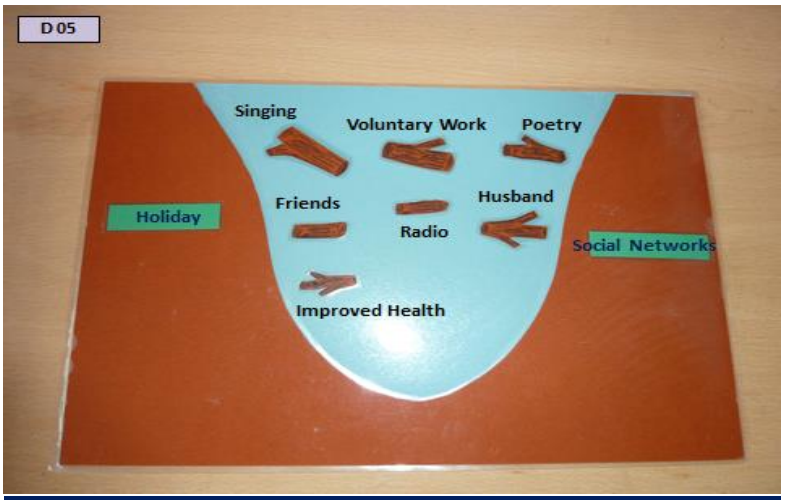


Diagram 32 Diane's Fifth Recovery Map (D05)

The multitude of factors represented by Diane within her personal maps were collated and presented in Table 14 below. All the factors in Table 14 were organised under the three Kawa Model component categories of ***challenges, life difficulties or concerns*** (rock); ***assets or liabilities*** (driftwood) and ***environmental influences*** (river sides and base). The data shown within Table 14 also represents the regularity with which each factor was highlighted by Diane within her series of maps throughout the year.

Table 14 Diane's Kawa Model Framework Index (Overview of factors within Diane's Kawa Maps.)

Personal Maps	Map 1	Map 2	Map 3	Map 4	Map 5
Challenges/Life difficulties/ Concerns (Rocks)					
Marriage Issues	X	X	X		
Lack of confidence	X				
Relationships	X				
Family relationships		X			
Assets or Liabilities (Driftwood)					
Singing/ singing lessons	X	X	X	X	X
Music /guitar	X				
Poetry/ writing poetry	X	X	X	X	X
Music group		X			
Being on the Radio		X			X
Involvement in Voluntary work	X	X	X	X	X
Outings	X	X			
Relating to others	X				
Husband					X
Involvement in Sports			X	X	
Improved Health					X
Friends					X
Environmental Factors (River sides & base)					

Social Networks	X	X	X	X	X
Noisy/stressful environment	X				
Family	X	X			
Holiday				X	X
Finance		X	X		

Diane described several factors within her Kawa maps that shaped and influenced her recovery journey during the year. The perceived value of each factor was however dependent upon it satisfying the same criteria previously highlighted in Table SF (Determining Salient Factors), which included regularity of representation, supporting interview response and emotional conviction. Once again the factors of salient value were indicated with a black **X**, in Table 14**.** Whilst, those highlighted with a **red X** were considered to have less salient value. The examination and scrutiny of several of the salient factor will be presented next.

Marriage issues

Diane's described her main concern during the year as the developing issues within her marriage. Although Diane highlighted her marriage as a main concern (rock) within her first (D01) and third (D03) Kawa maps, she did comment on her marriage situation within all her research interviews. Diane described in her first interview how she felt that her depression had adversely contributed to her marriage difficulties. Diane felt that the tension and unhappiness in her marital relationship were partly due to her depression and seemed frustrated that she was not able to find a solution or discover how to resolve the difficulties within her marriage as noted by rocks within her Kawa maps D01 & D03. In exploring this situation through using the Kawa maps and corresponding exploration, Diane was able to speak more openly about her concerns, frustrations, disappointment at not making progress. There was a sense of frustration too as Diane described a sense of disarray, of not knowing what to do, just sticking together and hoping it resolve itself.

"Because of my depression, it has given me a lot of marital problems which aren't too nice to deal with at home, so you can guess that is a big issue. We have sort of stuck together and muddled through but it has been a real mess." (Diane Interview 1)

Diane described in her comments below how the approaching return of her husband from his time away, would result in them having to confront their marriage difficulties. There was a sense of Diane being concerned as to whether her marriage would survive a deeper examination and scrutiny, now that they would be together again. Diane also described how her husband's absence felt like a form of temporary relief; as she was freed from having to think or confront the complex relational issues. Diane's depression might have also created an emotional gap between her and her husband, which might have been exacerbated by their prolonged absence from each other and with both having quite separate lives. In fact this physical separation could have been almost intentional as both Diane and her husband may have consciously decided to avoid each other and the issues they struggled with.

"The marriage issues are coming up, but because he has been away for quite a while, I haven't been involved in this problem so much." (Diane Interview 2)

Although Diane continued to identify her marital issues as a potential concern (rock) or stumbling block within her personal maps (D01-03), she appeared to have gained greater insight in respect of her life circumstances, enabling her to appreciate things differently. Diane also seemed to have derived a new sense of optimism by the end of the second interview after creating her Kawa map and engaging in a narrative discussion. Through examining her Kawa map (D02) Diane was able to observe the progress made within several areas of her life and how she had acquired a whole collection of assets from engaging with writing poetry, singing, being on the radio, voluntary work and increased

social support. All these positives appeared to help her feel more capable and confident about addressing her marriage issues.

> *"That is still a rock. It may be a rock when he comes back. I don't know. I may see it differently when he comes back because I have improved with all these other things. I am hoping that the confidence I have got since he has been away, by doing all this, will help me to overcome the problems. I may not see it as such a difficult problem when he comes back." (Diane Interview 2)*

In examining her series of Kawa maps during her final interview, Diane was able to visualise a more optimistic outlook on her life and seemed to also acquire a new perspective of her husband and began to regard him as being supportive of her. This new outlook seemed to lead to an overall improvement in her relationship with her husband and by her fourth Kawa map (D04); Diane ceased to identify her marriage as an area of concern (rock).

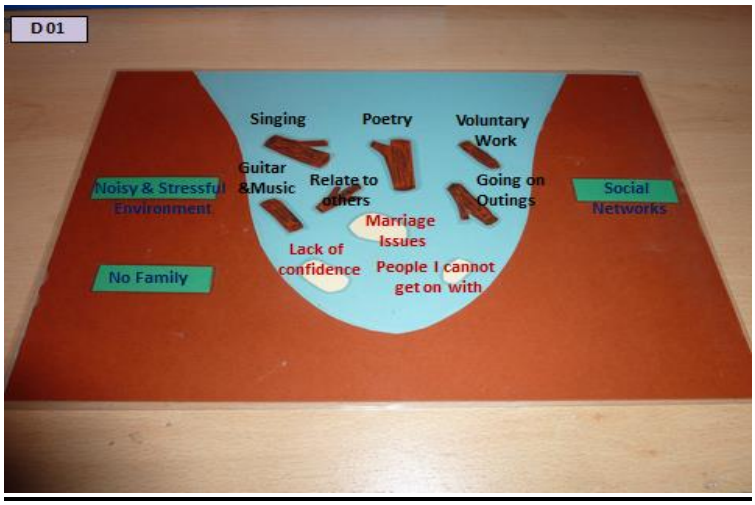
> *"Well I was delighted he was there. I see him in a different light now. I realise that he was supportive rather than, how can I put it, rather than a burden." (Diane Interview 5)*

During her last interview, Diane described being elated when her husband turned up to support her in one of her music performances. Diane described how over time she had viewed her husband in a different light and as someone who was understanding and supportive of her rather than obstructive or difficult. Diane could observed from examining her series of previous Kawa maps how she had perceive her husband as part of her marriage concerns (rock), within maps (D01-03) and her views of him shifting to such an extent that he was longer a rock but an asset by her final Kawa map.

Family and relationships

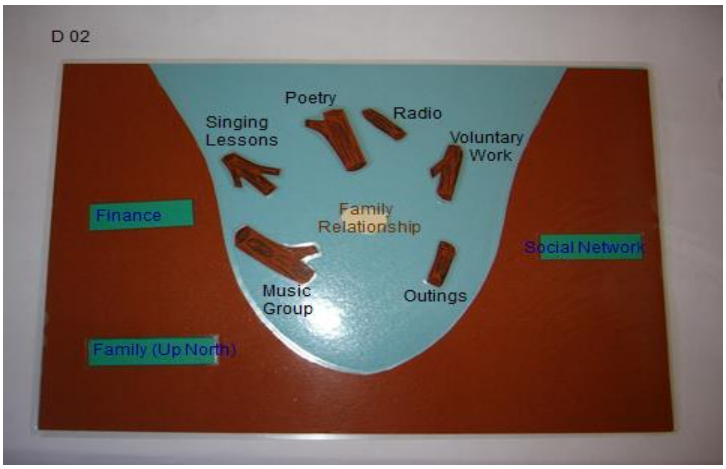
In her first personal map (D01) and initial interview Diane indicated that she had ‘no family’ (environmental support) and that she at times found it hard to ‘relate to others’ (a liability). She also described in her first personal map (D01), several occasions when she found it ‘difficult to get on with others’ (rock), which she felt made her more reluctant to socialise and form relationships. Diane attributed her social difficulties with her continued ill health and felt that her low mood had led her to become increasingly more isolated.

In examining her own Kawa Map (D01) above, Diane described how her lack of contact with her extended family, her only son and her husband, had added to her feelings of loneliness and isolation. There was a sense of Diane feeling almost ‘abandoned’ by those she regarded as closest and most important to her. She seemed to indicate that they were absent when she needed their support most, perpetuating her feelings of loneliness, isolation and disappointment.



“This environmentally means I haven’t got any family around me. I have got a son who is grown up now and a husband, but he is away a lot. Basically it means to me that I don’t really have a lot of support at home.” (Diane Interview 1)

Diane had initially highlighted in her Kawa map (D01) ‘no family’ as one of the environmental factors that influenced her health. However during her second interview Diane described how in re-examining her Kawa map (D01) she had realised that her extended family had not chosen to be absent when she was most unwell, but that she had in fact reduced contact with them when she was most unwell. Diane described how the depression caused her to withdraw and isolate herself from her family and reduced all contact she had with them. For Diane this initial misperception might have felt like her wider family was forsaking her and increased her sense of isolation and despair.



“The family issues are changing. I am much more in touch with my family now and I am going up north soon.”(Diane Interview 2)

In her Kawa map (D02) as indicated above, Diane continued to describe ‘family relationships’ as a challenge (rock) that she needed to overcome. As Diane’s mental state improved between the first and second interviews, she mentioned attempting to re-establish contact with her wider family (family up north). Diane explained during her second interview she had actually written and spoken to her siblings for the first time in a decade and had even arranged to visit her extended family in the following weeks. This notable change had seemingly resulted from

Diane creating her Kawa maps and noticing what she had been missing in her life and then deciding that she wanted it to be different. Examining her Kawa map in this instance had highlighted what was absent in her life and how she wanted to change this aspect of her life.

> *"I have a problem with communicating, because it comes from my depression. I have been ill for so long I don't quite understand what people mean and they don't understand necessarily what I mean." (Diane Interview 1)*

Diane's increased contact with her wider family seemed to coincide with an improvement in her mental state. Diane described how she felt that her increased self-belief and confidence had prompted a desire to socialise with others although she remained anxious about her ability understand and communicate effectively. In reflecting on her Kawa maps, Diane described how being depressed seemed to blunt her social skills, causing her to feel vulnerable when in the company of others. Despite her fear of being misunderstood, Diane seemed determined to change things around and to establish more social contact and work on her relationships with the whole range of individuals from her husband, to her family and new friends.

Creative interests

Diane indicated her main interest during the year, was engaging in creative and artistic pursuits. Diane described a range of different creative interests which were highlighted within her Kawa maps (D01-05) and interview responses. These included singing, poetry, music, learning the guitar, which she identified as assets within all her personal maps.

Diane described in her first interview that as her mental health improved, she became more aware of the different creative interests she had. Diane felt that the depressive symptoms she suffered had dulled her senses to such an extent that she had become unaware of her creative ability. In a sense Diane seemed to highlight a process of personal discovery taking

place, describing a distinct connection between her improved mental state and her increased engagement in creative activities of interest.

> *"A lot of my interests are all creative which I never knew existed in me before, when I wasn't well. I've got a lot of creative hobbies now." (Diane Interview 1)*

Diane also felt that as her mental health improved, her desire and motivation to try out different activities increased. In the quotation below Diane describes getting involved in a varied range of creative activities like singing, writing poetry, learning the guitar as she felt better within herself. There was a sense Diane's improved mental state seemed to reveal a hidden creativity, allowing her to more freely and confidently express her creative talents.

> *"Well since I started feeling well I have been a lot more creative. I like writing poetry, music. I am in a little music group that we have here. I am learning to play the guitar and I am singing in the church now." (Diane Interview 1)*

Through examining her previous Kawa maps, Diane noticed an increased personal interest and motivation within her and described feeling more energetic and interested about life in general as her mental health improved. She felt that her creativity and drive may have been curtailed by her depressive episodes. There was also a sense of Diane suddenly noticing the expanse of exciting activities before her as her health and recovery improved. Diane appeared to use the Kawa mapping as a form of therapy, to almost establish and gain some extra level of insight into what changes were important for her health and recovery.

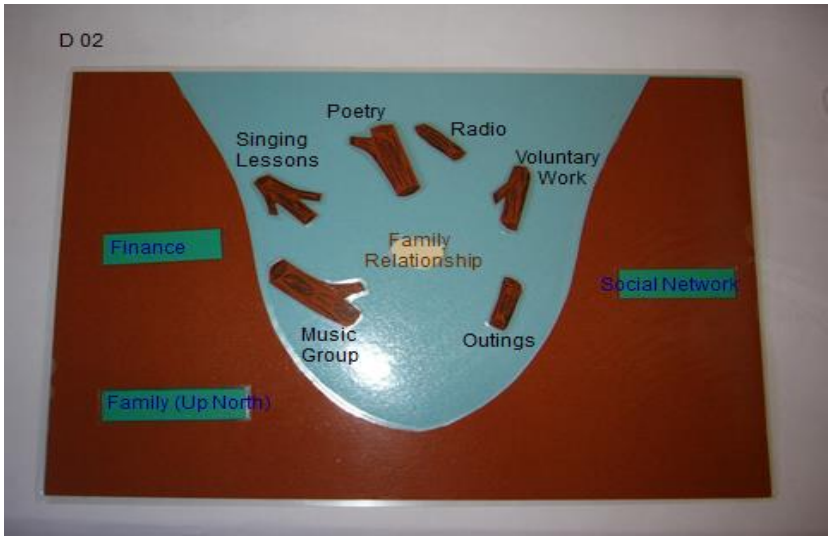
> *"I am very much more active. Far more interested in things, far more creative than I have ever been in all my life." (Diane Interview 3)*

Singing

Diane represented singing and singing lessons as an asset in all her five personal maps. She described in her very first interview how she derived enjoyment from singing and music. Diane selected equal size driftwoods within all her five maps (D01-05) to represent how her interest and enjoyment in singing and singing lessons did not diminish throughout the year. She constantly felt that singing and the singing lessons she engaged in were a valued asset within her lived experience. This valued position that singing and the singing lessons seemed to be influential throughout Diane's recovery journey. Whilst her love for music and learning the guitar which were regard as an asset in map (D01) and being part of a music group (asset) in map (D02) became combined with her singing in her subsequent Kawa maps.

> *"So I went to the workshop a couple of times and I got really interested and she told me actually that I had a beautiful voice and she was wondering why I had never used it before." (Diane Interview 3)*

Diane continued to demonstrate her interest in singing, when she described in her comments above attending a singing workshop. Diane explained how she had received very positive feedback and described feeling encouraged and affirmed by the praise she received and how it had helped her self-confidence. Diane described how the positive experience in attending the singing lessons spur her towards taking more singing lessons and professional coaching over the next months, which she highlighted as an asset within her Kawa map (D02). Diane also expressed a desire to fulfil one of her dreams to sing publically and felt that she could only achieve this dream by beginning with professional singing lessons.



"I would like to take up vocal lessons, proper singing lessons." (Diane Interview 2)

Diane also highlighted in her Kawa map (D02) how she had joined a music group/band with a view to performing in public which was a sign of her new self-confidence. There was a clear sense of these two aspects being interrelated, where Diane's confidence provided her the courage to be part of a band and to consider singing in public and that by performing in public her self-belief and confidence would improve.

"I am actually participating in a little band and singing in public which must mean I am gaining actual confidence." (Diane Interview 2)

In fact Diane explained how she had achieved her dream by taking part in a performance and had received praise and positive feedback about her singing. Diane's described feeling delighted and valued receiving such positive comments and this boosted her self-worth. Diane indicated in her comments below her surprise that her singing had been valued and how this experience had made enhanced her self-belief. It seemed to also provide Diane with a new identity and role, where she was not just a

mental health service user but also a singer/ performer and able to offer something back to others.

> *"I'm thrilled, it's a personal joy. For me it's my self-esteem. People actually appreciated it and said you have a beautiful voice. Of course that makes my head very big, I'm really pleased." (Diane Interview 3)*

Poetry

Diane also described writing and reciting poetry as an activity she really enjoyed and identified both activities as (assets) throughout all her personal maps (D01-05). She explained how her self-belief and confidence had increased as a result of her successes with her poetry and described feeling proud of her achievements in having some of her poems recently published in magazines. These successes similarly enhanced Diane's confidence and self-belief and encouraged her to be more ambitious, with Diane expressing a desire in to get her poetry published in a book.

> *"I already do that in bits and pieces, in newsletters, magazines and things like that. I would like to see if I can get them published. I am looking for a publisher for my poems; I would like to publish my poems in a book." (Diane Interview 1)*

Diane new level of confidence was reflected in her comments above where she believed that her poetry was of a good enough standard to be published. Diane subsequently described making contact with several book publishers and sending them samples of her poetry. For Diane this seemed to represent a substantial change in how she perceived herself and her abilities. In fact Diane recounted in her second interview how she 'got a slot' on a local radio station to read out some of her poetry. Although Diane mentioned being nervous, she managed to have the confidence to recite her poetry on radio. Diane described how the experience of reciting her poetry on life radio was a fantastic boost to her

self-esteem and something that she never imagined she would be capable of doing.

> *"I am a volunteer on the radio. Once a month I am on H FM and I recite poetry. Recently they said I can have a half hour slot monthly with a presenter who chats and lets me recite the poetry over the air." (Diane Interview 2)*

For Diane this experience enhanced her self-confidence immensely as she gained the recognition and approval of others about the quality of her poetry and her ability to present her work publicly. In her Kawa map (D02) Diane identified both the poetry and her experience on the radio as assets, which she felt enhanced her self-confidence, health and recovery. In fact poetry and poetry writing were highlighted as valued assets in all of Diane's five personal maps (D01-05) and seemed to provide her with a new focus and direction Diane's success and new self-confidence seemed to propel her towards believing that she could succeed with other creative interests and try something new.

> *"I think they help you to express yourself basically and that over a period of time I think it makes you relax and realise kind of your own potential and what you like to do and the person you are." (Diane Interview 1)*

Diane also described an added therapeutic side to the whole process of creating, writing, singing and performing. This new passion seemed to provide Diane with the motivation and drive to attempt other meaningful creative pursuits. Whilst, Diane also explained how expressing her feeling and thoughts through the creative activities helped her to also relax. Diane further explained how she had gained a new understanding and insight into her hidden self and that she felt more in touch with her own thoughts and feelings.

Social networks

Diane described how she saw social support and networks (environmental support) as valued elements in sustaining her health and recovery in all five maps. She explained how she valued the mutual acceptance and support within the social and activity groups organised through the mental health charity. Diane also described how engaging in the activities and groups organised by the mental health charity was a way of meeting other people. Diane felt she had a safe and supportive place to go to, get involved, be supported and socialise with others. Diane appeared to associate participating in the groups and activities as aspects which enhanced her quality of life and felt it helped her feel more connected, involved and supported. In fact the esteemed value that Diane ascribed to 'social networks' were reflected by its continued presence as an essential environmental support throughout all her five personal maps (D01-05).

> *"Coming here helps me an awful lot. Socially I make sure I am never lonely, never alone too much. I make sure I am not bored." (Diane Interview 5)*

Diane also described a sense of solidarity with others at the mental health charity, which prompted her to attend the self-help group. She valued the emotional support, the approval of others and more importantly the connectedness with other members in the group. Diane described the relief she felt of not having to defend herself as other group members understood her particular experiences and she felt accepted and a sense of belonging. This unique connection with other members seemed to fulfil a deeper need for unconditional acceptance too, as Diane valued not being judged and being regarded for who she was.

> *"The self-help group for women. We've got similar mental health problems. We go on holidays together and we have outings every month. So socially I make sure I am never lonely, never alone too much." (Diane Interview 1)*

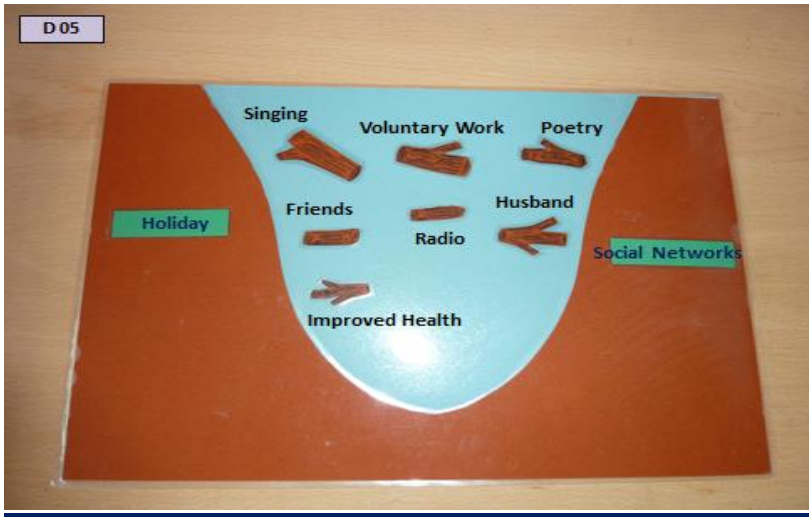
Additionally, the absence of close family support seemed to reinforce the importance Diane attached to the friends and even staff at the charity. Diane reflected on examining her Kawa maps how the friends and staff at the mental health charity seemed to represent almost a substitute family, providing her with the valued support and companionship she desired. Diane felt that the mutually supportive environment in the group helped her to also pursue her creative interest and promoted her health and recovery.

> *"Coming here helps me an awful lot. We have an art group here, they have the music group here and people you can relate to and this is open nearly every day of the week." (Diane Interview 1)*

Over the course of the year Diane self-confidence and sociability improved and through being support and accepted by others, her ability to relate to others improved. Such a shift was highlighted in her Kawa maps (D03), where Diane indicated began to indicate social networks as an important part of her (environmental support) and ceased mentioning a lack of confidence or relationships with others as concerns or challenges (rock) in her recovery. In her Kawa maps D04-05, Diane did not indicate any rocks within her Kawa maps at all demonstrating that she had perceived her health and recovery to have improved substantially by the end of the research year.

Voluntary work

Diane also described her involvement in voluntary work as something she highly valued and seemed to derive a sense of meaning, purpose and identity through her volunteering duties. For Diane there was a sense that she saw volunteering as a way to give something back and her own way of contributing to the welfare of others.



Diane described her experience of volunteering as rewarding and fulfilling, helping her to look beyond her own circumstances to the need of others. Diane explained that she volunteered in various ways, from helping on the acute ward to supporting events organised by the mental health charity. In fact through all her five personal maps, Diane represented voluntary work as an asset (D01-05) and indicated it as a fundamental element in supporting her health and recovery, as noted above in the Kawa map (D05).

> *"I am also a volunteer at R and in the Internet Café; I make teas and coffees and work with friends at the Internet Café at the hospital."(Diane Interview 1)*

In her role as a volunteer on the acute hospital, Diane also described drawing upon some of her previous experiences to support those in hospital. Although some of her tasks might appear to be modest, Diane derived a sense of satisfaction in being there for other service users, supporting them in their time of need or just empathising with their circumstances. Latterly, Diane explained how her contribution and value had been acknowledged through the confidence shown by the professional staff who agreed to her request to set up a music band in the unit and being entrusted to run the band/music group. Diane described how she felt this as an affirmation of her skills and ability to be trusted

with something she regarded as important. Diane described the trust she received as an approval of her contribution and she mentioned feeling her confidence multiplying and further encouraged to get even more involved as a consequence.

> *"Oh and I am striking up a little band at Mental Health Unit. I have been offered a separate little room, my own space." (Diane Interview 2)*

In reviewing her series of Kawa maps (D01-05) at the very last interview, Diane was able to observe a pattern occurring around the importance of volunteering both as a form of helping others, but also as a way of enhancing her own self-esteem and confidence. Her positive experiences as a volunteer seemed to help Diane to recognise her own potential and help her realise her own capabilities and self-worth. Diane was further able to visualise herself as more than just a mental health service user, but as someone who could use all her knowledge, skills and personal experience to contribute and improve on the experiences of others service users in a similar situation of need.

Confidence

Diane described how the progress she made over the year helped her to re-discover her personal confidence and self-belief. Diane highlighted in her initial Kawa map (D01) that one of the challenges (rocks) she faced was her 'lack of confidence'. This lack of confidence influenced how Diane perceived herself and the contribution she felt she could make. However through examining her series of Kawa maps and observing what she had been involved in over the year including her various achievements, Diane noticed several personal changes and how her confidence and self-worth had markedly increased.

> *"Well you know I am helping people again. It builds up my self-esteem. I am not just sitting at home." (Diane Interview 3)*

This new confidence seemed to instil a sense of confidence and Diane described how her personal goals and ambitions had amplified as a result of her new confidence. Diane described her experiences of singing and reciting her poetry in public, speaking on the radio and at the library as important confidence boosting events. This new confidence influenced her interaction with others and Diane described a more positive outlook and feeling more assured and relaxed in initiating and establishing new relationships.

> *"I am more positive. I am getting on better with people. I am learning how to get on better with people I think because I have got more confidence I suppose." (Diane Interview 2)*

Diane further explained how being entrusted with added responsibility within her voluntary role to set up the music group had substantially boosted her confidence. There was a sense the faith that others had of her abilities, helped Diane to have more self-belief.

> *"The Head there said I could perform music for the patients if I wished and I took my guitar and start playing for some of the patients." (Diane Interview 3)*

Diane's new confidence seemed to bring about psychological and emotional change within her, as she began to value both her own contribution and challenged her previous negative self-image. For Diane there was a sense that performing, and offering support to others was also an emotionally uplifting and psychologically enriching experience for her.

Summary of Diane's Kawa Maps

Like Peter, Diane was able to make use of the mapping process and the creation of her Kawa maps to help her to gain added insight and understanding of her circumstances and experiences of recovery. Diane

was much more positive with using the Kawa maps and was able to immerse herself in the whole process and highlighted at several points in the interviews how she identified with the metaphors and concepts of the Kawa model as reflective of her recovery journey. Particularly, Diane seemed to gained greater awareness of her life circumstances and she reviewed her series of maps and was able to observe the flow and journey of her evolving recovery.

Analysing the Kawa Model and Personal Recovery

Introduction

The following section will highlight the similarities and differences between the two participants in terms of their experiences in utilising the Kawa maps. Additionally, it will also contain the my evaluation of the benefits of using the Kawa maps as opposed to merely the interview alone in attempting to ascertain and understand the lived experiences and recovery journey of the participants.

First impressions

Both Peter and Diane responded quite differently when they were initially introduced to the Kawa model and maps. Peter for example admitted that he was initially sceptical about the value and usefulness of the Kawa maps in helping him to chart his personal recovery. Peter seemed to feel that the Kawa maps lack sophistication and he could not see how they would help him to examine or understand his own lived experiences. The scientific and analytical nature of Peter's previous University education in studying computer sciences might have influenced his scepticism about the natural concepts and underpinnings of the Kawa Model.

> *"To be frank I thought it was a bit airy fairy." (Peter Interview1)*

Diane on the other hand immediately related to the Kawa model and maps and was able to identify with the concepts and workings of the Kawa model almost instantaneously. Diane described how she had come to see the river metaphor as an exact replica of her life journey. Diane also felt that the Kawa maps she created were not a detached or separate image of her life journey, but actually a distinct representation of her personal self.

> *"That to me is the picture of me. It is not just a picture of my life but the river will be a picture of me." (Diane Interview 1)*

However as both Peter and Diane began to engage with the Kawa model throughout the research year, both participants began to see the positives in using the Kawa model and maps. Peter for example described how his views had changed over time and he could see the benefits of using the Kawa maps. Peter described how creating the Kawa maps had helped him reflect upon and better comprehend his lived experiences and recovery. He had also developed insight and understanding of how the different elements within his life had been influential in promoting or hindering his personal recovery both in the present and in the past.

> *"I was a little sceptical when we started it, but I have found it, particularly helpful in the session we have just had. I have found that this way of doing things has helped me understand the various things that have happened to me in the past few months, particularly over the years in a longer sense." (Peter Interview 4)*

Diane explained how creating and then examining her completed Kawa maps, seem to make everything much clearer for her. Diane indicated in her comments below how it felt like she was having her eyes opened to the reality of her life situation. That having a pictorial image of her circumstances, with everything laid out clearly in front of her seemed to bring awareness and insight. This new understanding had help her to appreciate how the different factors in her live had influenced her life

journey and recovery. In fact Diane's perspective complemented those of Peter in terms what they saw as the overall benefits of the Kawa model and maps.

> *"It is actually in front of your eyes and you are seeing things. It is probably supposed to help you see things clearly, make you more aware of yourself and your own circumstances at this present point in time." (Diane Interview 4)*

Clarity and connection

Both Peter and Diane described gaining clarity and a better feel for their personal situation through creating and examining their personal maps. They indicated how the process of thinking, visualising, physically placing the different pieces within the Kawa template and constructing their personal maps helped them to connect with what was happening within their lives and recovery experiences. Peter's described how the actual process of physically engaging with the construction of his personal maps, thinking about each component, deciding upon their importance, and placing it within his river, helped him to get a feel for his own life circumstances and brought clarity about the actual value of each factor and how they influenced his recovery journey.

> *"Actually doing it, picking up the pieces and putting it on the board it does make a kind of sense." (Peter Interview 1)*

Diane similarly described how being physically involved in constructing her Kawa map and then looking at her completed maps; seem to make everything much clearer for her. Diane indicated in her comments below how it felt like she was having her eyes opened to the reality of her situation. There was also a sense of Diane being able to commit her thoughts, worries and perspectives in tangible format and then stepping back and actually noticing how things were in her life, rather than mentally trying to make sense of it all.

> *"I never saw it that way but now I have actually fiddled about with all these little bits and pieces it is a different situation." (Diane Interview 1)*

Both Peter and Diane seem to agree that being able to physically manipulate and experiment with the Kawa map and the various component pieces helped them feel more connected with their own experiences and provided an added viewpoint in appreciating their circumstances. The process of physically creating the Kawa maps also enabled them to gather test out different scenario with a safe forum.

Longitudinal overview

Both Peter and Diane felt positive about having a collection of Kawa maps at their disposal which reflected their life journey across the year. They valued the opportunity to be able to review the series of Kawa maps they had created and consider the possible patterns, trends and the influence of the different factors in contributing to their overall health and wellness.

Peter described undertaking a process of self-examination, reflecting on what his life had been like not only across the research year but also looking back over the last decade. This period was particularly important to Peter as the last time he was admitted to hospital was over a decade ago and Peter was understandably keen to gather insight on what had helped him in remain well for such a long period in time.

> *"I have enjoyed it and it has made me think about the different factors that have come together over the last 10 years to result in me being stable for that long." (Peter Interview 5)*

Through exploring and examining his series of Kawa maps Peter was reminded of the challenges that he felt and recognised that he had made improvements over the years and had gained extra insight which he

hoped would help him to remain well and out of hospital. Peter described a determination to keep physically and psychologically well and was keen to continue with his recovery.

> *"I want to make sure I stay well, yes and not get into the silly mind things I was doing when I nearly became ill again. It made me think that I have done well over the last 10 years to be so well but I do want it to continue." (Peter Interview 5)*

Visual perspective

One of the distinct qualities of the Kawa maps was the creation of a pictorial image which the participants were able to then further explore and examine. These personal maps provided the participant with a unique visual dimension of their life circumstances and feature the various elements that they felt contributed to their life experience and recovery. Both Peter and Diane were extremely positive to have this extra facet of visualising and understanding their personal recovery.

Peter described how looking at his personal maps made him reflect upon what he actually valued in his life and therefore focus on what was most important. There was a sense that with so many conflicting interests to occupy his time it could sometimes be confusing for Peter to decide what he should devote his energies too. In fact Peter explained how through examining his Kawa maps and the range of activities he had been involved in, he was eventually able to prioritise and focus on meaningful activities that were most beneficial to his overall health and recovery.

> *"It makes you think about what is important in your life and what isn't." (Peter Interview 3)*

Diane similarly described the visual aspect of her Kawa maps as a positive as she was able to observe what she had been involved in through her life and then decide what she wanted to focus on next in

order to best sustain and enhance her health and recovery. Diane mentioned how creating her personal maps enabled her to express how she felt about her circumstances and to begin to work towards finding a solution.

> *"Makes you see what you are doing in your life and then you voice what you would like to do with your life in the future along the river." (Diane Interview 3)*

Discovering the wider context

Both Peter and Diane noted how the using the Kawa maps helped them to consider the wider context of their lives beyond their immediate interest or concern. In attempting to understand the factors that supported their recovery, they would instinctively focus upon their problems or challenges in life like their diagnosis or the particular factors that might support their recovery like medication. However the workings of the Kawa model were such that their attention would move beyond their presenting concerns (rocks) that impacted upon their lives and consider the wider range of (contextual and environmental) influences like family, social support, physical environment, cultural norms that may be influential within their lives. Additionally, the Kawa Model also encouraged participants to consider the different personal assets within their lives such as personal attributes and interest which they could make use of to positively enhance their lived experiences.

Peter explained how the Kawa maps helped him to look beyond himself and to focus on the multitude of external factors like assets and environmental factors which promoted and sustained his health and wellness. Peter described how he was able to identify such additional factors like his flatmate and settled accommodation, his relationship with health professionals or his freedom pass, which he would not have immediately considered to be influential to his recovery.

> *"I mean doing the maps has teased out some of the different features that helped in my case to stay well, which I had not really considered." (Peter Interview 5)*

Diane described how the whole concept of the Kawa maps was something which she regarded as helpful for understanding her own depression. Diane in examining her Kawa maps felt it provided her with a clearer outlook of how the assets in her life had been instrumental in supporting her recovery. She also noticed how her confidence, social networks, her extended family and re-establishing contact with her husband as all aspects which influential in her recovery.

> *"You see I've never really connected with him because of my illness. But we have had a lot of time together recently and I see him as a different kind of person." (Diane Interview 4)*

Engaging with the Kawa maps appeared to have provided both Peter and Diane with a level of awareness, insight and understanding in positively improving upon their health, well-being and recovery.

Summary

The above chapter focused on two specific participants, Peter and Diane and their engagement with the Kawa model and maps. This detailed examination of their individual experiences in mapping their own journeys of recovery builds on the previous findings of the chapter which adopted a collective examination of the value of the Kawa model and maps for the whole cohort of participants. As with the previous chapter, the Kawa Model Framework Index was introduced as a means of analysing the Kawa maps and within this chapter this has been applied on an individual rather than collective basis. Similarities and difference in opinions between both participants in terms of contribution of the Kawa model/maps have been examined.

The next chapter with a focus on a discourse of the preceding three Findings chapters, where existing research and literature will be employed in the discussion of the findings derived from the current research study. A critical analysis of the benefits and limitation of the current research study will be highlighted and my reflections of the research process will be examined through the use of the Kawa model as a reflective tool.

Chapter 8 Discussion

Introduction

I will in the following chapter provide a discussion of the findings from the current research and draw upon published literature, policy documents and previous research. I will also examine the personal interpretations of recovery and highlight what the participants felt to be influential in their personal recovery. I will debate the contribution of the Kawa model as a visual and narrative tool in exploring personal journeys of recovery and further discuss the use of IPA within the research. A critique of the strengths and limitations of the current research and my personal reflections as a researcher throughout the research process will also be presented.

Research Question

What is the contribution of the Kawa 'River' Model in exploring the personal journeys of recovery of mental health service users?

Research Aims

- Examining the personal experiences of mental health recovery from a phenomenological perspective.
- Examining the experiences that participants identified as influencing their personal journeys of recovery using the Kawa model.
- Examining the value of the Kawa model as a visual tool in exploring the personal journeys of recovery.

Outline

In the research I wanted to provide the participants with the opportunity to share their biographical interpretations of recovery. Having a voice and

being heard is an empowering experience (Borg and Davidson, 2008), enabling the individual to tell their story and share their personal thoughts, insights and feelings. Feeling empowered enhances self-belief, providing the individual with hope and confidence to set goals and plan for their future (Baker and Strong, 2001).

The choice of a longitudinal qualitative study centred on the use of the Kawa model in conjunction with exploratory semi-structured interviews provided the participants who were expert within their own lives (Pitt *et al*., 2007), the opportunity to explore and review their own journeys of recovery. The repeated interviews and creation of a series of Kawa maps over the year resulted in each participant having both visual and narrative records of their personal recovery. I will next discuss the different recovery perspectives and examine how the participants made sense of their personal experiences.

Meanings of recovery

> *"Learning to cope with your illness and to live as normal a life as you can." (Kim Interview 1)*

I wanted to ascertain how each participant perceived of their recovery and what they felt to be influential in maintaining their mental health and well-being. Anthony *et al.,* (2003) highlighted recovery as a personal concept and emphasised the importance of appreciating and understanding how each individual experiences, interprets and makes sense of their own recovery. In the research each participant described the individuality of their recovery through various personal statements made. Kim felt that achieving recovery meant being able to manage her condition in order to restore some form of normality in her life. Whilst, Anne highlighted discovering the source of her difficulties and achieving resolution as an indication that she had attained personal recovery.

Participants' personal interpretations

Personal awareness and insight was highlighted by the participants as crucial in supporting their own recovery. Allot *et al*., (2004) indicated that only by understanding their own recovery can the individual begin to take control and decide how to manage their own health and well-being. Promoting personal recovery requires the individual having insight, knowledge, skills and confidence to regain control of their own health and well-being (Repper and Perkins, 2003; Mancini, 2005). It also requires tackling the power imbalance that exists between service users and mental health institutions and practitioners. Only by redressing this power imbalance and recognising the status of the individual as the expert in their own life can the individual be proactively supported in their own recovery journey (Beresford, 2002). I emphasised the importance of this expert knowledge by reminding the participants that the focus of the current research was to gain specific insight into how they experience their own recovery rather than a universal approach to recovery. Mental health services must be tailored towards promoting health, well-being and recovery rather than merely achieving clinical outcomes and service targets. I felt that the current research provided an opportunity for such a rebalance of power, by acknowledging the position of the participants as experts and eliciting their perspectives, experiences and ascertaining what they perceived as supportive of their individual recovery.

Learning to manage

Although the research participants highlighted differences in what recovery meant to them, they were unanimous in emphasising the importance of proactively managing their own health and well-being. All the research participants had extended mental health histories of more than 30 years and had concerns beyond just the elimination of symptoms. They highlighted the importance of taking back control and having influence over their overall health and avoiding readmissions to hospital, views which were echoed by participants in previous studies by (Mancini,

2005; Borg and Davidson 2008). The experience of fluctuations in their mental health over many years and particularly the trauma of being admitted to hospital might have reinforced the desire to retain as much influence and control as they could within their own lives.

Curtis (1999) in her research study indicated how hope, self-belief, determination and personal resources were essential for those trying to cope with relapse and overcoming self-doubt. Service users also need sufficient knowledge and support to develop resilience and find solutions to manage the fluctuations within their mental health (Ridgeway, 2001; Higgins, 2008). Lloyd *et al*., (2008) in her research similarly highlighted how having hope and belief that their lives would improve, motivated service users to set personal goals for their future.

Actively maintaining health and well-being

The participants within the current research expressed different views around how they maintained their health, well-being and recovery. For some participants, it started with getting the basics right, beginning the day well, eating healthily, having a routine and getting sufficient rest. This perspective was reinforced by Pitt *et al*., (2007) in their research, where participants highlighted the importance of being able to continually engage in the simple aspects of their daily life and maintaining a healthy balance as essential to maintaining their health and recovery.

Borg and Kristiansen (2004) in their research highlighted how gaining insight and self-belief were instrumental in influencing health and recovery; a view also expressed by several of the current research participants. They described how gaining self-awareness and confidence helped them to understand what contributed and restricted their own recovery, with participants indicating exercise or joining a self-help group as practical examples in promoting their own health and well-being.

Trivedi and Wykes (2002) outlined how a combination of awareness, confidence and knowledge can empower the individual to move from the 'passive position' of a 'mental health patient' to becoming an active agent in promoting their own health and recovery. This perspective aligns both with my personal beliefs and also the ethos of occupational therapy, where enabling and empowering service users to be involved in their dictating their interventions is both valued and encouraged (RCOT, 2016). As an occupational therapist and someone who endeavours in being proactive, the participant's active approach in promoting their own health and recovery was an aspect I was keen to further examine within the research. Yet I had to find a balance to ensure that I continued to maintain my role as a researcher to explore these personal perspectives, rather than carry out active steps within the interview sessions, which might result in the series of interviews being perceived as therapy sessions by the participants.

Avoiding relapse and readmissions

All the research participants described the importance of avoiding a relapse and their fears of ending up in hospital. They agreed that being admitted to acute hospital was a traumatic experience which they wanted to avoid. Several of the participants also evaluated the success of their recovery according to the length of time they had remained out of hospital. Peter, felt he had not achieved recovery as long as he was susceptible to relapses resulting in hospital admissions. The trauma of being readmitted was highlighted by several participants and corresponded with the views expressed by mental health service user organisations such as MIND and Rethink, which highlighted the loss of autonomy, absence of privacy, lack of choice and independence as key concerns of acute hospital care (Sayce, 2000 and Mancini, 2007).

Mead and Copeland (2000) in describing their own mental health recovery reinforced the importance of taking personal responsibility for safeguarding their own health and well-being. Several of the research participants, for example Kim, Jill, Stewart and Diane in reflecting upon

their own experience of being readmitted to hospital, highlighted the importance of not rushing to achieve recovery. Instead they regarded investing time to get well and adopting a more measured approach as key to prevent cycles of readmissions. This perspective may have been particularly relevant to the group of research participants due to their long mental health histories, which may have prompted them to regard achieving recovery not as a 'sprint' but as a 'marathon'.

This view was similarly expressed by Nixon, Hagen and Peters (2010) in their phenomenological research study involving 17 participants who were recovering from psychosis. Participants highlighted their recovery as a continuous process that fluctuated and indicated the value of working with health professionals to determine the facilitators and barriers to their recovery. They also recognised the importance of keeping with their routines, developing new interest and actively monitoring their mental health to support recovery in order to remain out of hospital.

Facilitators and barriers to personal recovery: A subjective perspective

Within the current research, several overarching themes were identified as influential in contributing to recovery. An examination and discussion of the phenomenological perspectives will be highlighted next:

Feeling more socially connected

"Socially I am getting on better" (Diane Interview 2)

Participants within the research highlighted that they felt more socially connected and comfortable with others over the year due to a combination of different factors. This included a greater sense of belonging, feeling accepted by their peers, being listened to and increased network of relationships. All the participants were members of the same mental health charity and described a sense of belonging and

acceptance where they were able to be themselves. Mead and Copeland (2000, p.322) stated that “reaching out for support, connecting with non-judgmental, non-critical people who are willing to avoid giving advice, who will listen while the person figures out what to do is essential to feeling accepted and regarded”. Indeed the supportive culture of the mental health charity seemed to create a safe and supportive space for the members to explore, adopt new roles, try new activities and develop as individuals within their own right, without feeling judged or criticised.

Slade (2009) indicated the levels of discrimination and stigma that mental health service users often experience and the lack of social connectedness and inclusion within society as detrimental to their health and well-being. Having the support of friends within the charity, not feeling judged and being accepted as part of a group, enhanced the sense of belonging, connectedness and self-worth of the participants. This acceptance by others I believe enabled the participants to acquire the confidence to form relationships, get involved with new activities and groups beyond the charity, which increased their social networks and reduced levels of isolation. This view was echoed by participants in a study by (Borg and Kristiansen 2004) where peer-support, inclusion and connectedness were highly valued, reaffirming the importance of peer acceptance and sense of belonging in enhancing personal recovery.

Social support and relationships

The influence of family and close relationships was described as another contributory factor in supporting personal recovery and all the participants were able to outline how these various relationships had impacted upon their lives. The experience of many individuals with a mental health problem is that as their illness develops, it can negatively impact upon the relationships they have with those closes to them (Bonney and Stickley, 2008). The strain in their relationships can lead to further isolation and loneliness, which further contributes to a worsening of their mental health and well-being (Mancini, 2007). Several research studies have reinforced

support from family members, friends, healthcare professionals and peers as crucial to promoting recovery, by reducing isolation and loneliness amongst service users (Ahern and Fisher, 2001; Borg and Kristiansen 2004; Loumpa, 2012). Participants in the current research also reinforced this view, indicating relationships with siblings, children and partners as influential in enhancing their personal recovery. Indeed several participants in exploring the complexity of their family relationships, for example Peter relationship with his brother and Bert with his wife, seemed to acknowledge how the complex dynamics within their interpersonal relationships contributed both positively and negatively towards their mental health and well-being.

Health professionals

Support and relationships with health professionals was also indicated by several participants as being influential to their recovery. Haracz and Ennals (2015) suggested that the attitude and perspectives of health professionals can have a bearing on the rapport and trust between the service users and the health provider. Deegan (1993) highlighted the negative experience she had with a psychiatrist, whom she felt lacked compassion and understanding. She described how devastating the particular interaction had been for her, removing any sense of hope and optimism she had felt about her possible recovery. Several studies including those by O'Hagan (2001), Ramon *et al*., (2007), Pilgrim (2008), Chowdhury (2013), Katsouri (2013) similarly highlighted how the attitude and perspectives of health professionals and organisations can have either a positive or detrimental impact towards service users.

This prompted me to consider my interactions with service users in my previous clinical roles and within my new position as a researcher. Being aware of the power differential, made me conscious of how I engaged with the participants during the research interviews. How did I phrase the interview questions? Did I display a negative reaction to responses made

if I disagreed? Did I provide the participants enough time to answer and explain their perspective? Did I elicit their feelings and thoughts?

Due to my interest in the Kawa model and my previous experiences of using the Kawa model as a clinician, I needed to ensure I did not impose my beliefs and values upon the participants. I only introduced and explained the conceptual ideas and components within the Kawa model and did not engage in creating the Kawa maps or setting therapeutic goals with the participants. I stood back, observed what was created and requested clarification from the participants to gain deeper insight and understanding of their experiences. I also used my reflective diary and the Kawa maps I created as a researcher, as part of the reflective process and review my various thoughts and feelings.

Within the research, all the participants felt the relationships they formed with the respective health professionals, psychiatrist, psychologist, key worker, and occupational therapists were influential to their health and recovery. Several participants indicated how they respected the opinions of these health professionals and felt that the unconditional acceptance, respect they experienced, helped them feel more positive and confident about themselves and their abilities. One of the participants Jill described an encounter on the ward when she was told by the occupational therapist that she was ‘part of the team’ and felt she was treated as an equal even though she was a volunteer. Jill described the boost to her self-esteem and confidence she gained from the comment being made, as she respected the views of the occupational therapist.

However some participants also highlighted what they regarded as insensitive decisions which reflected the disparity in power between organisations, staff and services users. An example of this was highlighted by Peter who felt that the views of service users’ were disregarded when a new manager in a housing service decided to change the accommodation arrangements without consulting service

users first. Peter described what he saw as the new manager exerting his new acquired authority in making those changes without any regard of the wishes of the service users at all.

Both Stewart and Peter also spoke of how a change in their respective psychiatrist and key workers without prior warning, resulted in them experiencing added stress that could have led to a relapse. Both participants indicated that they valued the trusting relationships they had developed over time and felt there was a total lack of understanding of what they needed to maintain their well-being and recovery. These views were similarly echoed by Borg and Kristiansen (2004) in their research, where participants highlighted supportive therapeutic relationships, mutual respect and trust as key factors in enhancing health and recovery.

Looking outwards and getting involved

Adopting new roles, developing new interest and personal fulfilment were some of the additional ways in which the research participants evaluated their own personal recovery.

> *"You feel a sense of self-esteem that you've got something to contribute" (Jill, Interview 4)*

Another indicator of personal recovery highlighted by participants within the current research was to move beyond focusing within, to looking outwards. Participants seem to indicate that as their mental state improved they were less preoccupied by their own circumstances and more aware of what was happening beyond their specific situation. They also felt more motivated and confident to get involved, seeking to contribute towards the wellness of others. Bonney and Stickley (2008) described how recovery has become strongly associated with acquiring social roles, supporting others and engagement in meaningful activities, highlighting the importance of developing a sense of belonging, giving back and developing new roles and identities.

Making a contribution

None of the research participants were in paid employment, but found helping as volunteers to be a meaningful form of contribution, which enhanced their confidence, self-esteem and identity. This included organising and running activities on the acute psychiatric ward, making tea at the mental health charity or providing peer support. Engaging in these activities seemed to provide a sense of purpose, focus and fulfilment as the participants indicated a desire to 'give something back' and contribute towards supporting their peers.

Volunteering provided the participants with a sense of purpose, new roles and self-identity, which helped in shaping who they became over time. Several of the participants found that they were 'qualified' to contribute because of their lived experiences and availability rather than because they had specific qualifications or credentials. Setting out chairs, making tea for the women's group, peer support or being the chair of the local service user movement were various ways in which the participants felt involved and included. Increased self-esteem and satisfaction were benefits that were similarly indicated within several studies which examined the value of helping others. Research by (Mead, Hilton and Curtis, 2001; Coppa and Boyle, 2003; Casiday *et al*., 2008; Petersen *et al*., 2015) highlighted the benefits of providing peer support, whilst studies by (Perkins *et al*., 2012 and Meddings *et al*., 2015) reinforced the value of supporting and educating others.

Several of the participants were also involved in volunteering outside of the mental health context, for example contributing to the education of new health professionals at university, arranging the flowers in church and helping in the soup kitchen. Although involvement in such situations required moving beyond their comfort zone to volunteer in more public forums and endeavours, the participants seemed to derive greater sense of feeling valued, having meaningful roles and being regarded by others as equals, which further enhanced their confidence and self-belief.

Several of the research participants seem to re-evaluate their own roles and position through these experiences of being involved. They mentioned feeling more empowered as they adopted new roles, identity and responsibilities and recognising themselves as expert, able to use their own knowledge and personal experience to help others. This seemed to highlight an important shift in position and power, where they were regarded by others and also recognised themselves their position as mental health experts and theoretician of the self (Mancini, 2007). Involvement in educating students, being involved in Hospital Trust committees and working alongside health professionals reinforced the contrast between their new role, status and level of influence compared to their previous positions as patients on the receiving end of care.

Meaningful occupations

The participants were unanimous in highlighting the benefits of being engaged in occupations and activities that were meaningful to them. Participants describe being immersed in these different activities and deriving a sense of fulfilment and wellness. This corresponds with occupational science theory which highlights how engagement in meaningful occupations provides fulfilment and supports health and well-being (Christiansen 1999).

In the study by Eklund and Leufstadius (2007) which involved 103 mental health services users living in the community, participants indicated how being able to be meaningfully engaged in occupations and activities improved their overall health, well-being and quality of life. This reinforces the value of engaging in meaningful occupation as highlighted by Townsend and Wilcock (2005) in their discussion around the transformative power of occupation. Reinforcing the core principles of Occupational science theory and ensuring occupational justice for all service users to be included within society and have the opportunities to participate in occupations they find meaningful. Christiansen (1999) goes

further in asserting that involvement in occupations are instrumental in shaping and moulding the individual into who they will become.

All the research participants highlighted various creative occupations including, singing, art, poetry and music as activities which they particularly enjoyed. These creative occupations provided something meaningful to engage in and a means for self-expression, exploration and discovery. Csikszentmihalyi (1990) described how being immersed in creative activities can lead to state of 'flow' where the individual derives an optimal state of fulfilment. Previous research studies by Griffiths and Corr (2007); Reynolds and Lim, (2007); Van Lith *et al*., (2013); Horghagen, Fostvedt and Alsaker (2014); Lagace and Desrosiers (2016) have similarly indicated the benefits of being engaged in creative activities, which enhance both self-expression and discovery.

Participants in the current research also highlighted the value of physical activities such as walking, sports and dancing in enhancing their overall health and well-being. Participants describe how engaging in physical activities such as sports, helped in both improving their physical and mental health. All the participants recognised the link between their physical and mental health and were keen to be as active as possible. Peter for example described how he kept his bipolar disorder in check by regulating his walking levels to control fluctuations in his mood. The benefits of engagement in physical activity were similarly highlighted in previous research studies by (Dunn *et al*., 2005; de Geus, and de Moor, 2008; Teychenne, Ball, and Salmon, 2010) as beneficial in promoting mental health by curtailing mood swings and improving self-esteem.

Purposeful engagement in a range of leisure activities was also considered by the research participants to be beneficial to recovery. Several participants indicated how meeting up with friends, going dancing or being part of a choir, provided them with a routine, social contact and helped them to develop social skills, identity and confidence. The benefits

of taking time for leisure activities were supported by studies by (Henderson and Bialeschki, 2005; Bejerholm and Eklund, 2006; Fenton *et al*., 2017). Taylor and Kay (2015) emphasised the importance of leisure occupations, social connection, roles and the development of self-identity that promoted through meaningful and purposeful engagement in activities and occupations of choice.

Iwasaki *et al.* (2014) in their research amongst mental health participants further highlighted the dangers of boredom, loneliness and isolations that can occur when individuals are not being involved in leisure activities. Taylor and Kay (2015) highlighted how being engaged in leisure occupations can provide the individual with a self-identity, purpose and fulfilment. Whitford and Hocking (2012) indicated the importance of being able to participate and engage in occupations of choice and challenged the need for individual's to have choice and access to participate in meaningful occupations. This supports the principles of occupational justice which seek to ensure that individuals are provided with both the opportunity and choice to engage in meaningful occupations that support their overall health and well-being (Wilcock, 2006).

Coping with life's challenges

"I have been through the rapids and survived" (Peter, Interview 5)

Participants within the research highlighted how they had grown in confidence and developed a variety of life skills which helped them to cope with the challenges they encountered. Involvement in peer support, being a volunteer, engaging in creative activities, social groups and even involvement in public performances, helped enhanced their self–belief, resilience and self-esteem. Diane, for example, explained how she had, over the research year, become involved in many new areas, from speaking on the radio, to singing in public. She felt that her new confidence and self-belief helped her managed the challenges in her life, including the estranged relationship she had with her husband.

Confidence and self-belief

Participants were able to reflect back on the different Kawa maps they had created over the research year which highlighted how they had overcome previous challenges and barriers within their lives. Several of the participants indicated they were not afraid of facing the next challenge ahead as they had been through it all before and had succeeded, i.e. "*they had been through the rapids and survived*" (Peter, Interview 5). This new confidence helped them to reappraise any obstacles they had to face, manage the stressful aspects of their lives and feel more in control. Anne felt that she had made so much progress in dealing with her life circumstance that she had acquired a new determination to get to the root of her mental health problem. Hatchard and Missiuna (2003) in attempting to manage her bi-polar disorder, indicated that as her insight and her confidence increased, she began to have renewed self-belief in being able overcome her condition and to reclaim parts of former herself which had been 'lost to her illness'.

An evolving journey

"Life travels like a river...it moves" (Kim, Interview 5)

All the participants in the current research highlighted that their recovery had evolved over the research year. Three of the participants Peter, Maggi and Bert seemed at first to perceive that not much had changed for them as they indicated that their mental state and health had been stable for some time even before the research study. However, on examining the series of Kawa maps that they had created over the year, they described being surprised at noticing changes within their recovery journeys. They also noted how different aspects of their lives had shifted in prominence over the year indicating flow and fluctuations within their recovery.

Recovery is fluid and evolving

Slade (2009) described the process of recovery as dynamic and that its' fluctuates with the changing events and experiences in one's life. Comments from several service users within their own writings (e.g. Leete, 1989; Deegan, 1996a; Curtis, 1999; Mead and Copeland, 2000) describe in their own narratives a desire to move forward, to make progress and rediscover aspects of their former self and also establish a new identity. None of these authors felt overwhelmed by their illness but expressed a sense of hope, aspiration and discovery despite their health condition. Although three of the participants (Peter, Maggi and Bert), as described above, expressed some reservations about changes in their mental health, for the remaining five participants much had changed over the research year. They all described a sense of excitement and surprise when looking at their Kawa maps and noting the changes and progress they felt they had achieved over the research year.

By the end of the research year, there was sense of optimism and expectation amongst all the participants for something new to happen and new confidence to face the future. With new positivity, the participants seemed to indicate that they would cope and overcome the challenges ahead. Deegan (1996a) highlighted how a change in attitude and increased positivity can afford a new sense of belief to overcome the challenges one might face. For the participants the different responsibilities, roles and involvements they had undertaken over the year, created new opportunities to be involved in different ways and they expressed hope that their lives would continue to flow along unimpeded.

Contribution of Kawa Model to the Research

As highlighted previously, the current research adopted the use of a visual research tool in the form of the Kawa maps, in addition to eliciting verbal narratives through repeated interviews. The Kawa maps complemented the interviews, providing supplementary dimensions in

appreciating and understanding the recovery experiences of the participants. The Kawa maps provided a visual representation of the different elements that influenced the recovery journey of the various participants through the year. The tangible qualities of manoeuvring the pieces around the maps also enhanced the exploration of new perspectives within each situation. The Kawa model and maps were perceived to be valuable in several ways which will be discussed next.

Enhancing insight

The participants in this research were unanimous in highlighting that through constructing and reviewing their Kawa maps they derived additional insights and appreciation of their life world and recovery journey. The Kawa model were found to be useful in assisting the participants to focus beyond the immediate factors that might influence their recovery, for example their diagnosis or personal stress, to the wider spectrum of contributory factors that impact upon their health and well-being. Participants were required within the Kawa model to examine the whole collection of component/elements from challenges and barriers (rocks), to environmental factors (river sides and bottom), to assets and liabilities (driftwood) that may influence their overall health and well-being.

Participants within the research also highlighted what might be viewed as secondary factors that impacted upon their recovery, including having a freedom pass for free travel, being concerned about the electric meter, concerns about attending a wedding, pleasure from watching football, arranging flowers in church and singing classes as some examples of added factors which were influential within their day to day recovery. Many of these issues were not mentioned within the semi-structure interview stage that preceded the creation of Kawa maps. In this initial stage the participants were often more focused on highlighting what they perceived as primary factors influential in promoting their health and well-being. However through engaging with the Kawa maps, the participants were prompted to consider the wider range of environmental, social,

psychological, emotional and contextual factors that were influential in their health, well-being and recovery.

Acquiring increased personal awareness and insight through the Kawa maps was also supported by previous research studies into the Kawa model (Fieldhouse, 2008; Humbert *et al*., 2013; Owen, 2014; Bai, 2015; Dellow and Skeels, 2016). Paxton (2015), in examining the perspectives of occupational therapy students using the Kawa model as a reflective tool whilst undertaking their clinical placement, highlighted how the participants within her study felt that the whole process of creating their Kawa maps and subsequently reflecting upon what was represented in their maps, helped them to appreciate how different factors and events within their lives impacted upon their personal situation and health outcomes. Furthermore, Humbert *et al*., (2013) in her study involving women who had experienced domestic violence highlighted how the participants in her study indicated they had gained increased awareness and insight about their personal experiences through engaging with the Kawa maps and verbalising their narratives.

Visual clarification

A characteristic quality of the Kawa maps was that it provided individuals with something more definite than words alone to scrutinise and examine their collection of personal experiences. What was created within the Kawa map might represent something that the participant was not consciously aware of until it appeared within their maps. For example, Kim recounted that she had not realised, until observing her Kawa maps, how often she had taken on the role to help look after her grandchildren and how she would often sacrifice most of her weekends doing so. Likewise, Diane noticed from examining her Kawa maps that when she was most unwell, she had felt most abandoned by her family. However through creating her Kawa maps, Diane became conscious that during these difficult times she had actually chosen to isolate herself from her family, which increased her sense of feeling alone and abandon. Deriving

added insight was similarly highlighted in studies by Renton, (2010), Bai, (2015), and Paxton, (2015) where participants expressed how the ability to observe their personal circumstances within their Kawa maps and how it had evolved over time, enhanced clarity and understanding.

Jung (1957) described how 'thing which are vague or out of the conscious mind can become clearer when given a visual form' and that only by understanding our unconscious inner nature do we acquire greater self-knowledge. The unconscious event or story unspoken may remain hidden until there is help to raise it to our awareness (Jung, 1957). In drawing or placing the component parts within the Kawa maps, the participant might start to explore what was concealed and hidden from their consciousness and begin the first steps into gaining insight and personal realisation.

Reavey (2012) also highlighted the value of visual tools within both research and therapy, emphasising that visual methods are beneficial to those individuals' who might otherwise tend to over-verbalise or intellectualise their experiences, rather than recognising them for what they are and then connecting with them on an emotional level. Visual tools like the Kawa maps, for example, also help those that may have difficulty verbalising their thoughts and feelings to express what they feel or think in less structured ways. Rose (2016) indicated how visual methods within research can also help overcome the strong social desirability and self-editing process that can shape verbal story-telling, breaking up the 'rehearsed narratives' that individuals may have repeated many times before. These characteristic of visual methods enhanced the value of using the Kawa maps and mapping process within the research.

Something tangible to work with

Engaging with the Kawa model also provided the participants with something much more tangible to work with, where they were able to touch and pick up the component pieces within the Kawa template and to manoeuvre the different elements to shape their experiences. Several

participants valued the choice of picking up the Kawa component pieces and placing them within the different areas of their Kawa map to represent how they saw their experiences being lived out. This was a distinct experience which was not highlighted in previous research into the use of the Kawa model where participants were required to physically draw their Kawa maps rather than use the Kawa template and moveable component pieces that were developed for the this study.

The Kawa template and maps used within this research allowed the participants to physically manipulate the different component pieces within their river and therefore experiment with different scenarios. In undertaking this process, participants were able to create, visualise, consider and discuss their thoughts and views with the researcher. Previous research studies into the Kawa model (Carmody *et al*., 2007; Buchan, 2010; Renton, 2010; Richardson *et al*., 2010; *Owen et al*., 2014; Bai, 2015 and Paxton, 2015) did not involve the use of a Kawa template, with participants instead drawing their own Kawa maps. The participants in these studies did however describe the benefits they derived from being able to experiment, drawing different scenarios within their maps or a new map to represent different situations and outcomes they desired.

The benefits of having something that can be materially worked with, in attempting to understand personal circumstances and experiences is also highlighted by Zhou (2009) and Bertenthal-Smith (2015) who describe the use of sand trays in therapy. Bertenthal-Smith (2015) highlighted how participants could similarly choose different items to represent different aspects of their life and then physically deploy these within their sand trays to represent and construct how they saw or understood their own circumstances and shape their desired outcomes. Having something tangible to work with also enabled the participants to work through alternate scenarios and observe how their circumstances might be different dependent upon what actions and decisions they might make (Homeyer and Sweeney, 2011). When compared to other visual methods

like drawing a picture or creating a video, the use of the Kawa template were perhaps more structured and seemed to reduce level of anxiety, with participants indicating they were more comfortable and assured in using the template rather than drawing their own maps.

Safe exploration of personal experiences

In using the Kawa maps, the participants were able to undertake a process of self-exploration with the reassurance of a safe space within the research interviews to explore their thoughts and feelings. Using the Kawa maps to examine their personal circumstances seemed to promote examination of the 'inner self' as they had the space and time to examine their motivation and understand how their lives were influenced by the decisions they made. They could also create and examine alternative decisions and the possible consequences 'at a safe distance', without having to fully commit to a course of action until they felt ready to do so. Working with the Kawa maps, created a space to explore different scenarios, note the possible impact of different decisions and examine alternative solutions. The opportunity to examine their motivation, thoughts and mind set through the Kawa maps countered the views expressed by Wada that the Kawa model did not encourage self-examination (2010). The capacity of using the Kawa model to explore different scenarios and look at possible solutions was also highlighted in the previous studies involving the Kawa model with different groups of participants (Nelson, 2007; Buchan, 2010; Humbert *et al*., 2014; Gregg *et al*., 2015; Dellow and Skeels, 2016).

In the research conducted by Humbert *et al*., (2014), participants were asked to create a Kawa map representing their current circumstances and a second to reflect how they would like their circumstances to be different within 6 months. Participants were able to use their Kawa maps to explore their perception of the existing barriers which restricted their progress and also differentiate between what changes and goals they would set and work towards to enhance their own recovery. The

participants could therefore explore their personal circumstances, and actively work towards a solution. This was in contrast to the previous concerns voiced by (Keilhofner, 2008; Lee *et al*., 2012) around the lack of an assessment measure in the Kawa model, which might limit its' usability.

The physical construction of the Kawa maps was unique as the participants were able to create a visual representation of their preferred situation, explore what they needed to do and be empowered towards achieving the outcome they set. This was illustrated by Kim who indicated in her earlier Kawa maps that she was keen to go on holiday to Rome on her own. Kim not only explored what she wanted to do and how she might manage her trip, but subsequently planned her holiday, deciding on the places she wanted to visit and embarked on the holiday on her own.

Therapeutic space

I reminded all the participants at the start of the research process and also at the beginning of each interview that they were engaged in a research study. I also explained that my role within the whole process was that of a researcher seeking to understand their individual experiences of recovery and not to provide any form of therapy or clinical intervention. However it was impossible to prevent the participants over the course of repeated interviews and during the period of a year from developing a sense of connectedness with me. Indeed it was almost necessary to create a sense of safety and bond between the participants and me, to engender a supportive environment in which the participants felt comfortable enough to reveal and discuss different aspects of their daily life. Several of the participants Peter, Jill, Maggi and Stewart highlighted how they saw the multiple research interviews and working with the Kawa maps as almost like a form of therapy as they discovered more about who they were.

The participants were aware that they were involved in a series of five interview where they had the opportunity to talk about their experiences, thoughts, feelings freely and this might have provided them with a 'therapeutic space' to explore their ideas, views and emotions. Having spent a year talking with me at various intervals, might have created a deeper connection between both parties and felt to some of the participants like they were engaging in 'therapy', even though they were taking part in research interviews. In many ways the bond between the various participants and me was desirable as it created a safe space for a deeper level of examination and exploration of life events relevant to each participant.

Uniquely the four participants highlighted above, did not have access to any form of talking therapy (counselling or psychological input) at the time of the study and being afforded the time and space talk about their experiences and explore their recovery might have felt therapeutic. Indeed they might have considered the interviews not only as part of the research process but also as an opportunity to 'off load' their thoughts and feelings too. Although these exact findings from the current research were not echoed by participants within previous studies involving the use of the Kawa model. Participants in studies conducted by Richardson *et al*., (2010); Humbert *et al*., (2013); Humbert *et al*., (2014); Gregg *et al*., (2016) did indicate the benefits of having a safe space in which to explore and construct their own personal stories using the Kawa maps and to share their views without being judged. This seemed to suggest that both the Kawa model and maps were positively regarded by the participants as a beneficial medium to explore their lived experiences.

Heenan (2006), in a study conducted in Northern Ireland where art therapy groups were provided for those with mental health issues, highlighted how the art therapy groups seemed to provide an unconditional and safe space in which participants could explore their lived experiences and benefit from using art as a cathartic form of

personal expression. Although the study by Heenan (2016) was somewhat different from the current research, what was regarded by the participants in both studies appeared to be the unconditional regard, space and protected time they had to explore and derive personal insights.

Rose (2016), also highlighted that having a secure 'therapeutic space' encourages personal examination, expression of non–verbalised emotion, especially when it may be difficult to explain how one actually feels. The professional relationship between the researcher and the participant may create a 'safe professional distance' enhancing the opportunity for exploration of intimate feelings and views. In the current research, Stewart seemed to respond accordingly in several of the interviews, speaking without reservation about his desire to be in an intimate relationship, being envious of couples and fearing that he would never have the opportunity to find intimacy for himself.

Pictorial record and aide memoire

The Kawa maps also helped the participant's to remember their various experiences throughout the whole year. They assisted the participants' in recalling events and circumstances they had been through and provided a pictorial record of their year. Several participants mentioned how the series of Kawa maps enabled them to recall what their recovery journey had been like and also the situations they had overcome. Reviewing the maps had been particularly helpful for all of the participants as they could observe and assess trends emerging and gain a sense of how their recovery had evolved over the year, which were not as noticeable from just taking part in the interviews. Both Diane and Kim for example, mentioned their surprise at how busy their year had been and how involved they had been in various meaningful activities like voluntary work and creative activities, whilst Stewart and Jill were surprised by how they had managed to overcome a series of challenging events within the year. Rose (2016) described how social differences can more easily be

depicted in a visual format than verbally, allowing for comparisons over time to be made and similarities and differences between several participants to be compared.

Several participants also mentioned how the discussion that followed the creation of their Kawa maps provided an opportunity to explore, reflect and explain their own perspectives and interpretation of events. Bert, for example, felt that creating his Kawa maps and reviewing them had made him particularly aware of the key role his wife had played in relation to his recovery. Bert represented his wife as an 'asset' within his Kawa maps, whilst Peter noted the importance of his twin brother and being able to go for walks as fundamental elements which supported his recovery.

These positive views about the Kawa maps were similarly echoed within previous research into the Kawa model conducted by (Buchan, 2010; Humbert *et al*., 2013; Humbert *et al*., 2014; Bai, 2015; Paxton, 2015). Participants in these studies mentioned how they had benefited from being able to reflect upon their circumstances as a result of reviewing their own series of Kawa maps. Both Bai (2015) and Paxton (2015) in their studies which involved occupational therapy students who reflected upon their placement experiences, indicated how reflecting upon the series of Kawa maps, helped the participants to better understand the fluctuations in their placement experience and to appreciate what they could do to improve upon their learning on placement. Schaverian (1999) in his discussion about analytical art, referred to how a series of paintings made in art therapy may offer a way of documenting therapeutic change within an individual. He noted how the content of the art work, images presented and depiction of events would change over time, providing insights into the life world of the individuals concerned.

Reflections on the research process

An essential aspect of any research study is the research process, the systematic steps by which the research takes place. In qualitative

research, the researcher must undertake a course of personal examination and reflection as they attempt to comprehend the research process and understand how they might influence or be influenced by the research they are involved in (Koch and Harrington, 1998; Hess, 2004; Finlay and Ballinger, 2006). This process is described as reflexivity, which encompasses a commitment to work methodically in respect of how knowledge has been collected and to understand its potential impact on the researcher and the researcher's influence on the research process (Malterud, 2001; D'Cruz, Gillingham and Melendez, 2007; Alvesson and Sköldberg, 2009).

For me as the researcher it was important to recognise and be mindful of my values, beliefs and experiences in relation to the topic areas of mental health, recovery, meaningful occupation and the Kawa model. These various factors were influential in how I both engaged and related to various aspects of the research. In addition it influenced how I responded and managed the ethical aspects of the research and the relationship and power dynamic between me and the participants. My prior interest in the Kawa model, previous clinical background and personal views dictated what I chose to investigate, the research question and design; who were the participants; how the data was collected, analysed, interpreted and the discussions of the research findings (Malterud, 2001; Finlay and Gough, 2003; Etherington, 2004; Letherby et al., 2013; Bourke, 2014).

Finlay (2006) highlighted the concept of the 'self' as a research instrument and proposed that the researcher's own subjectivity comes into play within the research design, the analysis of findings and the interpretation of the outcomes. Bourke (2014) similarly highlighted how the interpretations of events are a product of the researcher's prior views and experiences and impact upon how they make sense of the participants' narrative and experiences. In undertaking my own self-examination I became more aware of how my personal values, beliefs and experienced might have influenced my interpretations of events as I

immersed myself in the research data. I had to be cautious in unpicking the different narratives, taking care to promote the participants voices and opinions to ensure that my positioning and subjectivity did not 'colour' how I presented or interpreted what was shared by the participants.

Bourke (2014) within his own research examined issues of racism and prejudice experienced by students of colour within a university campus. Bourke highlighted how he was confronted by his own position as a 'white, middle class, heterosexual male' and was aware that not having experienced racism or racial prejudice, might have influenced how he interacted and engaged with the participants within the focus groups and how he would engaged with the findings. He also acknowledged how his own positioning, which was distinct from the actual participants within his research, might have influenced how he made sense of the experiences of racism and prejudice that his participants shared.

When I considered my own position within the research, i.e. male, with a university education, an occupational therapist and without a mental health diagnosis, I became more conscious of and attentive to my personal position in relation to the participants and aware of my own perception and interpretation of events and experiences. I also became more wary of how I conducted the interviews, phrased the questions, analysed the data and syntheses the findings. I reminded the participants that they were the expert within their own experience and that I was interested in their understanding and interpretation of events in their lives. I allocated an hour for the five to six questions I had and allowed the participants sufficient time to consider, reflect and answer the questions.
Mansfield (2006) described how researchers can often use a variety of methods to assist them in the reflective process which could include keeping a reflective journal, using a model of reflection or using research supervision to make sense of their research experience. I found it particularly helpful to keep a reflective research diary, use the Kawa maps as a reflective tool and have regular discussions with my research

supervisors to review and reflect upon my own views, feelings, concerns and thought processes. I have included below a few excerpts from my reflective journal around my own thoughts around the research process.

'I found it hard when interviewing Mary not to provide her with some help. There were some situations where I felt I could steer her to find the possible solutions she needed and as an occupational therapist I would have suggested what she could do to improve upon the relationship with her son. However this was not my remit as a researcher and I had to stop myself from getting more involved. It felt somewhat frustrating being powerless to help more, when I felt I could.' (Personal Diary 3/12/08)

In the encounter above, I experienced a dilemma of being in a position of power and wanting to help Mary in her situation, but feeling somewhat constrained and powerless to assist her further. My role as a researcher and not an occupational therapist meant I could not provide the advice and assistance to Mary which she seemed to desire. I had to remind myself that my purpose in the context of the interviews was to gather her perspective, make sense of her experiences and ascertain how she felt. Speaking to my research supervisor was immensely helpful and I subsequently felt more at ease about my role as a researcher.

At the very start of the research process, I was aware of my own anxiety and worries around how the research would proceed what if the participants were not able to comprehend the workings of the Kawa model and therefore unable to create a Kawa map within the interview. This would pose problems for my research as the use of the Kawa in mapping personal recovery was a key aspect of the research. I had to accept that this was a possibly and think about how to deal with my emotions and also find a solution. Could there be an alternative way of explaining the Kawa model concepts and how it works or have a ready example to show the participants. In both instances I found it helpful to

reflect and note down how I felt within my reflective journal and to address this thoughts and feelings with my main research supervisor.

'When I first encountered the Kawa model I was immediately able to identify with it and understand the concepts and workings of the model. However I feel nervous about introducing the model to the participants, who are quite different from me. What happens if they just don't understand how it works? What if I cannot use it in the research? What should I do then? It is an essential part of the interview process? (Personal Diary 1/2/08)

Another challenge I experienced and found particularly difficult was deciding upon what to include and exclude within my findings chapters. My overriding objective was to 'give voice' to all the participants and with such rich biographical accounts, I wanted to share as much of their stories within my thesis. However it was impossible to include everything that the participants shared with me and I felt frustrated at several points, as I had to select which stories to highlight and which to leave out. As the researcher with sole power and responsibility to decide upon what to include or exclude, I had ultimate control over these decisions which I found an added challenge.

'To manage the immense amount of data, I need to decide which comments to include or not and yet this feels wrong, as some voices and would be lost as a result. I have the sole responsibilities in making the decision of what to include and exclude which is very stressful. How can I address the issue of redressing power and equality when ultimately I am responsible for deciding what is included, rather than the participants selecting what they would like to be recounted about their experiences.' (Personal Diary 23/06/17)

I initially tried to include as much as possible within the thesis and had five Findings chapters in my first draft, which was far too much. I eventually accepted that I had to take ownership of my research and

decide upon which narratives and experiences to share and discuss. Being respectful, inclusive and keeping true to what the different participants said and ensuring I provided supporting quotations to highlight the respective views was the most ethical approach. Subsequently I settled for three Findings chapters, reducing the number of personal accounts but maintaining as much breadth and depth of personal narratives. To ensure that I provided a balanced and trustworthy representation of perspectives shared, I reported on the range of views highlighted within the thematic tables in the findings chapters and provided supporting quotations.

Having the space to think things through, examine my thoughts and feelings, helped me to manage my emotions as a researcher. I realised the importance of reflexivity and acknowledging my own subjectivity in the process, not feeling guilty about how I felt at times, but recognising the importance of my views, emotions and values within the research process. By recognising my positioning and subjectivity as a researcher, I was able to approach the whole research with consideration of my own experiences and world views (Finlay and Gough, 2003).

Having reflected upon the whole research process there were several valuable lessons I have learned which would be valuable to be considered within future research.

- As a researcher I needed to appreciate how my positionality impacts upon my relationship with the research and also the participants, as this contributed to how I engaged with the various aspects of the research. I must actively consider how my personal value, beliefs, bias, views and experience influence how I related to the specific research topic area.

- A continuous process of reflexivity and reflection was crucial to understanding how I influenced and made sense of the research.

Subjectivity and being conscious of my perspectives on mental health, recovery, personal choice and empowerment, helped me to be more aware of my response towards the perspectives and views shared by the participants within the research.

- I also learned the need for the researcher to not merely adopt an ethical approach towards the research process, but also the importance of maintaining respectful attitudes and behaviours towards the participants. I needed to examine my own motivation as a researcher in engaging with the research topic and reasons behind the questions I chose. Did the questions and approach I chose allow the participants to fully engage with the enquiry and share their views and interpretation of experiences?

- A further aspect that I had not fully considered but became aware of was how the end of the data collection and close of the research might have impacted upon the participants. This was particularly relevant with regards to my longitudinal study, where the participants were engaged with me throughout the series of five interviews over the year. This extended period of time created a bond and connection between the participants and I and it felt wrong just to stop altogether after the final interview. I tried to prepare the participants in advance giving them notice about the end of the data collection. Also as they had been using the Kawa maps over the year to reveal personal details about their lives within the maps, I chose to provide each participant with a copy of the Kawa model template at the final interview, so that they were able to continue to engage with creating their own maps after the end of the research. The participants were also asked if they would like to be involved in future research studies around the Kawa model and maps, which they all stated they were agreeable to and this allowed for their continued future involvement. The key workers at the mental health charity also agreed to provide

continued support for the participants and provided them the space and time to discuss their views and experiences following the close of the research.

Personal Reflections

I have included in the next section a series of my Kawa maps and notes taken from my reflective diary, which span my research journey. Although some of the details within the maps represent contextual issues, they also reflected aspects of my personal and research experiences. I have mentioned family tensions, my work situation, health and personal worries, which were relevant to my research journey and attempted to relate my own insights derived from my Kawa maps with parallel insights I have gained from the participants within the research.

The overall focus of the research was to examine the contribution of the Kawa model in assisting service users to explore their journeys of recovery. A further aspect of the research was to ascertain if participants were able to use the Kawa maps to understand and reflect upon of their own recovery. Embarking on a parallel journey of creating my own Kawa maps, I felt helped me to appreciate what it may have been like for the participants to create and reflect upon their lived experiences.

Although the Kawa model had been used as a reflective tool in previous studies (Carmody *et al*., 2007; Renton, 2010; Cheng, 2010; Owen, 2014; Paxton, 2015; Bai, 2015) these had been confined to students and clinicians only. The Kawa model had not been used previously by a researcher as a reflective tool and I was keen to discover its potential in this respect. I therefore decided to use the Kawa model and maps as a way of examining my own reflections throughout the research process, mirroring the journey undertaken by the participants. I kept written reflections within a diary alongside my Kawa maps, to support my own reflexivity. These reflections in using the Kawa maps involved identifying a collection of challenges and concerns (rocks), assets and liabilities

(driftwoods) and environmental influences (river side and bottom) that I encountered throughout the research process, and I have included one Kawa map for each of the six stages I have identified as crucial stages within my research journey.

Reflections on the PhD Journey

PhD Journey (The start)

In considering a PhD study, I was aware of my interest in mental health recovery, the Kawa model and wanted to incorporate these aspects within my research. Having used the Kawa model in practice with service users, I was mindful of my positive views towards the Kawa model and the need to remain impartial throughout the research process. I adopted some steps to ensure this, firstly I created a verbal guide which I kept to when introducing the Kawa model to the participants, this was to ensure consistency and that I only explained the key concepts of the Kawa model and it use, without highlighting any of my views regarding Kawa model. Secondly, I checked that all the participants created their Kawa maps without any form of input from me as the researcher. Thirdly, I refrained from making any comments about the individual maps created by each participant and only after the maps were completed, did I ask the participants to explain was highlighted within their Kawa maps.

At the initial stage of the research I was concerned whether the Kawa model could be developed into a PhD research topic. I also felt that utilising the Kawa model as a research tool presented some challenges, as I was uncertain if the participants would be able to adapt to using it as a research tool. I was also worried about whether I could locate sufficient participants interested in the Kawa model as a research topic, gain ethical approval to proceed and acquire funding to carry out the research. These were all potential challenges (rocks) which impacted upon my river flow, as indicated in Diagram 33.

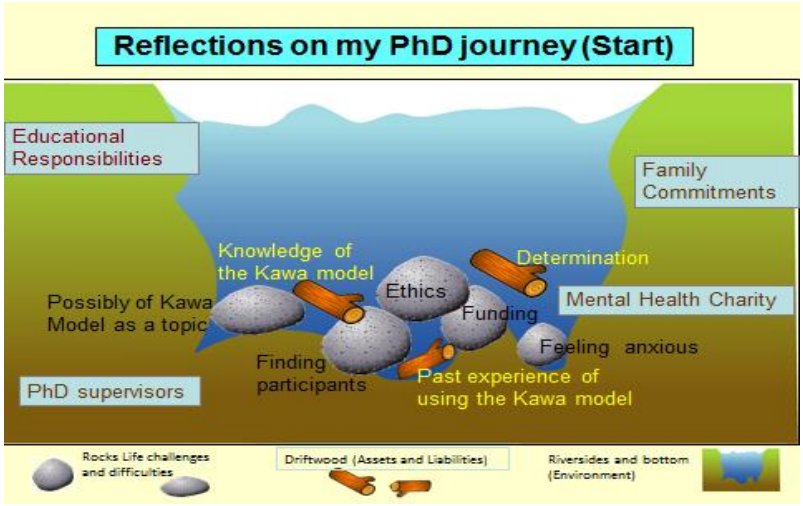


Diagram 33

Some of the assets (driftwoods) within my river at this stage included my previous knowledge and experience of using the Kawa model in practice. I was confident I would be able to explain the use of the Kawa model clearly and understood how to incorporate the model within the research study. My determination was another asset, as I was keen to research the contribution and value of the Kawa model in exploring personal recovery.

In terms of the environmental factors (rivers sides and bottom) that had an influential at this early stage. Having two experienced supervisors, who were supportive of my research ideas and positive interest from the Director of the Mental Health charity (MHC), who was open to me approaching her membership (supportive environmental factors) as potential participants, was affirming. The environmental factors of greater concern included managing my educational responsibilities and having sufficient time to undertake the research, especially with a relatively young family at the time. However as I started planning to undertake my PhD, several of the outstanding issues was resolved and created the opportunity to proceed with the research.

PhD Journey (The initial stage)

Having received ethical approval (asset), I started searching for funds for the research and applied to the Royal College of Occupational Therapists (RCOT) for a research grant. I was successful in getting a £10000 early career research grant (asset) which provided me with encouragement I needed. Achieving this grant to carry out my research into the value of the Kawa model, felt like a positive indication that my professional association (RCOT) was supportive of my research topic and this imparted a new determination (asset). Additionally, following my first conversation with the mental health charity and gaining ethical approval, I had some positive conversation with potential participants (asset) which enhanced my confidence about the viability research study.

I did have some initial anxiety as seen in Diagram 34, around recruiting enough participants (rock), however my early recruitment successes helped to allay my concerns. Two additional challenges were, having to step into a leadership role at work and the extra demands on my time (rocks), with added management and teaching duties (environmental factors). I feared that I had taken on too much and in a similar way with some participants in the research experienced a challenge in my priorities and how best to use my time to derive the best outcome. Having supportive PhD supervisors, family and positive discussions with MHC where I planned to recruit participants, were all assets which provided me with a confidence and reassurance. This was a very positive initial stage, as receiving ethical approval and funding meant I could advance swiftly with recruiting, selecting and interviewing the participants and I felt optimistic and determined about proceeding into the research.

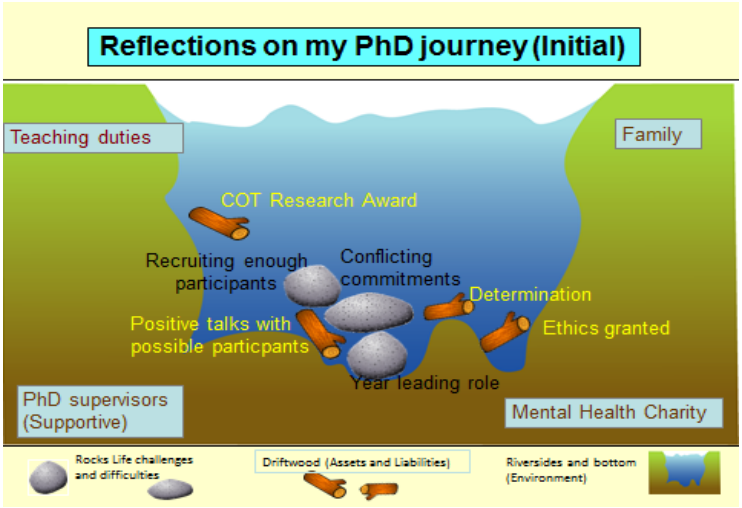


Diagram 34

PhD Journey (Data collection)

This was an extremely busy period as I tried to manage my increased teaching and leadership duties (rocks) with carrying out the research. Conflict of time and demands were sizable rocks that restricted my research flow and I was concerned about all the tasks I needed to complete as noted in Diagram 35. Reflecting on the research I was slightly anxious about refining my research interview skills (rock). Although I was experienced in interviewing due to my academic role, this felt different as I was undertaking research interviews and wanted to ensure I conducted them to the best of my ability.

My attempts at transcribing the initial interviews took much longer than anticipated (rock) and not having sufficient time nor being able to transcribe as effectively, led to me using some of the funding to pay for the interviews to be professionally transcribed. This was an important decision as I had to decide between immersing myself in the data at this point, which would have been enhanced by transcribing the interviews myself or delay this step of the analysis until after the interviews were transcribed verbatim. The pragmatics of limited time and not being able to transcribe accurately and with sufficient speed influenced my decision

and ultimately turned a potential challenge (rock) into a positive asset through employing the right help.

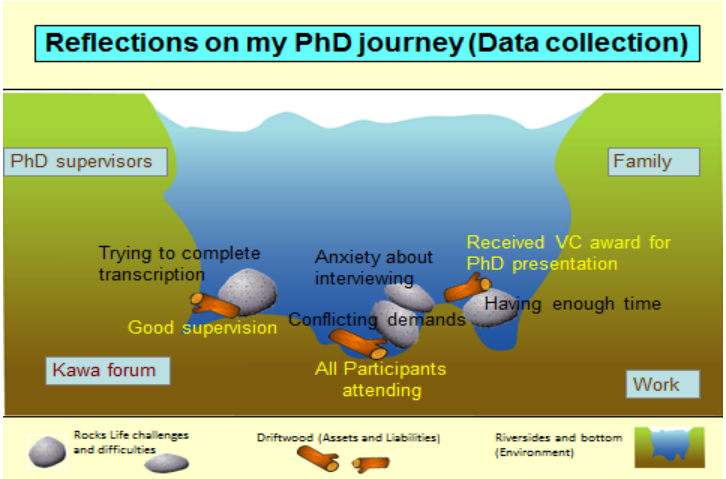


Diagram 35

In terms of environmental factors, I tried to find a balance with spending time with family, work demands and my research. I reflected on how these conflicting demands I faced, somewhat mirrored the challenges faced by the participants within the research. Where despite quite different set of circumstances and experiences, the participants were similarly required to prioritise conflicting demands of their time, manage different relationships and make some difficult choices. This was a helpful insight I would not have been aware of had I not engaged in the process of creating my own Kawa maps and reflecting upon my own situation. Continued support and supervision from my supervisors and engaging with new Kawa model forum where I was able to exchange ideas with other individuals using the Kawa model was an additional assets.

At the end of this stage, I also managed to win a University Vice–Chancellor award for my research (asset), based upon the preliminary findings from my research, which enhanced my self-esteem and confidence as it provided recognition of the value and quality of my research. All the eight participants who started the research continued to attend each subsequent interview and this felt extremely positive and a

form of affirmation, as their sustained involvement seemed to indicate that they valued being part of the research and this was a source of encouragement for me.

PhD Journey (Analysis)

The analysis stage was quite unsettling time for me due to time demands and family tensions (environmental factor), especially in trying to achieve a work life balance. The University was undergoing organisational changes and new work procedures (negative environmental factors), heightened stress levels. During this period I particularly identified with some of the research participants in wanting more order and certainty in their lives. The stress of not knowing what would happen next and having to manage so many changes in the same instance was unsettling and only lessened due to the support of my PhD supervisors and opportunities for regular supervision (assets). However having successfully collected all the research data and with all the eight participants continuing with the research throughout, proved a real encouragement.

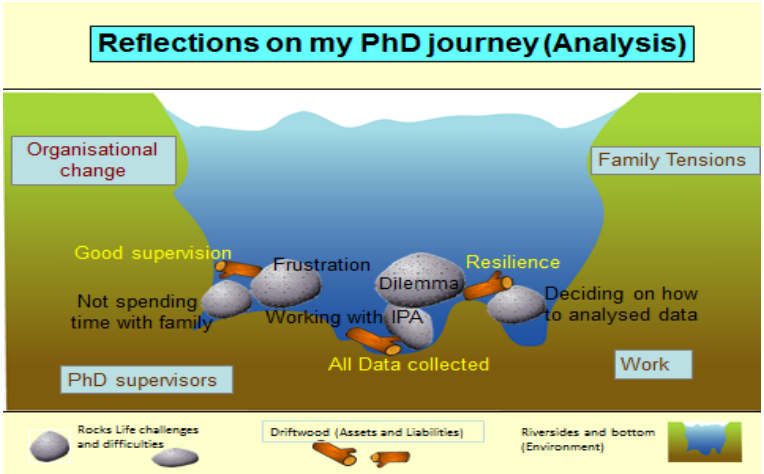


Diagram 36

In terms of barriers, there was a shift in terms of the types of rocks within my 'research river', these were less centred on the practical aspects of completing the research such as having time or achieving balance

between family, work responsibilities and research time. The challenges were instead around methodological concerns in terms of how to analyse the data collected in the most appropriate way and led to a series of dilemmas and periods of frustrations (rocks). Analysing the volume of interview data using interpretative phenomenological analysis (IPA) was challenging as the majority of IPA studies involved up to 8 interviews; however in my research study I was faced with a total of 40 interviews to analyse and synthesis.

An added frustration was deciding upon how to present the findings chapters. It was apparent that the analysis of 40 interviews and Kawa maps, that I would end up with far too much data to be able to present within the PhD and I would need to make a concession. A decision on which data would be included and excluded was something which I was unhappy with, as I was keen to present the idiographic perspectives and biographical accounts of all the participants within the research. Knowing that this would logistically be impossible meant having to find a compromise position which I felt particularly uncomfortable about as I struggled to decide what to include or not.

On a personal level I found it hard at times to reconcile not spending time with my family (rock) and working on the research. This meant not being involved in several family activities and having to make personal and family sacrifices. Once again this personal experience reminded me of the tension that some of the research participants described within the relationships they had with their partners, siblings or children. It highlighted for me why some of the participants would compromise on their own preferences in order to reduce tensions within their overall life.

PhD Journey (Initial write up)

The initial writing up stage as seen in Diagram 37 coincided with several changes that impacted on my ability to work on the research. A series of environmental factors, including the re-organisation within the University

(negative environmental factors) and the loss of several staff, including one of my PhD supervisors (rock) resulted in an uncertain and unstable period and left me enormously worried (rock) about how I would manage my thesis. This reminded me of some of the participants where the wider context and environment impacted upon their lives and they had to deal with issues neither of their own making nor within their control. The participants had to be resilient and evaluate what they could have influence over and which aspects they needed support to manage.

Other environmental factors during this period included leading the Occupational Therapy staff team, which felt like the right decision to make, to reduce the possible chaos within the team at the time. However in hindsight this might have been an unwise decision as it meant taking on a new management role during a crucial writing-up period. Reflecting on this situation helped me appreciate how the participants would on occasion make a decision which they knew would not necessarily be in their best interest but due to a wider set of more complex and multifaceted reasons would be the decision they had chosen. I realised that from a distance it was far easier to appreciate what might have seemed like the right or best choice, but that it was a far more difficult decision to make when I was personally immersed in the situation.

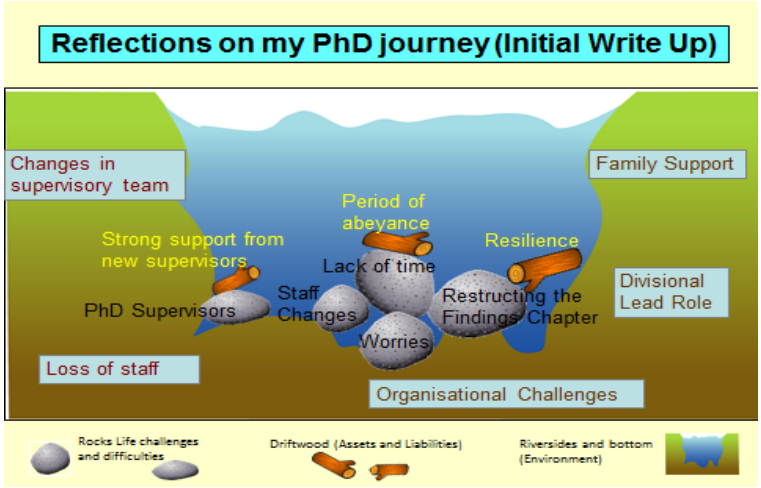


Diagram 37

The collection of barriers and challenges (rocks) included staff changes, lack of time to manage my daily work, concerns with restructuring my chapters and locating new PhD supervisors and forming supervisory relationships with them. The flow in this period, as can be observed by Diagram 37, indicated a river full of barriers and obstructions that impeded flow. Fortunately, I managed to establish a new PhD supervisory team, which was a respite from all of the stress and tension during this unsettling period. I eventually applied for abeyance which was granted (asset) and with my personal determination and resilience (asset); I acquired new vigour to complete the PhD.

PhD Journey (Final write up and submission)

This final section around writing up and planning for the submission of the PhD as indicated in Diagram 38 took place over the last 12 month period. Environmental factors that continued to have an impact upon my research journey included another change in my PhD supervisory team with a new first supervisor required, a substantial reduction in the Occupational Therapy staff and therefore an extensive increase in workload (environmental factors). My family continued to be extremely supportive although this was tinged with some frustration due the length of time it had taken to complete my PhD research, which created additional tension and stress.

With new supervisors in place, I derived a new focus and resilience (asset) to complete the PhD. The challenge to balance an increased workload due to loss of staff and more academic duties to fulfil, as well as working on a very tight schedule, led to a period of ill health due to stress. This was a crunch point and I then took the decision to step down from my management role in order to complete my writing up. This was a great relief and I felt a release of pressure and a new impetus, to complete and submit my thesis.

Diagram 38

Reviewing my own experiences made me consider how some of the research participants would describe specific points in their life when they became acutely aware of the need to make profound decisions in changing their life circumstances. The insight they acquired helped them to confront the situation they were in and to achieve a desired outcome. These complex decisions lead to a collection of relational and social consequences, but may be necessary to ensure their health is promoted and recovery enhanced.

Reflections of the Research Journey

I have provided a detailed account of my research journey through using both the Kawa maps and some of my reflective notes over the course of the research journey. This was a journey that had some similarities to those of the participants, although in essence their Kawa maps were reflective of their research year whilst my Kawa maps were of my journey through my PhD research.

Both the research participants and I ended up with a series of Kawa maps that reflected our respective journeys, providing a visual account of our personal experiences at specific points in time and also longitudinally overtime. I personally found creating my series of Kawa maps and

reflecting on them an enlightening experience as it increased my awareness and understanding of how my life circumstances had evolved over time. In so doing, I have also developed an appreciation of the perspectives and experiences of the research participants as they describe the struggles, enjoyment, successes and multitude of emotions they felt through the year.

In the studies by Bai (2015) and Paxton (2015) involving occupational therapy students, both researchers, who were Masters level occupational therapy students completing their dissertations, indicated how they had similarly gained an added level of insight and appreciation of the experiences faced by the student participants as they journeyed through their clinical placement. In observing the participants' Kawa maps and through analysing the interview transcripts, both researchers felt they were able to connect with the associated emotions and experiences indicated by the participants during their clinical placement journey.

Through using the Kawa maps, I became more conscious of my own challenges, experiences and capabilities as a researcher through the various stages of the research process. I began to realise how the Kawa Model prompted me to look at a whole set of supplementary factors that had an indirect but equally influential impact on my research journey, for example my family support, loss of staff resource and grant funding. The construction of the various Kawa maps also highlighted several internal and external challenges I had overcome and resources I had drawn upon to achieve the outcome I desired. These challenges included work responsibilities and role change, personal health, organisational change, family tensions, changes in my supervisory team and financial support. Supportive resources including regular supervision, being a member of the Kawa forum, being invited to present my research at conferences, my self-determination and resilience were positive aspects that supported my research journey.

Adopting the use of the Kawa maps raised my consciousness in respect of the research participants, as I became more insightful of the wider contextual factors and challenges that the participants encountered within their own circumstances. My assumptions and interpretations of what was influential in their lives or prominent in their decision making and actions, changed as a consequence of acquiring my own insight through using the Kawa maps. The Kawa model and maps were valuable visual tools and provided an added dimension to my understanding and allowed me to appreciate the broader range of contextual factors that were influential and aided my reflexivity.

Critical Review of the Current Research

An essential aspect of any research is an examination of the strengths and limitations of the research. This involves a process of critical thinking and self-criticism, i.e. being critical about one's own research (Finlay, 2002; Mansfield, 2006). A critical ability to assess the contributions of the research, highlighting both the strengths and limitations of the study is an essential aspect of such a critical review.

Strengths of the Research

Continuity

A particular strength of the research was that all the participants who started with the study, continued with the research throughout the year. The reason no participant withdrew from the study could be attributed to the topical interest and relevance of the research, with the participants embracing the opportunity to share their personal stories and explore their own recovery. Both Diane and Jill for example mentioned looking forward to their next interviews and indicated that the research gave them the opportunity to share their personal stories, gain insight and also explore how their recovery had changed over time.

Longitudinal perspective of recovery

The longitudinal nature of the research, with five repeated interviews and Kawa maps, provided me the opportunity to explore with each participant in greater depth how their recovery had evolved over the year. The participants were able to exemplify their recovery through the series of Kawa maps they created and reflect upon how their recovery had progressed over time. They were also able to note fluctuations and shift in patterns within their lives as well as establish what factors were most influential in their continued recovery. This long-term overview was a particular strength of the research, as previous studies examining personal recovery had not adopted a longitudinal perspective.

Research method and analysis

I felt conducting a qualitative study involving interviews and the creation of personal maps, prompted in-depth biographical accounts of personal recovery. The use of interpretative phenomenological analysis was appropriate for this study due to both its phenomenological and ideographical qualities. IPA acknowledges that the researcher is influenced by their own position and values, which may impact upon how they interpret the data and make sense of the perspectives and experiences of the participant through a process of co-creating understandings of experiences. I believe that this methodological approach adopt for the research was positive and fulfilled the aims of the research by promoting the exploration of idiographical perspectives of mental health recovery.

Participants' lacking of familiarity with the Kawa model

None of the participants had previous knowledge about the Kawa model and therefore did not have any preconceived views or bias in favour of the Kawa model. During the recruitment stage of the research, I questioned each prospective participant to confirm they had never previously heard or been exposed to the Kawa model. In doing so I was

able to ensure that they were not privy to any information or previous research about Kawa model, which might bias their perspective. Positively, despite not having any prior knowledge about the Kawa model, all the participants were optimistic about the contribution of the Kawa model as a visual and narrative tool within the research.

Kawa Model Framework Index

I created the Kawa model framework index (KMFI), Appendix 9, to assist me in examining and analysing the interplay of factors that were influential in the recovery experiences of each participant. The KMFI provided me with the opportunity to catalogue the collection of component factors highlighted in each Kawa map and provided an immediate contextual overview of each participant's life at a particular point in time. Adopting the KMFI also enhanced the analysis of the series of Kawa maps created by each participant providing an index of influential factors over time. The KMFI enabled comparisons to be made between the series of Kawa maps for each participant and across the whole cohort of participants in the research. Patterns and trends could be ascertained, whilst changes and differences between the different participants were highlighted too, creating opportunities for further examination and scrutiny. The KMFI has contributed to the overall usability and value of the Kawa model and provided a unique contribution towards the generation of new knowledge via the Kawa maps. It can be adapted with ease for use both within the arena of research but and clinical practice.

Kawa maps as a reflective tool for the researcher

The success with using the Kawa maps as a reflective tool throughout the research was another positive that arose from the research study. The Kawa maps had previously been used as a reflective tool by clinicians, students, services users, but not as a reflective tool by researchers. I used the Kawa maps to capture my reflections throughout my research journey and found it to be complementary to my reflective diary. The

Kawa maps provided an additional dimension to my reflections and allowed me to more easily review the whole research process, by simply appraising the series of maps. It also helped me be more aware of the collection of different factors that had an influence on me during the research process. The capacity of the Kawa maps as a tool of reflection for researchers confirmed the value of the Kawa model and maps.

Cultural relevance of the Kawa model

Reviewing the available research around the Kawa model indicated that the majority of research to date has been conducted in Western countries, such as Ireland, United Kingdom, United States (Carmody *et al*., 2007; Paxson *et al*., 2012; Ostyn, 2013; Humbert *et al*., 2013, 2014; Bai and Paxton, 2015). The research outcomes from these studies have confirm the utility of the Kawa model within varied clinical group and context and has highlighted the adaptability and flexibility of the Kawa model beyond its original socio-cultural origins in Japan. The current research contributes to the cross–cultural adaptability of the Kawa model, where all the participants who were from a white European cultural background were able to successfully use the Kawa model to explore their recovery.

Limitations of the Research

Scale of current research

By undertaking a qualitative research study involving 40 interviews and using interpretative phenomenological analysis, I was attempting too large a research data set for an IPA study. As indicated by Smith *et al*., (2009) and Pietkiewicz and Smith, (2014) the majority of research studies that use interpretative phenomenological analysis have involved up to 8 participants with a similar number of interviews (e.g. Reid *et al*., 2005; Reynolds and Prior, 2007; Pitt *et al*., 2009; Smith 2011).

The current research with 8 participants undertaking five interviews each generated a total of 40 interviews and 40 Kawa maps as all participants that began the research continued to attend all subsequent interviews. At one level this was a positive outcome, however the larger number of interviews required a much more extended process of analysis to derive the sense of meanings, perspectives shared and decipher the convergent and divergent views expressed by the participants. This far larger data set made detailed analysis much more demanding of time and might have inadvertently reduced the depth of analysis and the resultant presentation of research finding.

Frequency of interview meetings

I met with each participant a total of five times over one year and each interview took place approximately every three months. In attempting to understand the lived and recovery experiences of the participants over the research year, meeting with each participant at three monthly intervals was not frequent enough to capture the changes within their personal circumstances that happened on a daily, weekly or monthly basis which might impact upon their journeys of recovery. It is proposed that meeting the participant or in the case of a clinical setting meeting the service user monthly would be more suitable to evaluate change.

Diversity of the participant cohort

The majority of the participants within the research had average mental health histories of around 30 years and trying to understand the nature of their recovery over the period a year did not fully represent their lived experiences. The participants were all similar in age and, had extended mental health histories. Although the results from the research provided a valuable insight into their personal experiences, it might be that such a similar sample of participants would only provide a snap shot of the contribution of the Kawa model with those with extended mental health history. If a broader range of participants had been recruited from

difference age groups, life stage and with different lengths of mental health histories, this would broaden the possible contribution of the Kawa model in exploring the experiences of mental health services at different stages of recovery. Further all the participants that agreed to take part in the research were white Europeans and a more culturally diverse group of participants would have helped to demonstrate the cross-cultural utility and adaptability of the Kawa model.

Qualitative research is subjected to different standards of critique. Validity, reliability and generalisability synonymous with quantitative research are not relevant in qualitative studies involving relative smaller number of participants and focus on discovery perspectives and experiences rather than proving a given hypothesis. Such concepts as trustworthiness, rigour and credibility are more relevant in considering the value of the research findings. With regards to the current research, improvement could have been made to improve upon the rigour and credibility of the research by involving the participants in checking the interview transcripts for accuracy.

Carpenter and Suto, (2008) described this aspect of the research as ‘member checking’, which involves sharing the findings from the study with the participants and providing them with the opportunity to comment or change anything around to address possible discrepancies. Trustworthiness is an important principle within qualitative research where being authentic within the research process is necessary (Finlay, 2006). By keeping a reflective diary and creating my own Kawa maps I was able to catalogue and reflect upon my own thoughts and feelings within the research process. Trustworthiness could be enhanced through documenting the various phases of the analysis of both the interviews and Kawa maps so that the process of interpretation could be verified. I have addressed this aspect within the research by keeping an audit trail inclusive of the ‘raw’ interview data with coding notes which enabled a checking of themes highlighted in the research.

Limitations of the Kawa Model Framework Index

The Kawa model framework index does not in itself provided details of what is considered to be salient or central in each person's life, as merely looking at the KMFI does not explain the reasons behind what is highlighted. The researcher or clinician looking at the Kawa maps and the KMFI should avoid any assumptions and need to consult the participant in order to appreciate their reasoning and interpretation. Narrative clarifications provided by the participant offer valued insights to discern the perspectives, lives, experiences and thoughts of each person.

Appraising the value of the Kawa model and maps

The primary focus of the study was to examine the contribution of the Kawa model in exploring mental health recovery and the current research has been partially successful in fulfilling this objective. The results from the research indicate that the participants found the Kawa model and concepts easy to understand and relate to, they could identify with the component elements and use them to create and construct their own Kawa maps, and they identified with the metaphor of a river representing their recovery and lived experiences. They were also better able to understand how they could influence their own mental health recovery through exploring the use of the Kawa maps, and the impact of different elements in their life.

To more clearly establish the contribution of the Kawa model in helping participants within the research study to explore their mental health recovery, may require conducting a comparison study between solely using extended semi-structured interviews or the Kawa maps with the participants. As indicated previously, by using both together in the interview process it was difficult to differentiate the usefulness of the Kawa maps exclusively, as participants at times adopted the metaphors and terminology associated with the Kawa model in the wider interviews

to comment and explain what their life situation was like without further prompting.

Structure of the Interviews

Another possible limitation of the current research as indicated previously was the way the interview sessions were structured. The format involved a three stage process, firstly the initial semi-structured interview, followed by a second stage where participants created their Kawa map and then a third stage where they explored and discussed what they had represented within their maps. This structure was potentially confusing as the whole process of the research interviews was far more fluid in practice and participants were free to discuss different aspects of their lives or what they learned through using the Kawa maps throughout the interview. For example several participants would within subsequent interviews, express what they might have noticed about themselves due to having previously created a Kawa map or used the metaphor related to the Kawa model within the first stage of the interview process. This did not pose a major problem within the research, but did limit the ability to isolate and therefore attribute the exact benefits of using the Kawa model and maps to explore personal recovery.

Power and Conflict

Finlay and Gough (2003) highlighted the complexity of relationships and power within research and indicated how the researcher must be aware of the power they may possess over the participants and the component parts of the research process. Whilst, Letherby *et al*, (2013) reinforces the importance of the researcher remaining ethical throughout the research process and ensuring that participants are not coerced to take part, nor pressured to provide favourable responses within the research. In planning the research I had to take precautions to ensure the interview questions were not biased towards eliciting a positive response about mental health recovery.

Using the Brunel Service User Research Group which consisted of service users to check the interview questions was a way of ensuring the questions were not biased. To reduce any chance of coercion to take part in the study I only used the advertising board at the MHC to inform potential participants about the research and did not approach any members till their attended the research information session. Being aware of my position as a researcher and academic, I was conscious of how I might be perceived by the participants and whether it would have an impact on what they would say within the interviews. Making clear to the participants that there were no right answers I hope would encourage them to freely share what they wanted within the interviews. I also reminded the participants at the start of each of the interviews that they were free to withdraw from the research at any point and verified they were agreeable to carry on with the research.

As identified earlier it was crucial to acknowledge as a researcher that I could potentially be influenced by my own values, beliefs and prior experience and how being aware of these 'filters' helped me to be more conscious and careful in how I analysed and made sense of the findings. In reporting on the participants responses, I had the sole responsibility and power to choose what data to include within my thesis. The participants did not have a say in what was included and I therefore felt even more responsible in ensuring there was a balance and provided examples which both indicated positive and negatives perspectives on the use of the Kawa maps and experiences of recovery. This was reflected by including within the Findings chapter cohort wide perspectives to provide a broader view of the range of experiences, view and thoughts as shared by the participants, both individually and as a collective group.

Maintaining an Ethical Approach as a Researcher

I was mindful of the need to maintain an ethical approach throughout my research, acknowledging my own interest and position especially as I had previously used the Kawa model in clinical practice and also published chapters on the Kawa model. However instead of examining the use of the Kawa model in practice, what was different in the study was a focus on the use of the Kawa model as a research tool rather than as a clinical tool. The scope of the research was to explore the use of the Kawa model as a research tool to explore the recovery journey and experiences of the various participants.

I had to differentiate and manage my role within the complexity of the research keeping a clear boundary as a researcher throughout the research process. I introduced and explained the conceptual ideas and components within the Kawa model to the participants during the interview sessions, but did not engaged in creating the Kawa maps alongside the participants, which I might do within a clinical context. I also refrained from setting therapeutic goals with the participants from what was highlighted within their Kawa maps which would have been a natural part of using the Kawa model clinically. Instead I maintained a distance as the researcher and adopted a position of standing back and observing what was constructed and then seeking clarification from the participants as they created their individual Kawa maps.

I was explicit in explaining to the participant that the research was not an intervention based study but rather the opportunity to use the Kawa model to frame their experiences and for them to share and provide examples of what they considered enablers and barriers in supporting their health, well-being and recovery. I reiterated that my aim as a researcher was to come alongside the participants as they journeyed through their individual experiences through the year.

Summary

A discussion of the current research has been presented in this chapter with published literature, policy documents and past research examined in a discourse of the current research findings. An examination of the personal interpretations of recovery and elements that the participants considered to be influential in their personal recovery was discussed, followed by a debate of the contribution of the Kawa model and IPA in assisting mental health service users to understand their personal journeys of recovery. My reflections of the research journey and reflexivity have also been discussed and a critique of the strengths and limitations of the current research highlighted. The next chapter will consist of the conclusion to the research study, with emphasis on the contribution to new knowledge. The unique contribution of the Kawa model, my contributions to the theory and knowledge based of the Kawa 'River' model and implications for future research and clinical practice as a result of the current research study will also be highlighted.

Chapter 9: Conclusion

Introduction

In this chapter I will consider the research aims, methodological aspects of the research and provide additional personal reflections. I will also outline the unique contribution of my research to knowledge around mental health recovery, the Kawa model and occupational science. I will further highlight the implications for clinical practice, education and the opportunities for future research.

Research Aims

The research aims highlighted at the start of the study were to establish a phenomenological perspective of mental health recovery. To identify what participants considered influential to their personal recovery and to explore the contribution of the Kawa model as a visual and narrative-provoking tool in exploring recovery journeys. The research has achieved these aims, as personal views of recovery were established through the narratives gathered within the study, which provided unique personal insights. The Kawa maps also provided a visual record of the lived experiences of each participant over the research year and prompted further exploration and discussion of influential factors the participants perceived as sustaining their recovery.

Methodological Approach

Adopting a qualitative and phenomenological approach to the research was essential in capturing individual views, narratives and feelings associated with mental health recovery. The adoption of IPA within the study provided a valuable structure to the research inquiry and captured the phenomenological and idiographical aspects of the participant's experiences. The choice of IPA as a form of analysis was appropriate as it acknowledged the importance of co-creation, which occurred between

the researcher and the participants within the interviews and the interpretation of findings. The use of semi-structured interviews and the Kawa maps complemented the phenomenological approach within the research, allowing the participants to explore and share their personal perspectives and understanding of their experiences.

The overarching themes identified within the research as indicated in previous chapters were the; unique perspectives and meanings of recovery; feeling more socially connected; looking outwards and getting more involved; coping with life's challenges; an evolving journey. All the participants despite their extended mental health histories described positive changes in their recovery during the study. Participants commented positively upon the ease of use of the Kawa model, clarity of the concepts and the visual qualities of the Kawa maps. Engaging with the Kawa model and maps appeared to enhance insight and personal empowerment, and assisted the participants to take proactive steps in facilitating their mental health recovery.

The Kawa maps were effective as research tools and participants were able to frame and visualise their recovery like an actual 'river' journey. Uniquely the Kawa maps encouraged the participants to look beyond themselves towards a range of contextual factors that supported their recovery. It also facilitated a more detail examination of the complex challenges the participants faced in confronting and managing their mental illness. Base on the outcomes of this research, the Kawa model has a distinctive value in helping mental health service users to identify their strengths, capabilities and promote their mental health and recovery.

Reflecting on the Research

In reflecting upon the research I have discovered the multiple layers that make up the experiences of those with mental health conditions. I felt at the start, due to having worked clinically in mental health that I would be familiar with what the participants might reveal about their experiences of

recovery. However it has become apparent to me having immersed myself in the research and engaged more fully with the data, the complex nature of personal recovery. Taking time to listen to the personal narratives has been crucial to developing further insights about each participant. For me both as a researcher but also as an individual, the perspectives, experiences and feelings shared by the participants have been particularly enlightening, revealing the complex interplay of psychological, social and emotional factors that influence recovery.

As a researcher the repeated interviews and unfolding series of Kawa maps seemed akin to the process of 'peeling an onion'. Each subsequent interview and Kawa map felt like peeling back another layer of rich personal history filled with a mixture of hope, doubt, anxiety, excitement and surprise all wrapped up together. As I embarked upon peeling back the layers I discovered aspects of personal recovery that I had not considered before, like the need for intimacy and peer acceptance, sense of belonging and the value of engaging in meaningful activities and occupations.

Engaging with the research has prompted me to further consider the role of power within therapeutic environments and relationships. I have become more aware of how structural inequalities within health and social care impact upon the interactions between those providing and receiving care. It has raised further questions for me, such as the extent to which health professionals seek to empower service users, their significant others and redress power imbalances. Whether occupational therapy practice promotes choice, opportunity and confronts inequalities? What my agenda and motivation was in embarking upon the research?

On a more personal level engaging in the research study has helped me to acquire self-awareness and insight in relation to my own mental health and well-being. It has prompted me to consider how I could promote my own mental health and the changes I could incorporate to enhance my

own mental, physical and emotional well-being. One of the key changes I have decided on is to participate in a chosen occupation I consider beneficial in promoting my overall mental, physical and emotional well-being. I have always enjoyed cycling, photography, country walks, making sushi and going to the movies and have not engaged in such activities in recent times due to work and family commitments. My plan is therefore to undertake such occupations and activities on a fortnightly basis to ensure that I continue to create the space and time to enhance my overall mental health and well-being.

Contribution to Knowledge

This is the first research study examining the use of the Kawa model in exploring the recovery journey of mental health service users with enduring mental health problems. The research adopted a longitudinal approach with a focus on eliciting the personal perspective of a group of mental health service users as they experienced and made sense of their recovery over the period of a year. Each participant engaged in total of five exploratory interviews and created a series of five Kawa maps. The interviews comments were analysed via interpretative phenomenological analysis and the Kawa maps through the use of the Kawa model framework index.

The use of a longitudinal approach coupled with IPA derived a more in depth perspective of the concept and subjective meanings of personal recovery, as participants reflected on how their lives had developed over the year. Factors indicated in past research in relation to what mental health service users considered influential to personal recovery, such as social support and relationships; engagement with health professionals; meaningful participation in activities; promoted new roles and identity and improved self-esteem and confidence were supported by similar findings from the current research. Whilst new perspectives such as looking outwards; feeling more socially connected; needing to belong; learning to

cope with life challenges; making a contribution and a fluid evolving recovery were new themes highlighted within the current research.

The use of the Kawa model and maps in charting personal recovery across the research year provided a pioneering approach in understanding the experiences of recovery. The use of the Kawa maps provided an alternative dimension of envisioning personal recovery, where participants created a visual record of their personal journey and were then able to reflect, appreciate and understand how their past and current experiences might be influential towards their future recovery. The Kawa maps also prompted the participants to focus beyond their immediate concerns and to consider the wider range of contextual factors that might indirectly impact upon their recovery. This could include context influences like the socio-cultural environment, relationships or life events peripheral to the participant, for example family tensions, benefit changes or housing difficulties.

Focusing on the wider context has helped the participants to acquire additional insights and consider the broader range of factors that influences their health and well-being. Being more aware of the spectrum of internal and external factors has also helped the participants to move beyond a culture of self-blame when they have struggled with achieving their personal goals. Instead of feeling solely responsible for not achieving their goals, the participants have been able to appreciate how external factors, for example their housing conditions, limited resources or experiences of discrimination might have impacted upon their progress.

Phenomenological studies do not assert to reveal the full embodiment of a particular phenomenon but contribute towards a deeper understanding of what is being explored. I feel that the use of the Kawa maps in combination with exploratory interviews provided a more in-depth understanding of what the participants perceived and understood about

their own mental health and experiences of recovery. The Kawa maps and interviews served to complement each other as research tools within the study and the two research methodologies together provided a deeper understanding of how the participants interpreted and gave meaning to various aspects of their life.

A unique contribution of the research to mental health was the holistic emphasis on health, well-being and recovery. The participants through their narratives and Kawa maps highlighted a broad range of factors which they considered as supportive of their mental health. These included their psychological, emotional, spiritual and physical factors, which were less indicated in previous research examining mental health recovery. Several participants commented that keeping fit and engaging in such activities as walking, playing sports, socialising, developing new interest, intimacy and cognitive engagement enhanced their overall health and wellness. They also highlighted how their faith and spiritual beliefs were a crucial to them remaining well, supported and central to their mental health, well-being and recovery.

The use of the Kawa model and creation of the Kawa maps across the series of five interviews provided distinctive insights into the lives of the participants, even for the limited period of one year when the data was collected. The participants were able to reflect upon their lived experiences and gain understanding of how different decisions or actions resulted in fluctuations in their mental health across the year. Additionally they were able to also examine the wider spectrum of contextual factors like social networks, experiences of discrimination, family structures and feeling accepted by society, which might impact upon their mental health.

The impact on meaningful engagement in occupations and activities was another substantial contribution of the research. Participants highlighted being involved and engaged in a range of different activities such as art, music, flower arrangement, walking, self-help groups and being a

volunteer as instrumental in enhancing their health, well-being and recovery. They also indicated how involvement in a range different activities and groups provided them with a sense of belonging, social support, roles and identities which enhanced their self–esteem.

Unique Contributions of the Kawa Model

Evaluating the unique influence of the Kawa model within the current research highlighted several contributions towards current knowledge and understanding of personal recovery in mental health. Participants indicated the particular strengths of the Kawa model as: providing an alternative perspective on recovery; enhancing clarity; personal empowerment; helping in appraising changes in life and recovery; promoting self-discovery and personal growth. They also identified the ease of use of the Kawa model, concepts and maps as positives.

The Kawa maps provided a visual research tool whereby the participants could acquire a longitudinal perspective of their experiences by charting the progress and fluctuations within their recovery. Several of the participants mentioned putting up their Kawa maps on their fridge or notice board at home to remind them of the experiences and personal journeys they had travelled during the year. They found constructing the series of Kawa maps enhanced their self-discovery, providing a tool to appraise change, development and personal growth.

The introduction and use of the Kawa template provided an alternate way in which the Kawa model could be utilised both in clinical practice and research. Historically, engaging with the Kawa model involved participants physically drawing their own Kawa maps and then undertaking a process of exploring with researcher/clinician to make sense of the content and context of their own maps. The Kawa template I created for the research provided additional flexibility, as the participants were able to represent their lived experience by using the Kawa template to create their own Kawa maps.

A further benefit of the Kawa template was that the participants had the flexibility in constructing different scenarios and exploring proposed outcomes. They were able to move, reposition or replace different component pieces without having to draw a new Kawa map for each new scenario, making the whole process of using the Kawa templates less time-consuming and far more flexible and responsive in reflecting different circumstances. The Kawa template was also more tangible and responsive, allowing the individual to shape and assemble their experiences imaginatively. Since 2014, a Kawa model application has been made available and individuals can now download the application electronically on an iPhone or iPad and create their own Kawa maps. The availability of the Kawa template used by the participants contributes to the wider range of tools available for constructing personal maps.

The Kawa model framework index (KMFI) used to analyse the findings within the current research was a new development devised by the researcher to catalogue and distinguish possible patterns, themes and configurations across a series of Kawa maps. The KMFI proved beneficial in highlighting long term changes and patterns across time and enabled the researcher to derive additional perspectives and insights into personal experiences of recovery. Although the KMFI was solely used by the researcher within the current research to analyse the Kawa maps, the KMFI could also be used collaboratively with the participants in reviewing their Kawa maps. This would enable the participants to gain a clearer perspective of how different elements and aspects within their lived experience shifted in importance and prominence throughout their personal recovery. The KMFI can also be used without any further adaptation within clinical practice, allowing for both clinicians and service users alike to use it within any context or setting.

Recognising each individual as the expert, was an important contribution, as the Kawa maps allowed the participants to take ownership and present how they visualised and understood their own mental health, well-being

and recovery. The participants were in control of creating and explaining what their particular situation was like and how they perceive of what was an enabler or barrier to their own mental health recovery. The participants were regarded as the experts and could dictate how their own narrative was told and explained.

Although the Kawa model has been used previously by clinicians, students and service users alike as a reflective tool, it has not been used as a model of reflection for research purposes. As a researcher I found using the Kawa maps as a tool for reflection particularly helpful as it developed my insight as a researcher but also helped me to discover parallels between my experiences and those of the participants. From my personal experience I feel that the Kawa model was a valuable tool to aid personal reflection and reflexivity, and enhanced my reflective process. It enabled me in my role as a researcher to examine the overt, covert and wider contextual factors influential within my own research journey.

Expanding the Theoretical and Knowledge base of the Kawa Model

In undertaking the current research and engaging in research seminars, presentations and workshops, I have contributed to the knowledge based around the Kawa model. Over the course of the research, I have presented my PhD research at various international and national events including delivering oral presentations and/or workshops at the Council of Occupational Therapy in European Countries in Hamburg (2008); the South London and Maudsley NHS Foundation Trust annual conference (2009); the World Federation Occupational Therapy Congress in Chile (2010); the College of Occupational Therapists Conference (2010, 2011); Asia Pacific Occupational Therapy Congress, Changmai (2011); the European Master in Occupational Therapy Conference in Amsterdam (2011); the Refocus on Recovery conference in London (2012) and the World Federation Occupational Therapy Congress in Yokohama 2014,

where I also presented my PhD research at the First International Kawa Symposium which was streamed live globally.

I have also been involved in teaching and sharing how I have used the Kawa model and the results from the research across several University courses in the UK and with occupational therapy, social work and nursing students over the last five years. The list of conference oral presentations, workshops and seminars are listed in the beginning section of this thesis. I am also due to deliver a training session at Headley Court Military Hospital looking at the use of the Kawa model with armed service personnel experiencing Post Traumatic Stress Disorder. Throughout these opportunities I have shared my research based on the Kawa model and demonstrated its usability within the mental health practice and as a recovery framework. During these occasions, I have received positive interest and feedback about my research, which has encouraged me in completing this thesis.

Contribution to Occupational Science

Occupational science, as highlighted previously, is the study of humans as occupational beings and the relationship between occupation, health and well-being (Wilcock, 2006; Molinuex, 2017). The current research has contributed positively towards this theoretical field in supporting the relationship between meaningful occupation, participation and health. Participants within the research highlighted how being engaged in a range of occupations, from walking, art, singing, flower arranging enhanced their health and well-being. They also indicated how social networks, being socially included and deriving a sense of belonging from being part of a group or community were instrumental in reducing loneliness and isolation.

This finding demonstrates the need to promote occupational justice as indicated by Whiteford and Hocking (2012) highlight the importance of ensuring that individuals have the opportunity and access to participate in

occupations of their choice which promotes their overall health and well-being. Wilcock (2006) indicated how individuals who are involved in unproductive or repetitive tasks can experience occupational alienation, a concept that conveys the negative consequences of being limited in occupations and activities that lack meaning and purpose. The responses from the research participants reinforce the importance of ensuring that those with a mental health issue need to be included, supported and encouraged to engage in occupations and activities that enhance their personal recovery.

Participants indicated how being able to contribute as a volunteer, supporting the welfare of others by helping on the acute ward or being involved in self-help groups provided them with a purposeful role and responsibility which helped to promote their self-esteem. The research also highlighted the value of developing an identity based upon the personal skills, qualities and strengths that each person possesses rather than an identity that is related to their health condition or status. This sense of having a purpose, a role, supports the development of self-identity and self-worth, which enhance mental health recovery.

The importance of both self-identity and self-worth in providing an individual with purpose, self-belief and sense of belonging was highlighted by Taylor (2015) in her research, with participants indicating how leisure occupations or working as a volunteer provided them with valued occupational roles and helped to promote their self-identity and self-worth. For those with a long-term health condition, establishing an identity distinct from their position as a patient or service user may be particularly important, providing a status linked to their capabilities, interest and skills, rather than an identity related to being a patient.

Feeling that one has a purpose and role positively contributes to self-belief and esteem, which supports health and recovery (Kelly *et al*., 2010). Blank *et al*. (2015) indicated how the ability of the individual to

choose what they wanted to do, be supported and be meaningfully involved, promoted occupational balance, as they were not restricted in simply undertaking functional tasks but were able to participate in the range of activities and occupations which contributed to their health and wellness. Occupational balance is crucial to maintaining equilibrium in one's life where the individual is able to both sustain and also actively achieve quality of life. Sutton *et al*. (2012) similarly demonstrated the link between the ability to engage in meaningful occupations, maintaining a balance of leisure, work and productive activities with supporting overall health, well-being and recovery.

Implications for Future Research

There are several ways in which the current research could be taken forward in terms of improvements made, if this study were to be replicated or if new aspects of research involving the Kawa model were to be undertaken. To provide a broader examination of the contribution and applicability of the Kawa model across diverse groups, I target under-represented groups or communities to ensure that the participant study group was more varied in terms of the age, ethnicity, and diagnosis, length of contact with mental health services and stages of mental health recovery. Additionally, targeting groups of individuals with a specific diagnosis, for example those with bipolar disorder, post-traumatic disorder or self-harm behaviours would provide richer insights in relation to their lived experience and the value of the Kawa model. This would broaden the examination of the utility of the Kawa model and maps.

To ascertain the contribution and value of the Kawa model, it may be appropriate in future studies for participants to be provided with an individual Kawa model tool kit, which would include a Kawa model manual which explains how the Kawa model and maps are used, a copy of the Kawa template and a diary. Participants would then be asked to create their Kawa maps at regular monthly intervals to ascertain the

usability and capabilities of the Kawa model as a self-help measure, independent of the input of the researcher.

A study could include a randomised control trial evaluating the use of Kawa model and maps versus mental health monitoring and reviews within community mental health settings. Participants would be randomly allocated to either a Kawa model intervention group (where they would use the Kawa maps to set goals and monitor their progress), versus a control group receiving standard monitoring, review and support from mental health professionals. This study could also be extended where the participants are encouraged to continue to create their own Kawa maps at regular intervals after the end of their treatment would have provided an indication of longer term usefulness. If the participants were able to continue to create, reflect and review their own recovery in their over time, this could further explore the value of the Kawa model.

Clinical Implications

The research suggested that adopting the Kawa model to understand mental health recovery contributes added value. I believe that given the comments about the Kawa model as a therapeutic tool, it should be adopted for used with service users in reviewing and exploring their recovery journey. The Kawa model should form part of the tool kit of measures available to clinicians and future research could involve clinicians systematically using the Kawa model within their clinician sessions with their service users, where the creation of the Kawa maps would form an integral part of the, goal setting, ongoing assessment and intervention process. The clinical sessions would take place at monthly intervals over the period of one year and the Kawa maps could be part of an active intervention process to increase service user self-efficacy, agency and confidence in monitoring their own lifestyle changes. The views of both service user participants and clinicians in terms of the contribution and value of the Kawa model in promoting personal influence

and responsibility for one's own mental health and personal recovery could be established.

Additionally, the Kawa model could be promoted for use as one of the reflective self-help measures within the Recovery College courses that are delivered by several mental health charities including MIND UK and Rethink and several Mental Health NHS Trust, where participants could be taught how to use the Kawa model and maps as self- monitoring tools to assess their own mental state, mood and to assist them in setting personal goals towards promoting their own health and recovery.

The research participants highlighted the importance of being accepted and included by their family, peers and society at large. They indicated how being positively regarded by health professionals and their peers enhanced their self-esteem and image of themselves. They further highlighted the importance of inclusion and participation, being able to engage in occupations that promoted their identity, supported their confidence and provided structure within their lives. The findings from my research also highlighted the value of occupational therapists working towards an occupational justice agenda to ensure that service users are not denied their occupational rights to participate in the spectrum of activities and social groups. Occupational therapist should be encouraged to take on an occupational justice agenda when working with marginalised groups in society, such as mental health service users, and to focus beyond functional performance and work, towards promoting inclusion, engagement and meaningful participation.

Occupational therapists should also challenge the drive towards cost effective clinical services that adopt standardised care provision, but fail to take account of the individual needs of services users who may require more tailored packages of care and support. As this research showed, a more sensitive and collaborative approach to identifying what interventions and support are beneficial would be more valuable.

Implications for Education

The findings of this study will contribute towards the knowledge and understanding of mental health and recovery amongst both occupational therapists and other health care students. The research findings and outcomes emphasise the value of adopting a person-centred approach in promoting mental health and well-being, as opposed to applying standardised interventions to recovery, which may appear more cost-effective. The responses from the participants supported careful consideration of the occupational and social needs of mental health service users in promoting their health, wellbeing and recovery. What seemed equally important was regarding individuals' as 'social beings', where social acceptance, reducing isolation, developing a self-identity, having social and occupational roles were key in promoting recovery.

Further, the Kawa model and maps reinforced paying attention to the range of psychological, social and contextual factors which impact upon personal recovery. Highlighting the importance of adopting a holistic approach in working with service users in understanding what specifically enhances their mental health and recovery. The use of the Kawa model as a reflective tool could be further extended to students on the occupational therapy course, where it could be used as a reflective model in reviewing their educational journey and placement experiences. This would enable students to consider the range of psychological, socio-cultural and contextual factors that impact on their learning and educational experience.

Adopting a more holistic and person centred approach would be particularly useful in helping university students to manage and promote their own mental health and well-being while they engage in their university education. This is particularly relevant in the context of recent statistics in England, which indicates that 19 per cent of 16–24-year-olds experience a mental health condition (Thorley, 2017). Assisting students to reflect upon their personal journey at university and understanding how

they could promote their own mental health and well-being is a necessary step and the use of the Kawa maps to enhance this reflective process would be a positive step towards promoting self-awareness.

As the module lead for the mental health occupational therapy option, I will also draw upon the research findings and outcomes to educate students on the spectrum of recovery approaches for enhancing mental health and highlight the value of occupational engagement in promoting health. I will further encourage students to reflect upon and evaluate the strategies adopted and interventions provided in their placement practice to enhance the mental health and well-being of service users.

Undertaking this study has also helped me to understand the importance of owning all aspects of the research, including my own feelings and emotions. It has also altered my perspective in worrying about presenting an ideal piece of research. I have learned to be comfortable and accept that I could not present all the data I had gathered within my research. These are all valuable lessons which I have learned and will impart to my students as they engage with their own research, where they are often faced with similar concerns of worrying that the research will not work out as they had intended.

I feel that engaging in this research has changed me as a person and therefore also as an educator and scholar. It has emphasised the importance for all individuals and the community to have a voice and be heard. Whether it is students, children, older people, the homeless or mothers, each group or individual should be provided with the opportunity to share their narrative and voice their opinions. It has also prompted me to consider the journey that we all undertake as researchers and that we cannot remain emotionally disconnected from the research we are engaged in. Being involved in research leads to personal challenges and contributes to personal growth and development as we learn to manage

the tensions, challenge the perception and accept that can both be influenced by and influence the research we engage in.

Conclusion

In conclusion the research has provided a detailed examination of the personal perspectives on mental health recovery and confirmed the valued contribution of the Kawa model in exploring the personal journeys of recovery. The research aims were met within the study, with participants sharing their personal stories and providing in depth biographical accounts of their recovery. The participants were able to explore and examine different aspects of their daily life and consider how different events and experiences contributed to their overall health, well-being and recovery. The use of the Kawa maps as research tool complemented the interviews questions and provided the participants with an alternative means of considering and narrating their journeys through the year. The creation of a series of five maps allowed for a deeper examination of the spectrum of factors that influenced personal recovery and supported a longitudinal exploration of recovery, which was a unique aspect of the research, with previous studies focused on participant's recovery at a specific point in time.

The research also provided a deeper understanding of mental health recovery beyond individuals' achieving psychological well-being or a stable mental state. What seemed equally important was regarding individuals' as 'social beings', where social acceptance, reducing isolation, developing a self-identity, social networks and having social and occupational roles were influential in promoting health, well-being and recovery. The research also highlighted the importance of being able to participate and engage in meaningful occupations and having the opportunity, means and choice to be involved. Some of the participants highlighted sports, creative occupations like art and music, working as a volunteer, being part of a self-help group, provided them with an identity and purpose, which supported their health and well-being.

Through adopting the Kawa model and using the Kawa maps, the participants became more aware of the broader spectrum of contextual and environmental factors relevant to their recovery, which included societal views of mental health, community inclusion, the benefits system and family pressures. The examination of the individual Kawa maps prompted further reflections and deeper conversations around mental health, well-being and recovery.

The research has also contributed to new knowledge around the Kawa model and maps and has been successfully used as a reflective tool to reveal biographical insights into experiences of personal recovery. It has highlighted that mental health recovery is far more complex than a maintaining a balanced state of mind and that individuals should be encouraged to strive for future goals, be socially included, provided with opportunities to participate in meaningful occupations, develop new interest and roles, and be supported in enhancing their mental health, well-being and recovery.

References

Adame, A.L. and Knudson, R.M. (2007) '*Beyond the counter-narrative: exploring alternative narratives of recovery from the psychiatric survivor movement'*, Narrative Inquiry, 17(2), pp. 157-178

Ahern, L. and Fisher, D. (2001) *'Recovery at your own PACE; personal assistance in community existence'*, Journal of Psychosocial Nursing and Mental Health Services, 39(4), pp. 22–32

Ahn, A.C., Tewari, M., Poon, C. S. and Phillips, R.S. (2006) *'The limits of reductionism in medicine: could systems biology offer an alternative?*' PLoS Med 3(6), pp.208-213

Allot, P., Loganathan, L. and Fulford, K.W.M. (2004) *'Discovering hope for recovery.'* Canadian Journal Community Mental Health, 21, pp. 1-22

Allport, G. W. (1961) *Pattern and growth in personality*. Harcourt College Publishers

Alvesson, M. (2002) *Postmodernism and social research*. Open University Press

Alvesson, M. and Sköldberg, K. (2009) *Reflexive methodology: new vistas for qualitative research.* Sage Publications

Annandale, E. (1998) *The sociology of health and medicine: a critical introduction.* Wiley Publishers

Anthony, W.A. (1993) *'Recovery from mental illness: the guiding vision of the mental health system in the 1990s'*, Psychosocial Rehabilitation Journal, 16(4), pp. 11-23

Anthony, W.A., Rogers, E.S. and Farkas, M. (2003) *'Research on evidence-based practices: future directions in an era of recovery'*, Community Mental Health Journal, 39(2), pp. 101-114

Aresti , A., Eatough, V. and Brooks-Gordon, B. (2010) *'Doing time after time: an interpretative phenomenological analysis of reformed ex-prisoners experiences of self-change, identity and career opportunities',* Journal Psychology, Crime & Law 16(3), pp. 169-190

Ashworth, P. (2003) *'An approach to phenomenological psychology: the contingencies of the lifeworld*', Journal of Phenomenological Psychology, 34(2), pp. 145-156

Bai, O. H. (2015) *Exploring occupational therapy students' experiences of using the Kawa Model as a reflective tool.* Unpublished Masters Dissertation

Baker, S. and Strong, S. (2001) *Roads to recovery: how people with mental health problems recover and find ways of coping*. Mind Publishing

Ballinger, C. (2004) *'Writing up rigour: Representing and evaluating good scholarship in qualitative research'*, British Journal of Occupational Therapy, 67(12), pp. 540-546

Barham, P. and Hayward, R. (1998) *'In sickness and in health: dilemmas of the person with severe mental Illness'*, Psychiatry, 61, pp.163–170

Barker, P. (2001) *'The tidal model: developing an empowering, person-centered approach to recovery within psychiatric and mental health nursing.'* Journal of Psychiatric and Mental Health Nursing, 8, pp. 233-240

Basnett, F. and Sheffield, D. (2010) *'The impact of social work student failure upon practice educators'*, British Journal of Social Work, 40 (7), pp. 2119-2136

Becker, C. (1992) *Living and relating: an introduction to phenomenology*. Sage Publications

Beresford, P. (2002) *'User involvement in research and evaluation: liberation or regulation?'* Social Policy and Society, 1(2), pp. 95-105

Bertenthal-Smith, J. (2015) *'A brief introduction to sand trays'*, Lecture presentation AMHCA Annual Conference Philadelphia, Accessed 02/03/17

Bejerholm, U., and Eklund, M. (2006) *'Engagement in occupations among men and women with schizophrenia'*, Occupational Therapy International, 13, pp. 100-121

Berger, P.L. and Luckmann, T. (1967) *The social construction of reality: a treatise in the sociology of knowledge.* Garden City, Anchor

Biggerstaff, D. and Thompson, A. R. (2000) *'Interpretative phenomenological analysis (IPA): a qualitative methodology of choice in healthcare research'*, Qualitative Research in Psychology, 5(3), pp.214-224

Bjørkedal, S.T.B., Torsting, A.M.B. and Møller, T. (2016) *'Rewarding yet demanding: client perspectives on enabling occupations during early stages of recovery from schizophrenia'*, Scandanavian Journal Occupational Therapy, 23(2), pp. 97-106

Black, W. and Living, R. (2004) *'Volunteerism as an occupation and its relationship to health and wellbeing'*, British Journal of Occupational Therapy, 67(12), pp. 526-532

Blackman, L. (2001) *Hearing voices: Embodiment and experience*. London: Free Association Books

Blackman, L. (2007) '*Psychiatric Culture and Bodies of Resistance',* Body and Society, 13(2), pp. 1-23

Blank, A. and Hayward, M. (2009) *'The role of work in recovery',* British Journal of Occupational Therapy*'*, 72(7), pp. 324-326

Blank, A., Harries, P. and Reynolds, F. (2011) *'Mental health service users' perspectives of work: a review of the literature'*, British Journal of Occupational Therapy, 74(4), pp. 191-199

Blank, A., Harries, P. and Reynolds, F. (2015) *'Without occupation you don't exist: occupational engagement and mental illness'*, Journal of Occupational Science, 22(2), pp. 197-209

Blaxter, M. (2010) *Health*. (2nd ed), Cambridge: Polity Press

Boniface, G., Humpage, S., Awatar, S. and Reagon, C. (2015) *'Developing an occupation-and recovery-based outcome measure for people with mental health conditions: An action research study'*, British Journal of Occupational Therapy, 78(4), pp. 222-231

Bonney, S. and Stickley, T. (2008) *'Recovery and mental health: a review of the British literature'*, Journal of Psychiatric and Mental Health Nursing, 15, pp. 140–153

Borg, M. and Davidson, L. (2008) *'The nature of recovery as lived in everyday experience'*, Journal of Mental Health, 17(2), pp. 129-140

Borg, M. and Kristiansen, K. (2008) *'Working on the edge: the meaning of work for people recovering from severe mental distress in Norway'*, Disability and Society, 23(5), pp. 511-523

Bourke, B. (2014) *'Positionality: Reflecting on the Research Process',* The Qualitative Report, 19(33), pp. 1-9

Brocki J.M. and Wearden, A.J. (2006) *'A critical evaluation of the use of interpretative phenomenological analysis (IPA) in health psychology'*, Psychology and Health, 21, pp. 87-108

Britten, N. (1999) *Qualitative interviews in healthcare*. In Pope, C. and Mays, N. (eds) *Qualitative research in health care*. (2nd ed). British Medical Journal Books, pp. 11-19

Bryman, A. (2016) *Social research strategies: quantitative research and qualitative research.* In Bryman, A. (ed) *Social Research Methods*. 5th edn. New York: Oxford University Press, pp. 16-38

Buchan, T. (2010) *'Implementing appropriate support systems'*, Occupational Therapy News, 18 (7), pp. 26–27

Buchanan-Barker, P. and Barker, P. (2006) *'The ten commitments: a value base for mental health recovery'*, Journal of Psychosocial Nursing and Mental Health Services, 44, pp. 29–33

Burr, V. (1998) *Overview: realism, relativism and social constructivism and discourse*, In. Parker, I. (ed) *Social constructivism, discourse and realism.* Sage Publications, pp.13-26

Burr, V. (2015) *Social constructionism.* 3rd Edition, Routledge

Bury, M. (2001) '*Illness narratives: fact or fiction?',* Sociology of Health and Illness, 23, pp. 263–85

Bury, M. (2005) *Health and illness*. Polity Press, Cambridge

Cameron, J., Reardon, M., Brooker, S., Neale, P., Harris, J., Kemp, A., Pople, K. and University of Brighton, Sussex Recovery College, Sussex Partnership NHS Foundation Trust (2016) *'Building resilience for mental health recovery: a recovery college collaboration'*, British Journal of Occupational Therapy, Supplement, 79, pp. 14

Carducci, B.J. (2009) *The psychology of personality: viewpoints, research, and applications.* (2nd Ed) Wiley, Blackwell

Carmody, S., Nolan, R. , Chonchuir, N., Curry, M. Halligan, C. and Robinson, K. (2007) *'The guiding nature of the kawa (river) model in Ireland: creating both opportunities and challenges for occupational therapists'*, Occupational Therapy International,14(4), pp. 221 – 236

Carpenter, C.M. and Suto, M. (2008) *Qualitative research for occupational and physical therapists: a practical guide*. Wiley, Blackwell

Carter, T. and Repper, J. (2011) *'A review of the literature on peer support in mental health services'*, Journal Of Mental Health, 20(4), pp. 392-411

Casiday, R., Kinsman, E., Fisher , C. and Bambra, C. (2008) *'Volunteering and health: what impact does it really have?'* www.volunteering.org.uk/hsc.

Critical Appraisal Skills Programme. https://casp-uk.net/casp-tools checklists/

Chamberlin, J. (1990) *'The ex-patients' movement: where we've been and where we're going'*, National Empowerment Center, 11(3), pp. 323-336

Chang, Y., Heller, T., Pickett, S. and Chen, M. (2013) *'Recovery of people with psychiatric disabilities living in the community and associated factors',* Psychiatric Rehabilitation Journal, 36(2), pp. 80-85

Cheng, I. K.S. (2010) *'Transforming practice: reflections on the use of art to develop professional knowledge and reflective practice'*, Reflective Practice, 11(4), pp. 489-498

Chowdhury, P.S. (2014*) Exploring occupational therapists' perspectives on the implementation of the recovery approach in forensic mental health settings.* Unpublished Masters Dissertation

Christiansen, C.H. (1999) '*The 1999 Eleanor Clarke Slagle Lecture, Defining Lives: Occupation as Identity: An Essay on Competence, Coherence, and the Creation of Meaning'*, American Journal of Occupational Therapy, 53(6), pp.547-558

Clarke, C. (2009*) 'An introduction to interpretative phenomenological analysis: a useful approach for occupational therapy research'*, British Journal of Occupational Therapy', 72(1), pp. 37-39

Cleary, A. and Dowling, M. (2009) *'The road to recovery'*, Mental Health Practice 12, pp. 28–31

Cook, N. R., Phillips, B. N., and Sadler, D. (2005) *'The tidal model as experienced by patients and nurses in a regional forensic unit'*, Journal of Psychiatric and Mental Health Nursing, 12, pp. 536-540

Copeland, M. E. (2008) *WRAP: Wellness recovery action plan: WRAPP In' Virginia in Recovery, Richmond*: Virginia Department of Mental Health and Substance Abuse Services

Coppa, K. and Boyle, F.M. (2003) '*The role of self-help groups in chronic illness management: a qualitative study'*, Australian Journal of Primary Health, 9(2), pp. 68-74

Cotterill,P. and Letherby,G. (1993) *'Weaving Stories: Personal Auto/Biographies in Feminist Research'*, Sociology 27(1), pp.67-79

Creek, J. and Lougher, L. (2008) *The knowledge base of occupational therapy; occupational therapy and mental health*. (4th ed.) Elsevier Science

Cresswell, J.W. (2013) *Qualitative inquiry and research design: choosing among five approaches.* Sage Publications

Crotty, M. (1998) *The foundations of social research: meaning and perspective in the research process*. Sage Publications

Csikszentmihalyi, Mihaly (1990) Flow: The Psychology of Optimal Experience. New York, NY: Harper and Row

Curtis, L.C. (1999) *'Modeling recovery: consumers as service providers in behavioral healthcare'*, National Council News, Rockville, MD: National Council for Community Behavioural Healthcare

Curtis, L.C. and Hilton, D. (2001) *'Peer Support: A Theoretical Perspective'*, Psychiatric Rehabilitation Journal, 25(2), pp. 134-141

Cutchin, M. and Dickie, V. (2013) *Transactional Perspectives on Occupation*. London: Springer

Daston, L. and Galison, P. (2010) *'Objectivity'*, Journal for General Philosophy of Science, 41(2), pp. 395–403

Davidson, L. (2005) *'Recovery, self-management and the expert patient-changing the culture of mental health from a UK perspective'*, Journal of Mental Health, 14(1), pp. 25-35

Davidson, L. (2007) *'Habits and other anchors of everyday life that people with psychiatric disabilities may not take for granted'*, OTJR: Occupation, Participation and Health, 27, pp. 605-685

Deegan, P.E. (1992) *'The independent living movement and people with psychiatric disabilities: taking control back over our own lives'*, Psychosocial Rehabilitation Journal, 15, pp. 3–19

Deegan, P.E. (1996a) *Recovery and the conspiracy of hope*. Sixth Annual Mental Health Services Conference of Australia and New Zealand; Brisbane, Australia

Deegan, P.E. (1996b) *'Recovery as a journey of the heart'*, Psychiatric Rehabilitation Journal, 11(4), pp. 11–19

Deegan, P.E. (2002) *'Recovery as a self-directed process of healing and transformation'*, Occupational Therapy in Mental Health. 17(3), pp. 5–22

de Geus, E.J.C. and de Moor M.H.M. (2008) *'A genetic perspective on the association between exercise and mental health'*, Mental Health and Physical Activity, 1(2), pp. 53-61

Dellow, R. and Skeels, H. (2016) *'Development of a kawa model workshop for patients of an adult community mental health team'*, British Journal of Occupational Therapy Supplement, 79, pp. 102-103

Department of Health (1990) *Community Care Act*: DH

Department of Health (1991) *Care Programme Approach*: DH

Department of Health (1997) *Modernising National Health* Service: DH

Department of Health (1999) *National Service Framework for Mental Health*: DH

Department of Health (2000) *The NHS Plan*: DH

Department of Health (2000) *Service User Involvement and Empowerment*: DH

Department of Health (2001) *The Journey to Recovery*: DH

Department of Health (2004) *The NHS Improvement Plan*: DH

Department of Health (2004) *Social Exclusion Report*: DH

Department of Health (2006*) Amendment to Mental Health Act*: DH

Department of Health (2007) *Mental Health: New Ways of Working For Everyone*: DH
Department of Health (2009) *National Social Inclusion Programme: Vision and Progress*: DH

Department of Health (2009) *New Horizon: A Shared Vision for Mental Health*: DH

Department of Health) (2011) *No Health Without Mental Health: Mental Health Strategy for England*: DH

Department of Health (2012) *National Framework to Improve Mental Health and Wellbeing*: DH

Department of Health (2013*) Making Mental Health Services More Effective and Accessible*: DH

Department of Health (2014) *Closing the Gap: Priorities for Essential Change in Mental Health*: DH

Department of Health (2014) *Policy Paper: Mental health Priorities for Change*: DH

Department of Health NHS (2016) *5 Year Plan for Mental Health Services*: DH

Dickson, A., Knussen, C. and Flowers, P. (2008) *'That was my old life; it's almost like a past life now: Identity crisis, loss and adjustment amongst people living with chronic fatigue syndrome'*, Psychology and Health, 23, pp. 459-476

Domholdt, E. (2005) *Rehabilitation research: principles and applications*. Elsevier

Doroud, N., Fossey, E. and 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), pp. 378-392

Dowling, H. and Hutchinson, A. (2008) *'Occupational therapy - its contribution to social inclusion and recovery'*, A Life in the Day, 12(3), pp. 11-14

Dunn, A.L., Trivedi, M.H., Kampert, J.B., Clark, C.G. and Chambliss, H.O. (2005) *'Exercise treatment for depression: efficacy and dose response'*, American Journal Preventative Medicine, 28, pp. 1–8

D'Cruz, H., Gillingham, P., and Melendez, S. (2007) *'Reflexivity: a concept and its meanings for practitioners working with children and families*', Critical Social Work 8(1), pp 73-90

Easterby-Smith, M., Thorpe, R. and Jackson, P. R. (2008) *Management research*. (3rd ed) Sage Publication

Eatough, V. and Smith, J.A. (2008) *Interpretative phenomenological analysis*. In Willig, C. and Rogers, W.S. (ed) . *SAGE Handbook of Qualitative Research in Psychology*, Sage Pubilication pp179-195

Emerson, H. (1998) *'Flow and occupation: a review of the literature'*, Canadian Journal of Occupational Therapy, 65(1), pp. 37-44

Emmison, M. and Smith, P. (2000) *Researching the visual*. Sage Publications

Ennals, P. and Fossey, E. (2009*) 'Using OPHI-II to support people with mental illness in their recovery'*, Occupational Therapy in Mental Health, 25(1), pp. 138-150

Etherington, K. (2005) *Becoming a Reflexive Researcher - Using Our Selves in Research*: Jessica Kingsley Publishers

Farkas, M., Gagne, C., Anthony, W. and Chamberlin, J. (2005) *'Implementing recovery oriented evidence based programs: identifying the critical dimensions'*, Community Mental Health, 41(2), pp. 141-58

Fenton, L., White, C., Gallant, K.A., Gilbert, R., Hutchinson, S. and Hamilton-Hinch, B. (2017) *'The benefits of recreation for the recovery and social inclusion of individuals with mental illness: an integrative review'*, Leisure Sciences An Interdisciplinary Journal, 39(1), pp.1-19

Fieldhouse, J. (2008) *'Using the Kawa model in practice and in education'*, Mental Health Occupational Therapy 13 (3), pp. 101-106

Fieldhouse, J. (2012) *'Community participation and recovery for mental health service users: an action research inquiry'*, British Journal of Occupational Therapy, 75(9), pp. 419-428

Finlay, L. (2002) *'Negotiating the swamp: the opportunity and challenge of reflexivity in research practice'*, Qualitative Research, 2, pp. 209-230

Finlay, L. (2003) *The reflexive journey: mapping multiple routes: a practical guide for researchers in health and social sciences*. Oxford. Blackwell.

Finlay, L. (2006) *'Rigour, ethical integrity or artistry'*, British Journal of Occupational Therapy, 69(7), pp. 319-326

Finlay, L. and Gough, B. (2003) *Reflexivity: a practical guide for researchers in health and social sciences*. Blackwell Scientific

Finlay, L. and Ballinger, C. (2006) *Qualitative research for allied health professionals: challenging choices*. Wiley and Sons

Flowers, P. (2008) '*Temporal tales: The use of multiple interviews with the same participant'*, Qualitative Methods in Psychology Newsletter, 5, pp. 24-27

Forsyth, K. and Kielhofner, G. (2011) *The Model of Human Occupation: enabling the complexity of occupation by integrating theory into practice and practice into theory.* in: Duncan E, (Ed), Foundations for Practice in Occupational Therapy, Churchill Livingstone, pp. 51-80

Freund, P.E.S. (1990) *'The expressive body: a common ground for the sociology of emotions, health and illness'*, Sociology of Health and Illness, 12, pp. 452–477

Froggett, L. and Little, R. (2012) *'Dance as a complex intervention in an acute mental health setting: a place 'in-between''*, British Journal of Occupational Therapy, 75(2), pp. 93-99

Gadamer, H. G. (1960) *Truth and method*. Continuum Publishing Group

Gibson, R.W., D'Amico, M., Jaffe, L. and Arbesman, M. (2011) *'Occupational therapy interventions for recovery in the areas of community integration and normative life roles for adults with serious mental illness: a systematic review'*, The American Journal of Occupational Therapy, 65(3), pp. 247-256

Gomm, R. (2009) *Key concepts in social research methods*. Palgrave Macmillan

Gough, G. and Trehy, A. (2011) *'An internal audit of recovery within mental health occupational therapy service using the recovery self-assessment.',* Irish Journal of Occupational Therapy, 39(1), pp. 27-33

Gould, A., DeSouza, S., and Rebeiro-Gruhl, K. L. (2005) '*And then I lost that life: a shared narrative of four young men with schizophrenia'*, British Journal of Occupational Therapy, 68(10), pp. 467-473

Greenhalgh, T. (2014) *How to read a paper: the basics of evidence-based medicine* (5th ed). Chichester, West Sussex: John Wiley & Sons

Greenhalgh, T and Taylor, R. (1997) *'Papers that go beyond numbers'*, British Medical Journal, 315, pp. 740-743

Gregg, B.T., Howell, D. M., Quick, C.D. and Iwama, M. K. (2015) *'The Kawa river model: applying theory to develop interventions for combat and operational stress control'*, Occupational Therapy in Mental Health, 31(4), pp. 366-384

Griffiths, S and Corr, S. (2007) *'The use of creative activities with people with mental health problems: a survey of occupational therapists'*, British Journal of Occupational Therapy, 70(3), pp. 107–114

Grix, J. (2010) *Introducing the key research paradigms.* In Grix, J. (ed.) The foundations of research. 2nd edn. London: Palgrave, pp.77-100

Hagedorn, M. (1994) *'Hermeneutic photography: an innovative aesthetic technique for generating data in nursing research'*, Advance Nursing Science. 17(1), pp. 44-50

Hagedorn, R. (2001) *Foundations for practice in occupational therapy.* Edinburgh: Churchill Livingstone

Hammell, K. (2008) *'Reflections on...well-being and occupational rights',* Canadian Journal of Occupational Therapy, 75(10) pp. 61-64

Happell, B. (2008) *'Determining the effectiveness of mental health services from a consumer perspective: Part 2: Barriers to recovery and principles for evaluation'*, International Journal of Mental Health Nursing, 17(2), pp. 123–130

Haracz, K. and Ennals, P. (2015) *'Occupational therapy intervention in mental health should be individualised, occupation focussed, promote inclusion and occur in the context of an authentic relationship'*, Australian Occupational Therapy Journal, 62(5) pp. 365-366

Harper, D. (2002) *'Talking about pictures: A case for photo elicitation',* Visual Studies, 17, pp. 13–26

Harper, D. and Speed, E. (2012) *'Uncovering recovery: the resistible rise of recovery and resilience'*, Studies in Social Justice, 6(1), pp. 9-26.
Harrison, B. (2002). *'Photographic visions and narrative inquiry*', Narrative Inquiry, 12(1), pp. 87-111

Harrison, D. and Sellers, A. (2008) *'Occupation for mental health and social inclusion'*, The British Journal of Occupational Therapy, 71(5), pp. 216-219

Hasselkus, B.R. (2002) *The meaning of everyday occupation*. Thorofare, NJ: Slack

Hatchard, K. and Missiuna, C. (2003) *'An occupational therapist's journey through bipolar affective disorder'*, Occupational Therapy in Mental Health, 19(2), pp. 1-17

Heenan, D. (2009) *'Mental health policy in Northern Ireland: the nature and of extent of user involvement'*, Social Policy and Society, 8(4), pp. 451-462

Heidegger, M. (1962) *Being and time*. (translated. Macquarrie, J. and Robinson, E. (7th ed.). Oxford, UK: Blackwell Publishers (original work published in 1927)

Helman, C.G. (2007*) 'Culture health and illness'*, (5th edition), Article in International Review of Psychiatry 21(5), pp. 489-489

Henderson, K.A. and Bialeschki, M.D. (2005) *'Leisure and active lifestyles: research reflections'*, Journal of Leisure Science 27(5), pp. 355-365

Hick, C. M. (2004) *Research methods for clinical therapists: applied project design and analysis paperback*. Churchill Livingstone

Higgins, A. (2008) *A recovery approach within the Irish mental health services: a framework for development*. Dublin Mental Health Commission

Hitch, D., Hii, Q.K., and Davey, I. (2016) *'Occupational therapy in forensic psychiatry: recent developments in our understandings (2007 – 2013)*', British Journal of Occupational Therapy, 79(4), pp. 197–205

Homeyer, L. E., and Sweeney, D. S. (2011) *Sandtray: a practical manual.* (2nd ed.) New York, NY: Routledge

Hood, R. (2015) *'How professionals experience complexity: an interpretative phenomenological analysis'*, Child Abuse Review 24(2): 140–152

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

Humbert, T. K., Bess, J. L., and Mowery, A. M. (2013) *'Exploring women's perspectives of overcoming intimate partner violence: A phenomenological study'*, Occupational Therapy in Mental Health, 29(3), 246–265

Humbert, T. K., Engleman, K. and Miller, C. E. (2014) '*Exploring women's expectations of recovery from intimate partner violence: a phenomenological study'*, Occupational Therapy in Mental Health, 30(4), pp. 358-380

Hummelvoll, J. K., Karlsson, B. and Borg, M. (2015*) 'Recovery and person-centredness in mental health services: roots of the concepts and implications for practice'*, International Practice Development Journal, 5(7), pp. 1-9

Husserl, E. (1927) *'Phenomenology',* Article for the Encyclopedia Britannica

Inwood, M. (2000) *Heidegger: A Very Short Introduction*. Oxford University Press

Iwama, M.K. (2003) *'The issue is… toward culturally relevant epistemologies in occupational therapy'*, American Journal of Occupational Therapy, 57(5), pp. 582-588

Iwama, M.K. (2004) *'Revisiting culture in occupational therapy research; a meaningful endeavour',* Occupational Therapy Journal of Research; Occupation, Participation & Health. 24(1), pp.1-2

Iwama, M.K. (2005) *The kawa (river) model; nature, life flow & the power of culturally relevant occupational therapy*. In: Kronenberg F., Algado S.A., Pollard n. (eds), *Occupational Therapy Without Borders - Learning from the Spirit of Survivors,* Edinburgh; Churchill Livingstone, pp 213-227

Iwama, M.K. (2006) *The Kawa model: culturally relevant occupational therapy*. Churchill Livingstone

Iwama, M. K. and Fujimoto, H. (2005) *Situated meaning; an issue of culture, inclusion & occupational therapy*. In: Kronenberg F., Algado S.A., Pollard N. (Eds), *Occupational Therapy Without Borders - Learning From The Spirit Of Survivors*, Edinburgh; Churchill Livingstone, pp. 127-139

Iwama, M.K., Thomson N.A. and Macdonald, R.M. (2009) *'The Kawa model: the power of culturally responsive occupational therapy'*, Disability Rehabilitation. 31(14), pp. 1125-1135

Iwasaki,Y., Coyle,C., Shank,J., Messina,E., Porter,H. and Salzer,M. (2014) *'Role of leisure in recovery from mental illness'*, American Journal of Psychiatric Rehabilitation 17(2), pp. 147-165

Jung, C. G. (1957) *The Undiscovered Self (Present and Future).* New York: American Library

Katsouri, V. (2014) *Exploring occupational therapists perspectives on the implementation of the recovery approach in mental health settings*, Unpublished Masters Dissertation

Kielhofner G. (2008) *Model of Human Occupation: Theory and application* (4th ed.). Baltimore, MD: Lippincott Williams & Wilkins

Kelly, M., Lamont, S. and Brunero, S. (2010) *'An occupational perspective of the recovery journey in mental health'*, British Journal of Occupational Therapy, 73(3), pp. 129–135

Killaspy, H. (2007) *'From the asylum to community care: learning from experience'*, British Medical Bulletin, pp. 1-14

Klein, P. D. (2005) *Infinitism is the solution to the regress problem*, in Steup, M. and Sosa, E. (eds), *Contemporary Debates in Philosophy*, Malden, MA: Blackwell Publishers, pp. 131–40

Knight, M.T.D., Wykes, T. and Hayward, P. (2003) *'People don't understand: an investigation of stigma in schizophrenia using interpretative phenomenological analysis (IPA)*', Journal of Mental Health, 12 (3), pp. 209-222

Koch, T. (2006) '*Establishing rigour in qualitative research: the decision trail'*, Journal of Advanced Nursing, 53, pp. 91-103

Koch, T. and Harrington, A. (1998) *'Reconceptualizing rigour: the case for reflexivity'*, Journal of Advanced Nursing. 28(4), pp. 882-890

Kuhn, T. (1962) *The structure of scientific revolutions*. International Encyclopedia of Unified Science, 2(2) University of Chicago Press

Lagace, M., Briand, C., Desrosiers, J., and Lariviere, N. (2016) *'A qualitative exploration of a community-based singing activity on the recovery process of people living with mental illness'*, British Journal of Occupational Therapy, 79(3), pp. 178–187

Lal, S. (2010) *'Prescribing recovery as the new mantra for mental health: does one prescription serve all'*, Canadian Journal of Occupational Therapy, 77(2), pp. 82-89

Laliberte-Rudman, D., Yu, B., Scott, E., and Pajouhandeh, P. (2000) *'Exploration of the perspectives of persons with schizophrenia regarding*

quality of life', The American Journal of Occupational Therapy, 54(2), pp. 137-147

Langdridge, D. (2007) *Phenomenological Psychology. Theory, Research and Method.* Pearson Prentice Hall

Larkin, M., Watts, S. and Clifton, E. (2006) '*Giving voice and making sense in Interpretative Phenomenological Analysis'*, Qualitative Research in Psychology, 3(2), pp. 102-120

Larkin, M., Eatough, V. and Osborn, M. (2011) *'Interpretative phenomenological analysis and embodied, active, situated cognition'*, Theory and Psychology, 21(3), pp. 318 – 337

Leamy, M., Bird, V., Le Boutillier, C., Williams, J. and Slade, M. (2011) *'Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis'*, The British Journal of Psychiatry, 199(6), pp.445-452

Le-Boutillier, C., Leamy, M., Bird, V.J., Davidson, L., Williams, J. and Slade, M. (2011) *'What does recovery mean in practice? A qualitative analysis of international recovery-oriented practice guidance'*, Psychiatric Services, 62(12), pp.1470-1476

Lee, S.W., Kielhofner, G., Morley, M., Heasman, D., Garnham, M., Willis,S., Parkinson,S., Forsyth, K., Melton, J. and Taylor, R. R. (2012) *'Impact of using the Model of Human Occupation: A survey of occupational therapy mental health practitioners' perceptions'*, Scandinavian Journal of Occupational Therapy, 19, pp. 450–456

Leete, E.(1989) *'How I perceive and manage my illness'*, Schizophrenia Bulletin, 15, pp. 197–200

Letherby,G., Scott,J. and Williams,M. (2013*) Objectivity and subjectivity in social research.* Sage UK

Leufstadius, C., Erlandsson, L.-. Björkman, T. and Eklund, M. (2008) *'Meaningfulness in daily occupations among individuals with persistent mental illness',* Journal of Occupational Science, 15(1), pp. 27-35

Lim, K.H. (2006) *Case studies in the application of the Kawa model*. In Iwama, M.K, (ed) *The Kawa model; Culturally Relevant Occupational Therapy*. Elsevier Churchill Livingstone

Lim, K.H. (2008a) *Cultural sensitivity in context*, In McKay EA, Craik C, Lim KH & Richards G (eds) *Advancing Occupational Therapy in Mental Health Practice*. Blackwell Publishing, pp. 30-47

Lim, K.H. (2008b) *Working in a transcultural context*, In: Creek J & Lougher L (eds) *Occupational Therapy and Mental Health*. (4th Ed, In Print), Churchill Livingstone, pp. 251-274

Lim, K.H. (2009) *'Ebb and Flow: reflections on the Kawa model in practice and education'*, Mental Health Occupational Therapy 14 (2), pp. 101-106

Lim, K.H. (2015a) *Longitudinal study exploring the value of occupation in the recovery of mental health service users within the Kawa Model.* UKOTRF Final Project Report

Lim, K.H. (2015b) *Kawa river model*. [Lecture to European Masters Occupational Therapy Students] Hogeschool van Amsterdam, August 2015

Lim, K.H. (2017) *Mental health occupational therapy practice in context*. [Lecture to MSc Pre-reg Mental health option] Brunel University London, January 2017

Lim, K.H. and Iwama, M.K. (2006) *Emerging models- an Asian perspective: the Kawa (river) model*, in: Duncan E. (ed), *Foundations for Practice* in Occupational Therapy. Elsevier, pp. 161-189

Lim, K.H. and Iwama, M.K. (2011*) The Kawa 'river' model*. in: Duncan E, (Ed), *Foundations for Practice in Occupational Therapy*, Churchill Livingstone, pp. 117-137

Linge, D.E. (2008*) Philosophical hermeneutics, Hans-Georg Gadamer*. University of California Press

Lith, V.T., Schofield, M.J., and Fenner, P. (2013) *'Identifying the evidence-base for art-based practices and their potential benefit for mental health recovery: a critical review*' Disability Rehabilitation, 35(16), pp. 1309-1323

Lloyd, C., King, R. and McCarthy, M. (2007) *'The association between leisure motivation and recovery: a pilot study'*, Australian Occupational Therapy Journal, 54(1), pp. 33-41

Lloyd, C., Waghorn, G., and Williams, P.L. (2008) *'Conceptualising recovery in mental health rehabilitation*', British Journal of Occupational Therapy, 71(8), pp. 321-328

Lock, A. and Strong,T. (2010) *Social Constructionism: Sources and Stirrings in Theory and Practice.* Cambridge University Press

Loumpa, V. (2012) *'Promoting recovery through peer support: possibilities for social work practice',* Social Work in Health Care, 51(1), pp. 53-65

Lum, T.Y. and Lightfoot, E. (2005) '*The effects of volunteering on the physical and mental health of older people',* Research on Ageing, 27(1), pp. 31-55

Malterud, K. (2001) '*Qualitative research: standards, challenges and guidelines',* The Lancet. 358, pp. 483-488

Mancini, M.A. (2007) *'The role of self-efficacy in recovery from serious psychiatric disabilities, a qualitative study with fifteen psychiatric survivors'*, Qualitative Social Work, 6(1), pp. 49–74

Mancini, M.A., Hardiman, E.R. and Lawson, H.A. (2005*) 'Making sense of it all: consumer providers' theories about factors facilitating and impeding recovery from psychiatric disabilities',* Psychiatric Rehabilitation Journal, 29(1), pp. 48-55

Mannay, D. (2016) *Visual, narrative and creative research methods: application, reflection and ethics.* Routledge

Mansfield, S. (2006) *Keeping a critically reflexive research journal.* University of Dundee

Martyn, D. (2002) *The experiences and views of self-management of people with a schizophrenia diagnosis*, Rethink, London.-Review (Accessed: 01/03/2017)

Matthews, B. and Ross, L. (2010a) *Knowledge, theories, paradigms and perspectives.* In Matthews, B. and Ross, L. (eds) Research methods: a practical guide for the social sciences. UK: Pearson Education. pp.16-41

Mays, N. and Pope, C. (1996) *Qualitative research in health care. London*: BMJ Publishing Group, 1996

McCloughan, P., Batt, W.H., Costine, M. and Scully, D. (2012) *Participation in volunteering and unpaid work. Second European Quality of Life Survey.* Luxembourg: Publications Office of the European Union, 2011

McLeod, J. (2001) *Qualitative Research in Counselling and Psychotherapy*. Sage Publications

McKay, E., Craik, C., Lim,K.H. and Richards, G. (2008), *Advancing occupational therapy in mental health practice*. Oxford, UK: Blackwell Publishing

McManus, S., Bebbington, P., Jenkins,P. and Brugha, T. (2016) *Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014*. Leeds: NHS Digital

Mead, S. and Copeland, M. E. (2000) *'What recovery means to us: consumers' perspectives'*, Community Mental Health Journal, 36(3), pp.315-328

Mead, S., Hilton, D. and Curtis, L. (2001) *'Peer support: a theoretical perspective'*, Psychiatric Rehabilitation Journal, 25(2), pp. 134-141

Meddings, S., Guglietti, S., Lambe, H. and Byrne, D. (2014) *'Student perspectives: recovery college experience'*, Mental Health and Social Inclusion, 18(3), pp. 142-150

Meddings, S., McGregor, J., Roeg, W. and Shepherd, G. (2015) *'Recovery colleges: quality and outcomes'*, Mental Health and Social Inclusion, 19(4), pp. 212-221

Mee, J. and Sumsion, T. (2001) *'Mental health clients confirm the motivating power of occupation'*, British Journal of Occupational Therapy, 64(3), 121-128

Meehan, T.J., King,R. J., Beavis, P. H. and Robinson, J. D. (2008) *'Recovery-based practice: do we know what we mean or mean what we know?'* Australian and New Zealand Journal of Psychiatry, 42(3), pp. 177-182

Mental Health Foundation (2016) *Fundamental facts about mental health 2016. Mental Health Foundation*. https://www.mentalhealth.org.uk/sites (Accessed: 20/03/2017)

Mind, (2016) *Building on change: Mind's 2016-21 strategy*, Available at: http://www.mind.org.uk/media/4205494/building-on-change_booklet_final_pdf_21march1 6.pdf (Accessed: 23/02/17)

Moran, D. (2000) *Introduction to Phenomenology*. Oxford. Routledge

Myers, N.A.L. (2016) *'Recovery stories: an anthropological exploration of moral agency in stories of mental health recovery'*, Transcultural Psychiatry, 53(4), pp. 427-444

Nazroo, J. and Matthews, K. (2012). *The impact of volunteering on well-being in later life*. A report to WRVS, May 2012

Nelson, A. (2007) *'Seeing white: a critical exploration of occupational therapy with indigenous Australian people'*, Occupational Therapy International, 14, pp. 237–255

Nettleton, S. (2006) *The Sociology of Health and Illness*. Polity

New South Wales (2009) *Developing a Recovery Oriented Service Provider Resource for Community Mental Health Organisations*. NSW Advisory Group

Newell, S. (2009) '*Boredom, mental health inpatients and occupational therapy',* Mental Health Occupational Therapy, 14 (1), pp. 25-27

Nightingale, D. J. and Cromby, J. (1999) *Social Constructionist Psychology– A Critical Analysis of Theory and Practice*. Open University Press,

Nixon, G., Hagen, B. and Peters, T. (2010) *'Recovery from psychosis: a phenomenological inquiry'*, International Journal of Mental Health and Addiction, 8(4), pp. 620–635

Noorani, T. (2013) *'Service user involvement, authority and the 'expert-by-experience' in mental health'*, Journal of Political Power, 6(1), pp. 49-68

Odawara, E. (2005) *'Cultural competency in occupational therapy: Beyond a cross-cultural view of practice',* American Journal of Occupational Therapy, 59, pp. 325-334. doi: 10.5014/ ajot.59.3.325

Okuda, M., Iwama, M. and Hatsutori, T. (2000) *'A Japanese model of occupational therapy; One; the 'river model' raised from the clinical setting'*, Journal of the Japanese Association of Occupational Therapists 2000; 19, Supplement: 512.

Onken, S.J., Craig, C.M., Ridgway, P., Ralph, R.O. and Cook, J.A. (2007) *'An analysis of the definitions and elements of recovery: a review of the literature'*, Psychiatric Rehabilitation Journal, 31(1), pp. 9-22

Owen, A. A. and Franszen, F.D. (2010) *'Factors influencing model use in occupational therapy'*, South African Journal of Occupational Therapy, 44(1), pp. 41-47

Owen, A. A. (2014) *Model use in occupational therapy practice with a focus on the Kawa model.* Unpublished Masters Dissertation

Ostyn, M. (2013) *The Battle With The Kawa Model In A Psychiatric Care Center. Investigating In The Value In The Occupational Therapy And As A Basis For Client-oriented Care*. Unpublished Masters Dissertation

O'Doherty, Y.D. and Doherty, D.T. (2010) *'Recovering from recurrent mental health problems: giving up and fighting to get better'*, International Journal of Mental Health Nursing, 19(1), pp. 3–15

O'Hagan, M. (2001) *Recovery Competencies for New Zealand Mental Health Workers.* Mental Health Commission

Patton, M.Q. (2002) *Qualitative research & evaluation methods* (3rd ed.) Thousand Oaks, CA: Sage Publications

Paxson, D., Winston, K., Tobey, T., Johnston. S, and Iwama M.K. (2012) *'The Kawa model: therapists experiences in mental health practice'*, Occupational Therapy in Mental Health, 28(4), pp 340-355

Paxton, H. (2015) *Exploring occupational therapy students experiences of using the Kawa Model as a reflective tool*, Unpublished Masters Dissertation

Perkins, R., Repper, J., Rinaldi, M. and Brown, H. (2012) *Recovery Colleges*. Sainsbury Centre for Mental Health: London

Perkins, A., Ridler, J., Hammond, L., Davies, S. and Hackmann, C. (2017) *'Impacts of attending recovery colleges on NHS staff'*, Mental Health and Social Inclusion, 21(1), pp. 18-24.

Petersen, K.S., Friis, V.S., Haxholm, B.L., Nielsen, C.V. and Wind, G. (2015) *'Recovery from mental illness: a service user perspective on facilitators and barriers'*. Community Mental Health Journal, 51(1), pp.1-13

Pettican, A. R. and Prior, S. (2011) *'It's a new way of life: an exploration of the occupational transition of retirement.'* The British Journal of Occupational Therapy, 74(1). pp. 12-19

Pietkiewicz, I. and Smith, J A. (2014) *'A practical guide to using interpretative phenomenological analysing qualitative research psychology'*, Czasopismo Psychological Journal, 20(1), pp. 7-14

Pilgrim, D. (2009) *Key Concepts in Mental Health*. Second Edition. London. Sage

Pitt, L., Kilbride, M., Nothard, S., Welford,M. and Morrison, A. P. (2007) *'Researching recovery from psychosis: a user-led project'*, Psychiatric Bulletin 31, pp. 55-60. doi: 10.1192 / pb. bp.10 5.0 0 8 532

Polgar, S. and Thomas, S. (2005) *Introduction to Research in the Health Sciences*. Elsevier Churchill Livingstone

Polkinghorne, D. E. (2005) *'Language and meaning: data collection in qualitative research'*, Journal of Counseling Psychology, 52(2), pp. 137-145

Pope, C. and Mays, N. (1995) *'Qualitative research: reaching the parts other methods cannot reach: an introduction to qualitative methods in health and health services research'*, British Medical Journal, 311, pp. 42–45

Quinn, C. and Clare, L. (2008) *Interpretative phenomenological analysis,* In Watson, R., McKenna, H. , Cowman, S. and Keady, J. (eds) *Nursing Research: Designs and Methods*. Elsevier, pp. 375-384

Radley, A. (2010) *'What people do with pictures'*, Journal of Visual Studies, 25(3), pp. 268-279

Rake, C and Paley, G. (2009) *'Personal therapy for psychotherapists: the impact on therapeutic practice. A qualitative study using interpretative phenomenological analysis*', Journal of Psychodyanamic Practice, 15 (3), pp. 275-294

Ramon S., Healy, B. and Renouf, N. (2007) *'Recovery from mental illness as an emergent concept and practice in Australia and the United Kingdom'*, International Journal of Social Psychiatry 53, pp. 108–122.

Ratner, C. (2002) *'Subjectivity and Objectivity in Qualitative Methodology'*, Qualitative Social Research 3(3), pp.16 –17 assessed: http://www.qualitative-research.net/index. php/fqs/article/view/829/1800

Reavey, P. (2012) *Visual Methods in Psychology: Using and Interpreting Images in Qualitative research*. Psychology Press, Taylor Francis Group

Rebeiro Gruhl, K. L. (2005) *'Reflections on the recovery paradigm: should occupational therapists be interested?'*, Canadian Journal of Occupational Therapy, 72(2), pp. 96-102

Reid, K., Flowers, P., and Larkin, M. (2005) *'Exploring lived experience: an introduction to interpretative phenomenological analysis'*, The Psychologist, 18, pp. 20-23

Renton, L. (2010) *Student's views on the use of the Kawa model for their professional development*. WFOT Conference Presentation, Chile (2010)

Repper, J. and Perkins, R. (2003) *Social Inclusion and Recovery. A Model for Mental Health Practice.* Bailliere Tindall

Repper, J. and Carter, T. (2011) *'A review of the literature on peer support in mental health services'*, Journal Of Mental Health, 20(4), pp. 392-411

Repper, J. and Perkins, R. (2012) *'Recovery: a journey of discovery for individuals and services'*, In Phillips, P., Sandford, T. and Johnston, C. (eds), *Working in Mental Health: Practice and Policy in a Changing Environment*. Routledge, pp. 71-80

Reaume, G. (2008) *'A History of Psychiatric Survivor Pride Day during the 1990s'*. The Consumer/Survivor Information Resource Centre Bulletin, No. 374

Reynolds, F. and Prior, S. (2003) *'Sticking jewels in your life: exploring women's strategies for negotiating an acceptable quality of life with multiple sclerosis'*, Qualitative health research, 13(9), pp. 1225-1251

Reynolds, F. and Lim, K.H. (2007) *'Contribution of visual art-making to the subjective well-being of women living with cancer: A qualitative study'*, Arts in Psychotherapy, 34(10), pp. 1-10

Reynolds, F., Vivat, B. and Prior, S. (2008) *'Women's experiences of increasing subjective well-being in CFS/ME through leisure-based arts and crafts activities: a qualitative study'*, Disability and rehabilitation, 30(17), pp. 1279-1288

Richardson, P., Jobson, B. and Miles, S. (2010) *'Using the Kawa model: a practice report'*, Mental Health Occupational Therapy, 15(3), pp. 82-85

Ridgeway, P. (2001) *'Restoring psychiatric disability: learning from first person recovery narratives'*, Psychiatric Rehabilitation Journal. 24(4), pp. 335–343

Roberts, G. and Wolfson, P. (2004) *'The rediscovery of recovery: open to all'*, Advances in Psychiatric Treatment, 10 (1), pp. 37-48

Rogers, A and Pilgrim, D. (1991) *'Pulling down churches: accounting for the British Mental Health Users Movement'*, Sociology of Health and Illness, McGraw Hill, Open University Press

Rose, G (2016) *Visual methodologies*. (4th Ed) Sage Publications

Royal College of Occupational Therapists (2006) Recovering ordinary lives: the strategy for occupational therapy in mental health services 2007–2017; a vision for the next ten years. Royal College of Occupational Therapists

Royal College of Occupational Therapists (2007) Building the evidence for occupational therapy: priorities for research. Royal College of Occupational Therapists

Royal College of Occupational Therapists (2015) Code of ethics and professional conduct. Royal College of Occupational Therapists

Rubin, H. J. and Rubin, I.S. (2005) *Qualitative Interviewing: The Art of Hearing Data.* Sage Publications

Saavedra, J., Perez, E., Crawford, P. and Arias, S. (2017) '*Recovery and creative practices in people with severe mental illness: evaluating well-being and social inclusion',* Journal of Disability and Rehabilitation 40(8), pp. 905-911

Sainsbury Centre for Mental Health (2004) *The Ten Essential Shared Capabilities*. London: SCMH

Sainsbury Centre for Mental Health (2007) *Work and wellbeing: Developing primary mental healthcare services.* London. Sainsbury Centre for Mental Health

Sainsbury Centre for Mental Health (2009) *Implementing recovery. A new framework for organisational change*. London. Sainsbury Centre for Mental Health

Salvatore, S. and Valsiner, J. (2010) *'Between the General and the Unique: Overcoming the nomothetic versus idiographic opposition'*, Theory and Psychology 20(6): 817–833

Sargeant, J. (2012) *'Qualitative research part II: participants, analysis, and quality assurance'*, Journal of Graduate Medicine Education, 4(1), pp. 1–3

Sayce, L. (2000) *From psychiatric patient to citizen*. St Martins Press

Schäfer, M. (1999) *'Nomothetic and idiographic methodology in psychiatry--a historical-philosophical analysis'*, Medical Health Care Philosophy 2(3), pp.265-274

Schaverien, J. (1999) *The Revealing Image*. London and Philadelphia: Jessica Kingsley Publishers

Schiff, A.C. (2004) *'Recovery and mental illness: analysis and personal reflections'*, Psychiatric Rehabilitation Journal, 27(3), pp. 212-218

Schwandt, T. A. (1994) Constructivist, interpretivist approaches to human inquiry. In Norman K. Denzin, and Lincoln, Y. S. (ed) *Handbook of Qualitative Research*. Sage Publications, pp. 118-137

Scotland, J. (2012) *'Exploring the philosophical underpinnings of research: relating ontology and epistemology to the methodology and methods of the scientific, interpretive, and critical research paradigm'*, English Language Teaching, 5(9), pp. 9-16

Secker, J., Membrey, H., Grove, B. and Seebohm, P. (2002) *'Recovering from illness or recovering your life? Implications of clinical versus social models of recovery from mental illness for employment support services'*, Disability and Society, 17, pp. 403–418

Sells, D., Stayner, D., and Davidson, L. (2004) *'Recovering the self in schizophrenia: an integrative review of qualitative studies'*, Psychiatric Quarterly, 75, pp. 87-97

Shepherd, G., Boardman, J. and Slade, M. (2008) *Making recovery a reality*. Sainsbury Centre for Mental Health: London

Shepherd, G., Boardman, J. and Burns, M. (2011) *Recovery: A Methodology for Organisational Change.* Sainsbury Centre for Mental Health Policy Guidance. London

Silverman, D. (1993) *Interpreting qualitative data: methods for analysing talk, text and interaction*. London. Sage

Silverman, H.J. (2014) *Questioning Foundations: Truth, Subjectivity and Culture. Routledge*

Skipper, L. and Page, K. (2015) *'Our recovery journey: two stories of change within Norfolk and Suffolk NHS Foundation Trust'*, Mental Health and Social Inclusion, 19(1), pp. 38-44

Slade, M. (2009) *Personal recovery and mental illness: a guide for mental health practitioners*. Cambridge University Press

Slade, M. (2010) *'Mental illness and well-being: the central importance of positive psychology and recovery approaches'*, Health Services Research, 10(1), pp. 26

Slade, M., Adams, N. and O'Hagan, M. (2012) *'Recovery: past progress and future challenges'*, International Review of Psychiatry, 24(1), pp. 1-4

Smith, G. (2006) *'The Casson memorial lecture 2006: telling tales — how stories and narratives co-create change'*, British Journal of Occupational Therapy, 69(7), pp. 304-311

Smith, J.A., (2007) *'Hermeneutics, human sciences and health: linking theory and practice',* International Journal of Qualitative Studies on Health and Well-being, 2, pp. 3-11

Smith, J.A. (2011) *'Evaluating the contribution of interpretative phenomenological analysis'*, Health Psychology Review, 5(1), pp. 9-27

Smith, J.A., and Osborne, M. (2008) *Interpretative phenomenological analysis*. In J.A. Smith (ed.) *Qualitative Psychology. A Practical Guide to Research Methods*. (2nd edn). Sage Publications, pp. 51-80

Smith, J.A., Flowers, P. and Larkin, M. (2009) *Interpretative Phenomenological Analysis. Theory, Method and Research*, Sage Publications

Social Exclusion Unit (2004) *Mental Health and Social Exclusion: Office of the Deputy Prime Minister Office*. London, Social Exclusion Unit

Spender, J. C. (1998) *'Pluralist epistemology and the knowledge-based theory of the firm',* Organization, 5(2), pp.233-256

Stewart L and Wheeler K (2005) *'Occupation for recovery'*, Occupational Therapy News, 13(11), pp. 24–25

Strenski, I. (2015) *Understanding Theories of Religion: An Introduction*. Wiley and Sons

Sutton, D.J., Hocking, C.S. and Smythe, L.A. (2012) *'A phenomenological study of occupational engagement in recovery from mental illness'*, Canadian Journal of Occupational Therapy, 79(3), pp. 142-150

Sweeney, K. and Kernick, D. (2002) *'Clinical evaluation:constructing a new model for post-normal medicine'*, Journal of Evaluation in Clinical Practice 8, pp. 131–138

Synovec, C. E. (2015) *'Implementing recovery model principles as part of occupational therapy in inpatient psychiatric settings'*, Occupational therapy in mental health 31(1), pp. 50-61

Taylor, J. (2015) *'Expressing care in narratives of occupation'*, The British Journal of Occupational Therapy, 78(10), pp. 606-613

Taylor, J. and Kay, S. (2015) *'The construction of identities in narratives about serious leisure occupations'*, Journal of Occupational Science, 22(3), pp.260-276, DOI: 10.1080/14427591.2013.803298

Teoh, J. Y., Venkataraman,S, Kamso, S.A. and Iwama, M.K. (2013) *Lived experiences of Malaysian adults with visual impairments: a comparative study between the Kawa model and the Canadian model of occupational performance*. Unpublished Dissertation

Tew, J., Ramon, S., Slade, M., Bird, V., Melton, J. and Le Boutillier, C. (2012) *'Social factors and recovery from mental health difficulties: a review of the evidence'*. British Journal of Social Work, 42, pp. 443–460

Teychenne, M., Ball, K. and Salmon, J. (2008) *'Physical activity and likelihood of depression in adults: a review'*, Preventive Medicine, 46, pp. 397– 411

Townsend, E. and Wilcock, A.A. (2004) *'Occupational justice and client-centred practice: a dialogue in progress',*Canadian Journal Occupational Therapy, 71(2), pp.75-87

Thapar-Bjorkert, S. and Henry, M. (2004) *'Reassessing the research relationship: location, position and power in fieldwork accounts'*, International Journal of Social Research Methodology, 7(5), pp. 363-381, DOI: 10.1080/1364557092000045294

Trevedi, P. and Wykes, T. (2002) *'From passive subjects to equal partners: qualitative review of user involvement in research'*, The British Journal of Psychiatry, 181(6), pp. 468-472

Thorley, C. (2017) *Not by Degrees: Improving student mental health in the UK's universities.* Institute for Public Policy Research https://www.ippr.org/publications/not-by-degrees

Urlic, K. and Williamson, P. (2012) *'Evidence supports the effectiveness of occupational therapy interventions in improving components of recovery for adults with serious mental illness'*, Australian Occupational Therapy Journal, 59(4), pp. 332-334

Van Lith, T., Schofield, M.J. and Fenner, P. (2013) *'Identifying the evidence-base for art-based practices and their potential benefit for mental health recovery: a critical review'*, Journal Disability and Rehabilitation 35(16), pp. 1309-1323

Van Mens-Verhulst, J. (1991) *'Perspective of power in therapeutic relationships'*, American Journal of Psychotherapy, 45(2), pp. 198-210

Volunteer Now (2011) *Making the connection 2: a further exploration of the attitudes, lifestyle and volunteering activity of the 50+ age group in Northern Ireland.* Belfast: Volunteer Now

Wada, M. (2011) *'Strengthening the Kawa model: Japanese perspectives on person, occupation, and environment'*, Canadian Journal of Occupational Therapy, 78(4), pp. 230-236

Wilcock, A.A. (1998) *' Reflections on doing, being and becoming'*, Canadian Journal of Occupational Therapy, 65(5), pp. 248 – 256

Wilcock, A.A. (2006) *An Occupational Perspective of Health*. Second Ed. New Jersey. Slack

Willig, C. (2008) *Introducing Qualitative Research in Psychology. Adventures in Theory and Method*. Maidenhead. Open University Press

Whiteford, G. and Hocking, C. (2012) *Occupational Science: Society, Inclusion, Participation.* Wiley and Blackwell Publications

Wong, S.R. and Fisher, G. (2015) *'Comparing and Using Occupation-Focused Models',* Occupational Therapy In Health Care*, 29(3),* pp 297-315, DOI: 10.3109/07380577.2015.1010130

Yardley, L. (2008) Demonstrating validity in qualitative psychology. In Smith. J. A. (ed.) *Qualitative psychology: A practical guide to methods* (2nd edn), Sage Publication, pp. 235–251

Yoshimura, N. (2006) *'A Japanese interpretation and application of the Kawa model in a context of mental health practice',* In Iwama, M.K, (ed) *The Kawa Model; Culturally Relevant Occupational Therapy*. Elsevier Churchill Livingstone, pp.184-192

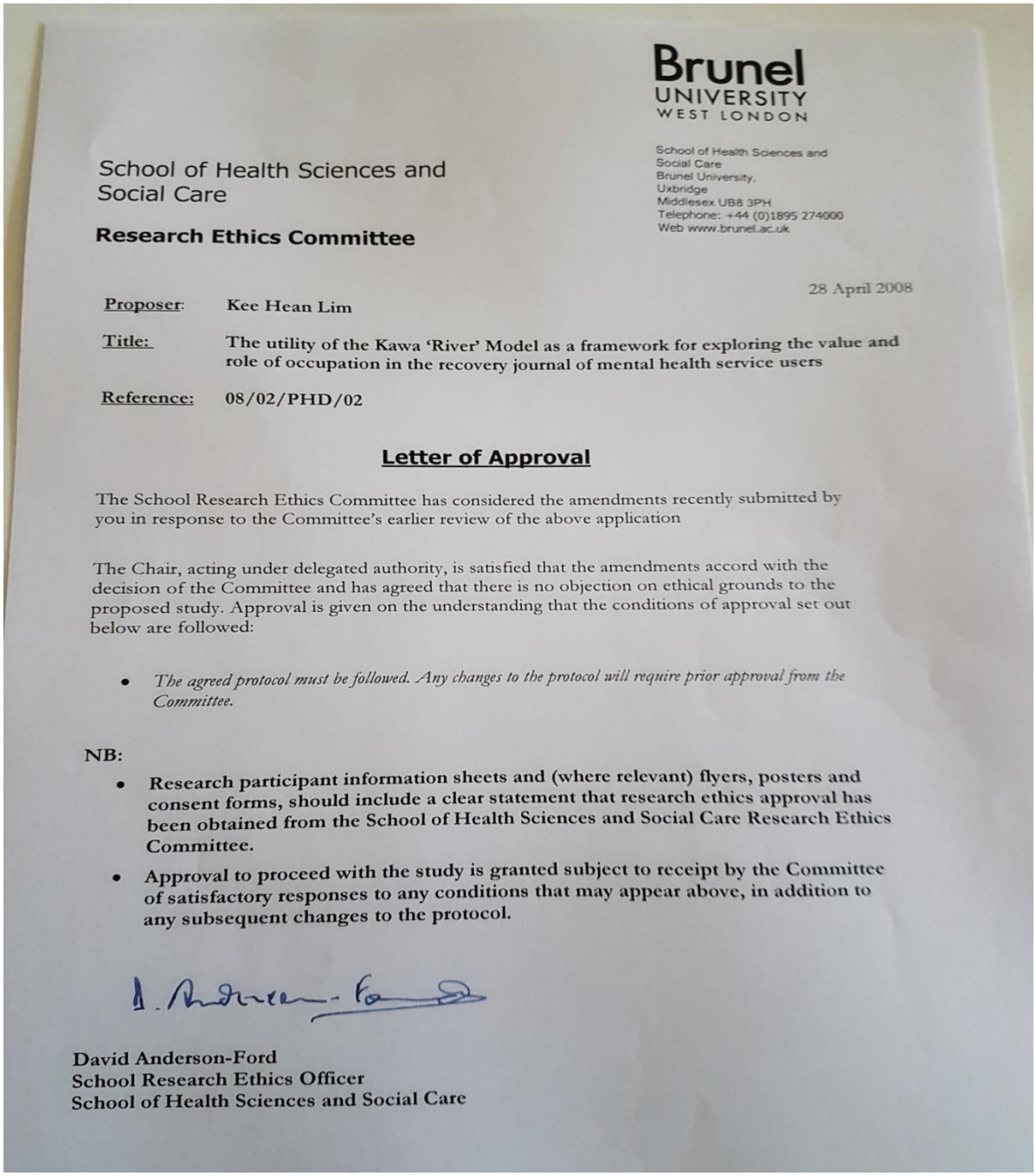
Zahavi, D. (2003) *Husserul's Phenomenology*. Stanford University Press

Zhou, D. (2009) *'A review of sandplay therapy'*, International Journal of Psychological Studies, 1(2), pp. 69-72

Appendices

Appendix 1 Approval Letters

Brunel Research Ethics Approval Letter



Brunel
UNIVERSITY
WEST LONDON

School of Health Sciences and Social Care
Brunel University,
Uxbridge
Middlesex UB8 3PH
Telephone: +44 (0)1895 274000
Web www.brunel.ac.uk

School of Health Sciences and Social Care

Research Ethics Committee

28 April 2008

Proposer: Kee Hean Lim

Title: The utility of the Kawa 'River' Model as a framework for exploring the value and role of occupation in the recovery journal of mental health service users

Reference: 08/02/PHD/02

Letter of Approval

The School Research Ethics Committee has considered the amendments recently submitted by you in response to the Committee's earlier review of the above application

The Chair, acting under delegated authority, is satisfied that the amendments accord with the decision of the Committee and has agreed that there is no objection on ethical grounds to the proposed study. Approval is given on the understanding that the conditions of approval set out below are followed:

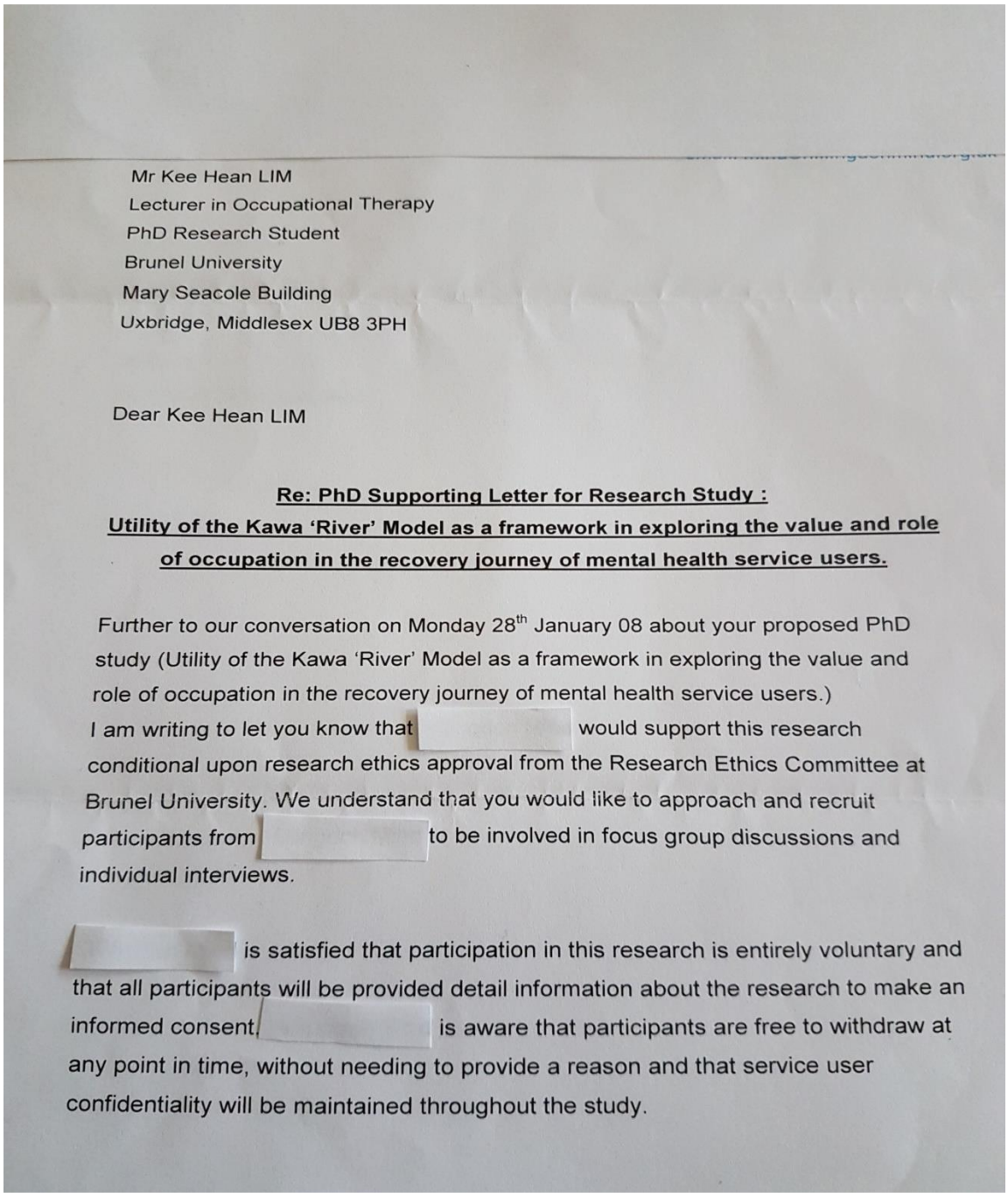
- *The agreed protocol must be followed. Any changes to the protocol will require prior approval from the Committee.*

NB:

- **Research participant information sheets and (where relevant) flyers, posters and consent forms, should include a clear statement that research ethics approval has been obtained from the School of Health Sciences and Social Care Research Ethics Committee.**
- **Approval to proceed with the study is granted subject to receipt by the Committee of satisfactory responses to any conditions that may appear above, in addition to any subsequent changes to the protocol.**

David Anderson-Ford
School Research Ethics Officer
School of Health Sciences and Social Care

Mental Health Charity Approval Letter



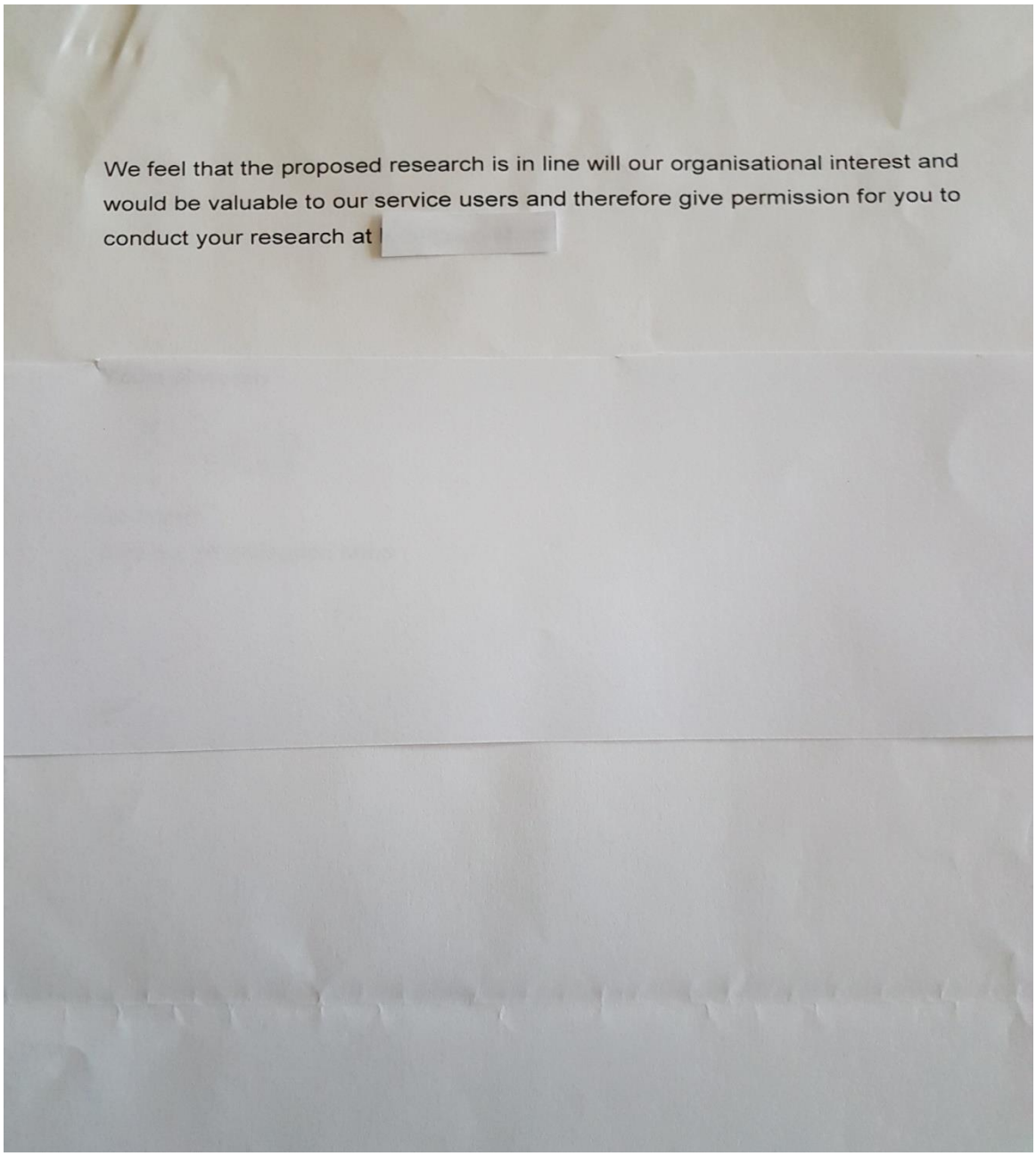
Mr Kee Hean LIM
Lecturer in Occupational Therapy
PhD Research Student
Brunel University
Mary Seacole Building
Uxbridge, Middlesex UB8 3PH

Dear Kee Hean LIM

Re: PhD Supporting Letter for Research Study :
Utility of the Kawa 'River' Model as a framework in exploring the value and role of occupation in the recovery journey of mental health service users.

Further to our conversation on Monday 28th January 08 about your proposed PhD study (Utility of the Kawa 'River' Model as a framework in exploring the value and role of occupation in the recovery journey of mental health service users.) I am writing to let you know that [redacted] would support this research conditional upon research ethics approval from the Research Ethics Committee at Brunel University. We understand that you would like to approach and recruit participants from [redacted] to be involved in focus group discussions and individual interviews.

[redacted] is satisfied that participation in this research is entirely voluntary and that all participants will be provided detail information about the research to make an informed consent. [redacted] is aware that participants are free to withdraw at any point in time, without needing to provide a reason and that service user confidentiality will be maintained throughout the study.


We feel that the proposed research is in line will our organisational interest and would be valuable to our service users and therefore give permission for you to conduct your research at

Please note that all identifiable details for the mental health charity have been concealed for confidentiality reasons and are available on request, if required.

Appendix 2 Participant Information and Consent

Brunel UNIVERSITY WEST LONDON

Research Participant Information Sheet

Dear Participant

The study: The utility of the Kawa 'River' Model as a framework for exploring the value and role of occupation in the recovery journey of mental health service users

Personal Introduction:
My name is Kee Hean Lim and I am a lecturer in occupational therapy at Brunel University and am starting my PhD research.
My research interest is in mental health and the recovery experiences of mental health service users. I have also been actively involved in researching a new model of practice in occupational therapy known as the Kawa 'River' Model and aim to explore these areas of my interest within my PhD research.
I am looking for volunteers who are interested in exploring their own journey of personal recovery.

Ethical Approval:
Research ethical approval has been granted by Brunel University for this research study. Approval has also been granted from [redacted] for this research to be conducted on its premises and with its members.

Introduction and context:
It is jointly recognised on a national policy level, by the occupational therapy profession and by service user organisations like Rethink and Mind, that supporting service users to better understand their own recovery journey and experiences is essential. This would help to ensure client-focused effective health and social care. The research explores the framework of the Kawa 'River' model to find out about the factors that may have an influence on an individuals' personal recovery. It seeks to discover whether engaging in occupations/activities have an influence on recovery.

Research process:
This research study covers a period of one year.

You are invited to take part in a year-long research project aimed at exploring your personal recovery journeys. Your personal journey will be tracked and examined within the framework of the Kawa 'River' Model, to establish what factors and experiences contribute to your individual recovery and the perceived value and role of occupation within your personal recovery. The outline of the Kawa 'River' model will be explained to you within the first interview session. As a participant you will be requested to attend five individual interviews with the

researcher lasting approximately 45mins each and at regular three-monthly intervals over the period of a year.

The interviews will be audio recorded, transcribed and analysed for personal and common themes. Although comments made within the interviews may be included in the write up of the research, no individual participant will be personally identified or named.

The research will be conducted at [redacted] with Brunel University as an alternative, dependent upon the preference and convenience to participants.
Travel expenses will be reimbursed at each interview to participants upon production of a valid travel ticket.

Your participation:
To be involved in this research, you agree to be interviewed at regular points in the year by the researcher. You will also be provided with a journal by the research and encouraged to keep a personal account of your recovery experiences throughout the year. You may refer to your journal during the interviews and more importantly it may serve as a useful reminder of your experiences within your recovery. The researcher will not have any access to your personal journal throughout the study unless permission is granted by you and it will remain as your property. Although I hope that you would be able and willing to take part in all the interviews, your participation is appreciated and valued even if you have to miss an interview through personal circumstances at the time.

The focus of the research is to assist you to think positively about your health and personal recovery, however should any discomfort arise, please be assured that you can request to have a break or to have the interview discontinued.

Participation in this study is entirely voluntary and you have the right to withdraw from the research study at any time without having to give a reason and this will not affect your status and the quality of your care and provision from [redacted].

Confidentiality and security of Data:
All data will be kept confidential and anonymous. Only the researcher and his research supervisors will have access to the data. All information will be store securely in a locked metal cabinet. No personal names or addresses will be included with the data.

Study Results.
A summary of the results will be made available to you at the end of the project.

For Further Information:

Principal Researcher
Mr Kee Hean LIM
Occupational Therapy Lecturer
Brunel University
kee.hean.lim@brunel.ac.uk
Work: 01895 268744

PhD Researcher Supervisor
Dr Frances Reynolds
Reader in Health Psychology
Brunel University
frances.reynolds@brunel.ac.uk

Brunel UNIVERSITY WEST LONDON

Research Consent Form

Study: The utility of the Kawa 'River' Model as a framework for exploring the value and role of occupation in the recovery journey of mental health service users

Consent to Participate in Research Interviews

Please complete the whole of this sheet

	Yes	**No**
I have read the participant information sheet and have had the opportunity to ask questions and have received satisfactory answers.	☐	☐
I understand that I will <u>not</u> be referred to by name in any report concerning the study.	☐	☐
I agreed to the interviews being recorded.	☐	☐
I understand that I am free to withdraw from the study:		
-at any time.	☐	☐
-without having to give a reason for withdrawing.	☐	☐
-without it affecting the service I will receive from Hillingdon Mind.	☐	☐
I understand that quotations may be used but no identifying details or names will be included in the publication of findings relating to the study.	☐	☐
I agree to take part in the Research Interviews.	☐	☐

Signature of Research Participant: _____

Name in capitals: _____

Date: _____

Appendix 3 Interview Schedule and Questions

Brunel UNIVERSITY WEST LONDON

Interview Schedule /Interview Questions (1)

1. What do you understand by the term mental health recovery?

2. What factors influence your mental health recovery and why? (Explore thoughts and feelings of participants)

3. What influence does involvement in activities that are meaningful have upon your personal recovery? (Consider feelings, thoughts, self-image and relationships)

4. What are the key factors that have an influence on your recovery at present? (Explore thoughts and feelings about these factors)

5. What are your goals for your recovery during the next 3 months? (What do they hope to achieve?)

Part of the first Interview session includes a 15 mins section centred around explaining the Kawa Model and how it can be used as a framework to represent the recovery journey of service users. Participants with the assistance of the researcher will then create a visual recovery map/sketch reflecting upon their current stage of recovery.

Introduction to the Kawa Model and creating a visual map

- Introduction to the metaphor of thinking about life and recovery as a river journey.
- Introduction to the basic conceptions within the Kawa Model.
- Provide the participant with the Kawa model template and mapping aids.
- Assisting the participant in creating a visual map of their current recovery.
- Discuss their visual map and examine how it links up with their comments within the interview process.
- Taking a digital photographic image of the map and providing the participant with a copy.

Main questions to explore engagement with the Kawa maps

Kawa Maps Question?
Can you tell me what these various elements/components are within your Kawa maps?
Why have you included these elements/components within your Kawa maps?
How are these elements/components influential to your personal recovery?
How have you felt about using the Kawa Maps?

Brunel UNIVERSITY WEST LONDON

Interview Schedule/Interview Questions (2)

1. Can you describe your current recovery 'River' journey?
(Explore thoughts & feelings of participants)

2. What factors have influenced your recovery since our last meeting?
(How have they had an influence)

3. What are the obstacles 'Rock' that have restricted your recovery?
(How have they restricted your recovery)

4. What assets can you draw upon to enhance your recovery?

5. What are the environmental factors that have influenced your recovery?
(Social, physical, home, financial, occupational factors)

6. Where is your current stage of recovery compared to your goals for it, three months ago? (Explore thoughts and feelings of participants)

7. What are the goals for your recovery during the next three months?

8. What are your views of the Kawa Model framework in assisting your understanding personal recovery?

Main questions to explore engagement with the Kawa maps

Kawa Maps Question?
Can you tell me what these various elements/components are within your Kawa maps?
Why have you included these elements/components within your Kawa maps?
How are these elements/components influential to your personal recovery?
How have you felt about using the Kawa Maps?

Brunel UNIVERSITY WEST LONDON

Interview Schedule/Interview Questions (3)

1. Can you describe your current recovery 'River' journey?
(Explore thoughts & feelings of participants)

2. What factors have influenced your recovery since our last meeting?
(How have they had an influence)

3. What are the obstacles 'Rock' that have restricted your recovery?
(How have they restricted your recovery)

4. What assets can you draw upon to enhance your recovery?

5. What are the environmental factors that have influenced your recovery?
(Social, physical, home, financial, occupational factors)

6. Where is your current stage of recovery compared to your goals for it, three months ago? (Explore thoughts and feelings of participants)

7. What are the goals for your recovery during the next three months?

8. What are your views of the Kawa Model framework in assisting your understanding personal recovery?

Main questions to explore engagement with the Kawa maps

Kawa Maps Question?
Can you tell me what these various elements/components are within your Kawa maps?
Why have you included these elements/components within your Kawa maps?
How are these elements/components influential to your personal recovery?
How have you felt about using the Kawa Maps?

Interview Schedule/ Interview Questions (4)

1. Can you describe your current recovery 'River' journey?
(Explore thoughts & feelings of participants)

2. What factors have influenced your recovery since our last meeting?
(How have they had an influence)

3. What are the obstacles 'Rock' that have restricted your recovery?
(How have they restricted your recovery)

4. What assets can you draw upon to enhance your recovery?

5. What are the environmental factors that have influenced your recovery?
(Social, physical, home, financial, occupational factors)

6. Where is your current stage of recovery compared to your goals for it, three months ago?
(Explore thoughts and feelings of participants)

7. What are the goals for your recovery during the next three months?

8. What are your views of the Kawa Model framework in assisting your understanding personal recovery?

9. What is your view about thinking of your recovery as a river journey?

Main questions to explore engagement with the Kawa maps

Kawa Maps Question?
Can you tell me what these various elements/components are within your Kawa maps?
Why have you included these elements/components within your Kawa maps?
How are these elements/components influential to your personal recovery?
How have you felt about using the Kawa Maps?

Brunel UNIVERSITY WEST LONDON

Interview Schedule/ Final Interview Questions (5)

1. Can you describe your current recovery 'River' journey?
(Explore thoughts & feelings of participants)

2. What factors have influenced your recovery since our last meeting?
(How have they had an influence)

3. What are the obstacles 'Rock' that have restricted your recovery?
(How have they restricted your recovery)

4. Reflecting back over the last year of your recovery what has it been like?

5. What has been most significant to your recovery over the last year?

6. What has it been like taking part in this research?

7. Would you be interested in being involved in future research around the Kawa model or mental health recovery?

Main questions to explore engagement with the Kawa maps

Kawa Maps Question?
Can you tell me what these various elements/components are within your Kawa maps?
Why have you included these elements/components within your Kawa maps?
How are these elements/components influential to your personal recovery?
How have you felt about using the Kawa Maps?

Sample of Interview Notes

Initial Interview Questions (Session 1)
01/A /08/08

1. What do you understand by the term mental health recovery?
Finding a resolution and not be mentally ill anymore.

2. What factors influence your personal mental health recovery and why?
(Explore thoughts and feelings of participants)
No stress and pressure. Having structured time. Having a social life with friends. Having people you can trust. Being financially secure. Overcome fear.

3. What influence does involvement in activities that are meaningful and relevant have upon your personal recovery? (Consider feelings, thoughts, self image and relationships)
Therapeutic singing and drama therapy. Voluntary work. Involvement in self help group.
Involvement inresearch group.

4. What are the key factors that have an influence on your recovery at present
(Explore thoughts and feelings about these factors; maybe also explore barriers too, here?)
Good support network of friends. Financially secure. Positive feeling and self-confidence.
Active creative life

5. What are your goals for your recovery during the next 3 months?
(What do they hope to achieve?)
Remain stress free Being present to self

Part of the first Interview session includes a 15 mins section centred around explaining the Kawa Model and how it can be used as a framework to represent the recovery journey of service users. Participants with the assistance of the researcher will then create a visual recovery map/sketch reflecting upon their current stage of recovery.

Kawa Maps Question?

Kawa Maps Question?
Can you tell me what these various elements/components are within your Kawa maps?
Why have you included these elements/components within your Kawa maps?
How are these elements/components influential to your personal recovery?
How have you felt about using the Kawa Maps?

Appendix 4 Participant Inclusion and Exclusion Criteria for Selection

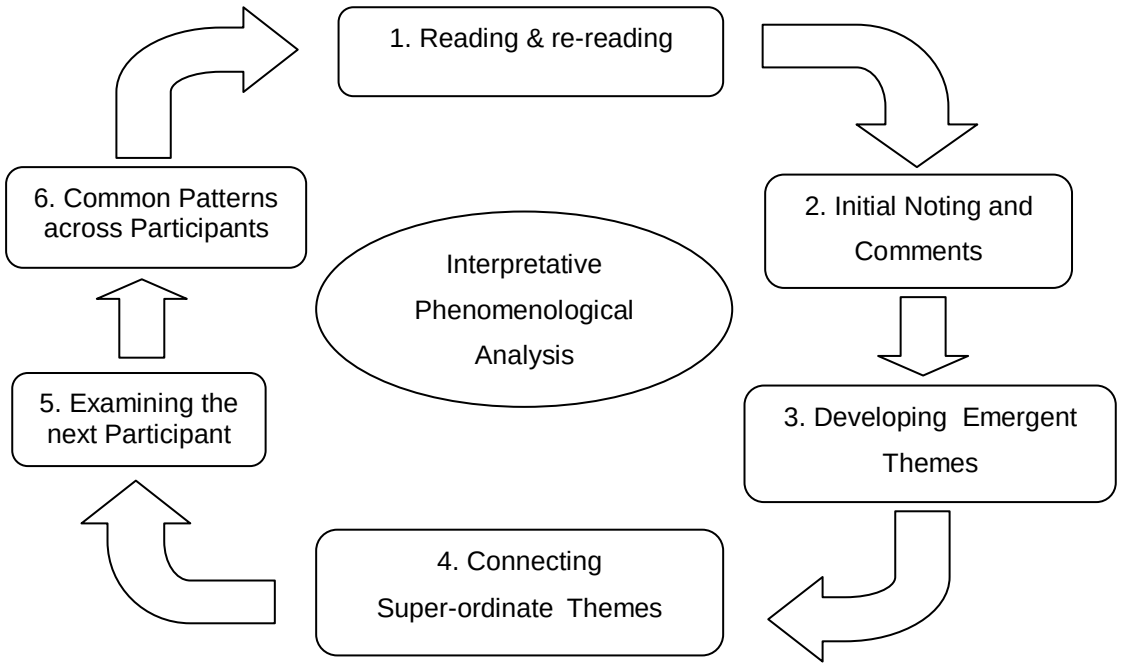
Inclusion Criteria	Exclusion Criteria
Have a history of mental health difficulties.	Participants must not be receiving acute inpatient treatment at the time of each interview.
Be member of the specific M H Charity.	Not a member of the specific M H Charity
Have the mental capacity to consent to take part in the research.	Not have the mental capacity to consent to take part in the study.
Be mentally stable at the time of recruitment and at each interview.	Participants must not be floridly psychotic or be in relapse at the point of each interview.

Appendix 5 Participants' Demographics

Pseudonym	Age	Status	Ethnicity	Diagnosis	Mental Health History
Maggi	58-67	Divorced	White Irish	Schizophrenia	35 years
Kim	48-57	Divorced	White English	Depression	34 years
Peter	48-57	Single	White English	Bipolar	30 years
Anne	48-57	Single	White Italian	Schizophrenia	28 years
Diane	58-67	Married	White English	Depression	36 years
Bert	48-57	Married	White English	Bipolar	32 years
Jill	48-57	Widowed	White English	Schizophrenia	28 years
Stewart	48-57	Single	White English	Schizophrenia	33 years

Appendix 6 IPA Analysis

The Analytical Process for the Research Study



Appendix 7 Samples of Interview Transcript with Preliminary IPA Analysis

Kim

Emerging Themes	Original Transcript K02	Comments
	INT. Could you describe your current recovery journey?	
Movement and evolving. Feeling positive and increased confidence and sense that all will be okay.	**K.** Well it is really good. I feel as if things are shifting. I am sort of going on very steadily. It is a nice easy pace and as you say in the context of a river journey very enjoyable, view is good, the future looks good, optimistic and just a very nice feeling of gentle movement. **INT.** Can you elaborate a little bit about, I know you said it is good, what things make it good? What is happening that makes it optimistic or good? **K.** For me it is relationships because they	There is movement. Sense that things are working out, gradual change. It is going well, feeling positive and confident. Nice feeling, just enjoying it, nice and good pace.

Personal relationship and intimacy has changed my attitude and view. Improved family relationships. New sense of optimism	have always, or seem to have been, in the past, one of my major problems. So family is going well, I have a one to one relationship, that is going well and I think that is a big plus in keeping the whole thing going. **INT.** I know you talked about feeling optimistic but are there any other feelings that you can identify which you feel maybe relate to how it is at the moment. **K.** If you are saying about the river model I can see that I want to stay on the journey and I am making short term plans and long term plans so my navigation is to look further into the future more than I thought I would ever dare to do. **INT.** So it has sort of given you some courage to look beyond.	How well I get on with people has always being a concern. Also new personal relationship has made a difference in how I appraise my experiences.
Feeling positive about future. Looking forward and actively planning ahead. Having an aim and focus. Adopting the River metaphor		Feeling optimistic and planning ahead. Setting targets for self to work towards. Using metaphor of the River, navigating my future.

Self –confidence and belief. Willing to take a risk.	**K.** Yes definitely. Maybe going a bit into the unknown but with courage. **INT.** So not with apprehension but being positive about it? Any other factors you think that also have contributed to how you are feeling at this moment in terms of your recovery journey? **K.** Well the holiday I have just come back from, I went with my family to Italy and then from there I was taken to the railway station and made my way to Rome. So I was in Rome for 3 days on my own with a map and finding my way around and I knew before I went that once I had done it, it would give me a great sense of achievement. I have never done anything like that before on my own and coming from a place where I know what it felt to feel absolutely impossible to get out of bed, so actually do that and come	Having confidence to venture into the unknown. Family holiday went well, good experience. Real sense of achievement and success, feeling very positive about the whole experience. Recognising and acknowledging the improvement made. Look where I have come from, not being able to get out of bed to doing this. I was not worried and people also felt it was a great achievement. Self-belief
Positive experience and encounter. New adventure and challenge Time for self. Sense of achievement & boosts to confidence and self-belief. New sense of confidence and self-belief		

Feeling supported and encouraged, people are rooting for me!!	back on my own was a great sense of achievement. A lot of people that I told what I was doing said 'Oh my goodness, I couldn't do that'. As it was coming closer my daughter said to me, 'Are you worried?' and I said 'I am not actually'. I couldn't understand why but I had a lot of people rooting for me. It was if they were on the bank of the river cheering me on. **INT.** I am assuming you planned beforehand, before you went on holiday that is what you were going to do in terms of spending some time with your family and then going on your own. **K.** Yes it was all planned.	Support and encouragement from others. Everyone wanted me to do well to get better to succeed. Feeling really supported. Not in it alone.
Importance of having dreams and achieving those dreams. Having a focus, doing something I wanted	Rome had been a dream of mine in years and it just seemed to be the time was right. I did my own planning.	It was a dream of mine and I always wanted to do it. I achieved one of my dreams.

Sense of belonging Spiritual renewal and connectedness Feeling positive.	**INT.** So how were those few days? **K.** It was incredible, I was very happy with my own company. There was no fear, I felt very at home. I really had a feeling of coming home. I don't know whether that was spiritual. I am a practising Roman Catholic so I was going there for a sort of pilgrimage. It was a spiritual adventure. **INT.** So was it intentional that it would be a pilgrimage in some ways or did it just become part of it. **K.** Yes exactly. **INT.** But you didn't originally plan to go on a pilgrimage as such? **K.** No, but I knew I wanted to go to St. Peter's and go to the Vatican that was one of the things I wanted to do but I didn't	Comfortable with self. Sense of belonging. Sense of a spiritual, emotional and physical fulfilment (Pilgrimage). Revitalised, I found myself again. Planning and achieving a personal goal. Deserving a special present, a reward.
Deserving a reward, sense of a spiritual fulfilment.		

Surprise at managing to achieve aim.	know what to expect. It was just my daughter had been and said 'Mum you will not be disappointed' but I couldn't know what to expect. So it was the most wonderful surprise, like a gift and I took as many pictures as you like. I kept pinching myself. **INT.** That is good. I know it is all positive but I was wondering whether any particular things, since I last saw you which might have been obstacles, not necessarily on holiday, but I was just wondering whether there were any obstacles in the way which might have affected your journey over the last few months? **K.** Definitely there have been some rocks. I have got two adult daughters who are married with children and I have grandchildren so I have never been a grandmother before and I did hit a great	Still not quite believing I achieved it. Challenges in the relationships with my daughter Using river metaphor to describe the experience.
Family relationships and dealing with conflicts		

Using the metaphor of the Kawa model. Being strong enough to deal with upset and disappointment. Reacting positively. Learning to cope and manage.	big rock with my eldest daughter who has twin boys who are 18 months. Her husband has to go away on business fairly regularly and she said will you come and stay and I went one day and thought she just doesn't want me here. But I had to deal with it rather than saying you don't need me, I am going to crash out the door. So I had to deal with that. I had to sit and think. I felt very uncomfortable but it has healed and it has come back better.	Learning to deal with the disappointment and maybe even rejection from daughter. Managing negative emotions

Stewart

Emerging Themes	Original Transcript S02	Comments
	INT. Thank you S for agreeing to have a second interview. I am just going to ask you a series of questions. Feel free to say as much or as little as you want. If you want to have a break let me know. I am wondering, what your recovery journey has been like since I last saw you 3 months ago.	
What matters to me might not matter to others. Subjective importance of things for each person. Sense of perspective noticed from map. The ease with sorting the electricity metre, out maybe amplifiers the bigger problems I have my mental illness, there is no quick solution. Importance of	**S.** The business about the electricity metre is done. I can see that is one of the obstacles in the last picture that I made. That was really quite a minor thing. Obviously the major obstacle is my illness continues. I have still got the environment of accommodation, my church, and mental health professionals. I	The issue with electricity metre being viewed as an obstacle. A strong word/association to use. Maybe feeling of it being external, imposed and outside of control but sense of completion. Realises worry is small when compared to other issues, yet still major concern at the time. It has been resolved, it can be resolved my mental health condition,

supportive, thoughtful and helpful people for me to keep well. (church & mental health practitioners)	suppose where accommodation is concerned, I have been under stress. Maybe this might be another obstacle but I have been under stress because I am finding a set of neighbours difficult. They are not bad, they could be a lot worse. I don't have a dispute with them but they are really rather thoughtless and inconsiderate basically.	which is on-going. It is minor, in relation to the larger scheme of things that impact upon him. Church(supportive and friendly people) contrast with new neighbours, stressful unhelpful, inconsiderate, thoughtless. My accommodation, church and mental health professionals are certainties I have which are important to my MH. Stress with neighbours, but maybe they are not that bad? They are really difficult, but actually I haven't had contact with them? Real or perceived? This can really impact upon my mental health.
	INT. In what way are they ….?	
It is not my imagination! It real, I am not making it up, to be believed. Worried about the possible impact.	**S.** I know because I was told by another neighbour that they were throwing marijuana butts out of the window. He picked up about 10 or 15 maijruana	'It is true, I am not making this up, it is not part of my illness.' Maybe sense of others doubting him before. 'It not my illness, it has

I get stress when I am uncertain of what is going to happen next. Need to feel secure and have certainity. Not knowing how it is going to turn out.	butts from the garden. He lives below them. The people in Flat 4 and they have just left a suitcase downstairs. I don't know what we can do with it. They have had a habit of leaving the front door to the block of flats on the latch all the time making it insecure. I mean it doesn't really bother me but other neighbours have been affected by the noise so I don't know how things are going to work out but that is the sort of concern that I have about my circumstances. **INT.** Does that cause you some stress? **S.** Yes, it has been	happened.' Another neighbour has had issues with them and it could become a problem for me. They are causing me worry. Feeling safe and secure is important to me, their behaviour and actions are causing me to feel unsafe. Contradiction: It doesn't really worry me and Yes it does, these things concern me.
Worries are always present. Able to identify and relate to metaphor. Again trying to get reassurance, I am not making it up,	worrying me. As far as the driftwoods are concerned, the assets and liabilities, the driftwoods and probably the picture from last time; one is medication because I still take	Continued to be worried. Using the river metaphor and relating to the Kawa concepts. Identifying with driftwoods, assets and liabilities. Medication is an

someone has interfered with the work. (Need to feel safe and secure)	medication. I have been having some difficulty in the Barge with my artwork, in that somebody damaged the beginnings of the sculpture I was doing and that was a source of stress. **INT.** So were you upset?	important part of keeping well. What has caused me real stress is actually the situation at the barge with my artwork. (Maybe neighbours are not such a real issue for me) My artwork is very important to me.
People I think who are interfering can cause me to become paranoid. (Awareness that it could be real or imagined)	**S.** I became paranoid to a degree and anxious about the situation. I was put out of gear by it. **INT.** Because you thought it was intentional or something?	Insightful someone interfering with my artwork caused me to become paranoid and affected my mental health.
Feeling unsettled by it all. Need to continue to feel safe and secure. Assured of my safety. Artwork is a real	**S.** Yes I thought maybe, although not always. There are people with behavioural problems at the Barge. There are people who have been in prison and I felt at the time may be this is part of	It can be unsafe on the Barge What is the long term situation? Has being harassed happened before? Did the people in charge

important and meaningful activity.	a long-term situation where I would be harassed by other people who use the Barge. It seems to have settled down now I suppose. I go to the Barge Mondays and Wednesdays for the time being. **INT.** Was this something that happened some time ago or fairly recently? **S.** This happened about a month ago. **INT.** So since then has anything else happened? **S.** I have had conversations with the manager about the situation. He has been quite supportive although he doesn't want to make accusations. **INT.** So although the Barge situation might be stressful or a bit uncertain in some other	do anything? Yet going to the Barge and engaging in the artwork is very important to me, I don't want not to go. Just want to feel safe Recent experience. Opportunity to voice concern and be heard Supportive people who listen are very important.
Having a voice and important to be taken seriously.		

	ways, you are enjoy going to and getting involved? **S.** Yes. I get support from L, the artist and C,	
Insight into mental state and self–awareness of what triggers illness, it is very important to understanding condition.	the Manager. I am inclined to be paranoid, it is part of my illness, so when I am under stresses like this, I have to be careful not to act on my paranoia, I have paranoia and I have to be careful not to act on it which basically means that there is some difficulty in dealing with stresses like this, you know. **INT.** Do you find, you are more able now to deal with these things?	Getting the support I need. Awareness of how I am, paranoia is part of my condition. Stress causes me to be paranoid. Statement repeated twice, reinforcing I have paranoia and I must not act on it (repeating it twice).
Difficult to accept I am getting better. More able to deal with my condition. Relating recovery and wellness to	**S.** My psychiatrist, at the last case meeting, we had a case meeting since I last saw you, we have them every six months. He said that I am more able and aware. He spoke in words similar to	Both my psychiatrist and you seem to suggest that I am more able to deal with stress now. You might be wrong. Maybe lack some self-confidence

being better able to deal with illness. Differences perspectives: What they believe and what I believe about how well I am doing. Long-term symptoms: Cost of treatment/medication: side effects.	the ones you have just spoken to me and he said that you know, I think he said you are more able to deal with this is over the last ten years; he is talking about, in the long term you are more able to deal with problems that arise than you used to be. I am not sure that I necessarily agree with him. In the long term… I have got a bit of a shake in my hand, in both hands, which means that if I want to key in a pin number sometimes my hand shakes, and it makes it difficult to do that. It is not bad so I can't do it but if I have had exercise I have to sort of calm down before I try doing that. Obviously my hands are shaking after I have had exercise. I am just saying that is not a problem that I had 10 years ago. So in that sense things are more difficult with things	that I am doing better than before. Relating physical health to mental health. Some things have got more difficult over time. I have the shakes. I don't know if I have got better over time. Example of not improving as I did not have these shakes before.

	problems like that. **INT.** So some of the physical things may be more difficult now?	
Impact of mental illness over time. Physical health and mental health are inter-related.	**S.** Yes. I am not as fit as I was 10 years ago obviously. You talk about the last few months I don't think I really changed in the matter of months. **INT.** I was just wondering whether you would have dealt with the recent incident differently if you looked back a year. **S.** The one at the Barge? **INT.** Yes, in a similar situation where things have arisen whether a year ago, would you have managed it any differently? **S.** I think I, the manager told me I couldn't be	Physical health and fitness has been affected/ deteriorated.My physical health has been affected by my mental illness. Mainly my fitness. Long term experience, things don't change much for me in the short term.

Sense of handling the situation correctly and well. Feel assured I am doing better, better able to handle the situations I am faced with. A different and more considered approach. In the past being more reactive or you could say assertive? I have dealt with it differently this time	faulted in the way I behaved about the incident. He said I couldn't be faulted, he actually said that. I might have, I mean, years ago, we are talking about the long term. I don't know whether this is relevant to your study but I remember going back, about I think it would be about 13 years I had some very difficult neighbours and I called the police in because I wanted to stop them from leaving their rubbish outside the front door because they lived opposite me. They were also quite rude, they would be verbally harassing and make comments about me. So I brought the police in. I haven't done that with these recent problems and that is a step forward. I think it would be very easy to get the police involved in a neighbour situation.	I handled the situation correctly. I did the right thing, (I couldn't be faulted) repeated twice. I did well in the situation. Important to come across as having done the right thing, more in control and less influenced by my paranoia. I am dealing with such situations better, I used to call the police, but now I can deal with it better. It would ask someone else to sort it out, now I can manage with it myself. Being able to handle and manage things yourself may reflect improvement in your mental health Even though he has not met his new neighbours he is making a judgement about what they are like.

	Mind you I think about 10 years ago I had better neighbours than I have got now. They were more respectable.	

Diane

Emerging Themes	Original Transcript D 05	Comments
	INT. So I just want to clarify, but do you feel mentally?	
Making progress. Some tangible indicators. To rediscover who I was before I became ill. Recover to old self before I became ill. Finding a new identity	**D.** Well looking back I can only say that looking back a year, I do feel much, much better. I have got more energy. I can sleep better. I am happier. I am positive. In fact I am probably myself, but I am the self that I didn't know I could be because I have been ill for so long. Can you understand what I am saying? I am somebody that I don't really recognise. Can you understand what I am saying?	Reflecting back over recovery and life you discover things about yourself and your circumstances. I feel more well, content and optimistic now. Realisation of how ill I had become: it totally affect how I saw and experienced my situation. I re-found myself, the self that was lost due to the illness. Even a new identity
	INT. Do you recall the last time you felt this way?	
Emphasised the length of time being affected by the mental illness	**D.** Oh a long, long, time ago.	I cannot even remember it was such a long time ago
	INT. A long time ago, so you have moved a long	

	way.	
Can believe the progress I have made, how far I have come. How well and improved I am now. Recovery has really evolved and improved.	**D.** It is difficult thinking how poorly I was you know. Poorly I must have been. I think it is possible, although I don't like to say it, but I was probably, the last time I felt like myself, I was probably 5 years old. **INT.** So it is really important to keep yourself well and do all things that will continue to keep yourself well?	Far too long 'I don't even want to imagine.' I can't believe how ill I have been. Something has really changed over the last year.
Looking forward to the future, feeling positive and optimistic. Planning ahead. New life and identity?	**D.** Oh yes definitely, absolutely, I mean you know, I think I kind of put the past in the past somehow, you know I have put it out of my mind. **INT.** So how important is it to be involved in doing things like the poetry and writing music and singing you highlighted	I want to move forward to focus on the future, what's ahead, not the past.

I have found myself again. Discovering self in the process of engaging in the activity. Finding pleasure and satisfaction, what I want to do, fulfilling. Self-esteem and confidence from the comments. Looking ahead to the future feeling positive. How you illness can hide and conceal all that you at good at.	**D.** They are very, very important because they are the things I really love to do which I didn't know I loved to do them, you see. I never really known myself to that extent, to understand really what I enjoyed and how creative I am because I mean I never really known the person I am, I don't think. And these help me realise who I am because this is what I really love doing, you see. Not only that I have got the capacity for doing it. I have the creativity, have the talent apparently. People do tell me I do have the talent, which I never knew before either, so that makes a big difference. These are definitely the things I will pursue in the future. I mean I am 62 years old now but I have got some life left. My sister said to me when I told her my music teacher told me that I had a beautiful voice, she said to me 'It is just a shame you never did all this	They give me real pleasure although I did not realise it this now. Being involved in activities and occupations of meaning is very important to keeping me well, sustaining my mental health. Finding my creative side and interest. Discovering a new skill, talent and identity. Real sense of pleasure and satisfaction in discovering the real self and the talents that go with it. The illness has hidden , rob me of my talent?! But there is still time to do something about it. New optimism.

	years and years ago', and I said 'I am just glad I am doing it at all', you know don't say that to me after all these years. Obviously these talents have all laid hidden in me for many years. **INT.** So do you think apart from feeling much better in yourself and feeling well, do you think there are other things that have helped you to find that creative side in you?	
Making progress, moving forward in life. Adopting the Kawa concepts.	**D.** Well I think mainly realising I am moving along you see. It is a river isn't it and moving along. I can see I am moving along. I can see now I have moved along. **INT.** Yes.	Making progress in my life and journey Using the metaphor of the Kawa model. Not static life but making progress.
Utilising the metaphor of the river. Adopting the Kawa concepts and metaphor. The	**D.** Oh this has got something to do with me making people aware, you see. That's the therapy in it isn't it? It has all got something to do with	Using the metaphor, I am moving along like the river. Making progress in recovery. The use of the maps to understand what is happening.

maps have brought a self-realisation.	making people aware of what they are doing at this point in time, that's what it is. Something like that. **INT.** So do you find it helpful to use the Kawa model? Thinking about your own recovery journey?	
Kawa process is therapeutic in itself. Mapping and creating bring insight. Kawa maps provide a snap shot.	**D.** Well I wouldn't have realised it at the time but the method of it, the movement of it, you see in the, you know, the present point in time catches up. It catches up with you eventually and you start to realise what you are doing. **INT.** Yes so it helps you may be in a visual way capture what is going on or what has happened, or gone on?	The therapeutic value of engaging in the Process of creating the Kawa maps and exploring what is happening. That it is therapeutic in itself to engage in the process of using the Kawa.
It reveals itself to you, the benefits. Revelation and reflection.	**D.** I think what you do is that you catch up with the present by seeing it in a kind of format. Do you know what I am saying? When you catch up with the present you realise you are	Developing an overview across time, what happened before and what it is like now. Present circumstances.

	in the present. That is you. **INT.** Yes. **D.** Is this an on-going thing? Is it a new thing? **INT.** Well this is part of the research I am doing, which is basically getting people to try to visualise their journey through life or their recovery as like a river journey. A way of being able to see things at a certain point in time or over a longer period. **D.** Well I can only say that there is something in it. There is something in it that makes you link with yourself eventually. This catches up with you somewhere in your head, it catches up. The past catches up. Mainly when you are very depressed or not well you are still in the past, you are living in the past. This could be it. So when I am here now but looking at the past I am linking up here and now with what happened in the	
Bring clarity and realisation. You can look back and forward. Maps the past, present, future. You discover yourself, you begin to understand how it fits together.		It wasn't clear to me then that it would help me. It is only when you get involved in it that you realise what you are doing, you start to understand and realise. Sense of all things being interconnected how our past, present and future are all interlinked. The Kawa maps and looking at them allows for reflecting on what has happened before.

	past but the past is linking up with the present. That's it something like that. You know what I am saying? **INT.** And this helps you?	
Importance of being assured	**D.** Realise it, yes. Well it would wouldn't it? Oh you must agree with that don't you? **INT.** Yes, obviously different people might find it helpful in different ways. So for you it might be helpful this way and for someone else it might be nice to just see where they have come from to where they are today. Shall we do a Kawa map for today? **D.** Oh yes please. **INT.** So to remind you again, the rocks are any kind of problems or life difficulties or challenges you currently face, the green bits are any kind of an environmental things, so external things that support	Seeking assurance, validating view. You realise what is going on and what things matter.

	you or keep you well or not and then the driftwoods are things that are either assets or liabilities.	
Occupations of meaning and value. Important to do what I enjoy More positive outlook on life. Identifying with the Kawa Model and assets and positive to support recovery. Supportive husband	**D.** Poetry. There is my singing. Well the poetry is different now it is recitals basically, it is not just poetry. It has turned out into something bigger hasn't it? So I would call that recital now, really. Recital and the singing, well I am actually kind of working on that so we'll leave that as singing, shall we? Hopefully that will be performing soon. My other assets oh I'm on the radio but that is linked in with the poetry isn't it? Other assets well my health has improved. I have a lot more friends. My husband is more supportive isn't he. He is not the problem that I thought he was so he is becoming a kind of asset. It sounds silly but you know he's much better than I thought he was so he is a kind of asset. He is isn't he	Productive and meaningful occupations, sing, reading poetry (recitals). Feeling productive and contributing. Range of assets and positives, husband, holiday, presenting on the radio. Change in perception about husband, asset rather than problem. Husband being an asset, first time she had mentioned it and how supportive he has been throughout.

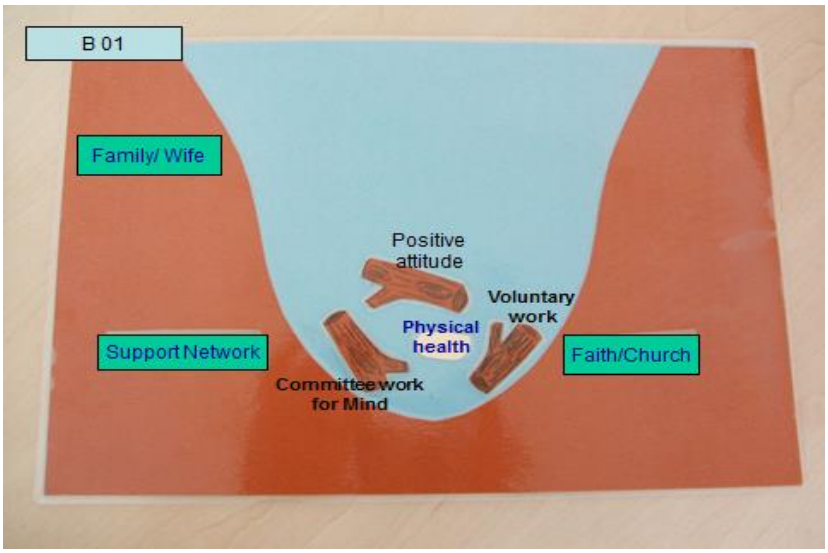
	if he is supportive? We have got a holiday flat now that we can go to each year. Escape to the sun in the winter so that is an asset for my health isn't it, holiday flat?	Holiday to look forward to.
	INT. Is this in E then? How does it influence your recovery?	
	D. Yes it is by the seaside. It is very healthy there, time for rest.	Health is important and resting
	INT. I think the last time you came back from the holiday you said how much you enjoyed it and how it was helpful, peaceful and quiet and a break from the routine.	
Enjoyment and quality of life. Time to get away, to have a break.	**D.** Yes and I found it very beneficial just to get away and relax in the sea air. Good food, peace and quiet. Not only that they have the internet over there and I can do my poetry as well. I write for the Gazette now. I am on the	Time away to relax, to get away and do the things I enjoy.

	community web site and twice a week I submit poems to the Gazette web site. **INT.** Oh and this Gazette is? **D.** Local Newspaper. **INT.** Oh I see? What do these represent?	
Self-esteem and confidence from published work and recognition from others. Engaging with the maps and deciding on what the elements represent.	**D.** That all comes under the poetry. Well I don't know. The poetry comes into the web site, the recitals, comes into a lot of things. I am writing lyrics for songs from poetry so I don't know whether I should put them separately or one great big one. **INT.** Well it is up to you?	All my interest keep me well, engaging in them. Exercising creativity Working through the Kawa maps Achievements from singing, poetry, music
Maybe not quite believing she has achieved it?	**D.** We'll put them together. I don't want to show off. **INT.** Are there any kind of environmental factors?	Understanding and interpreting the Kawa components differently. Modest about personal achievement

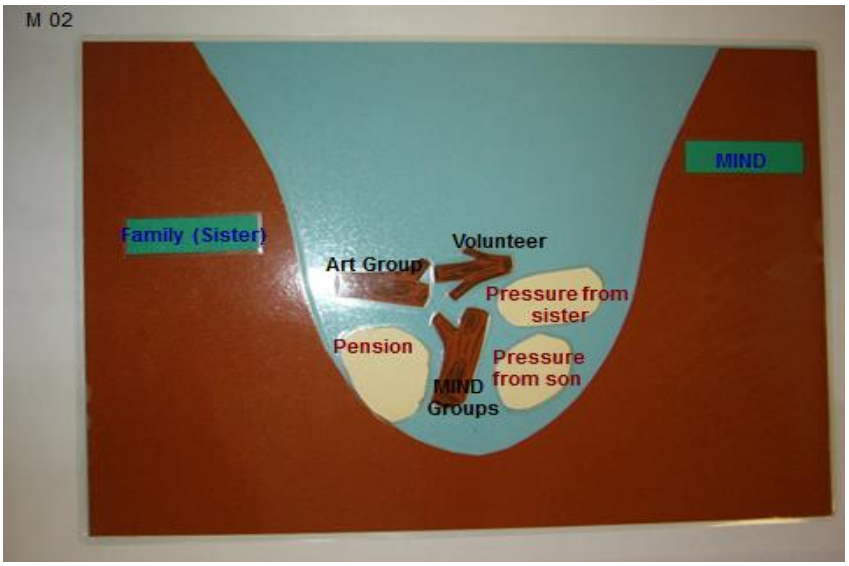
	D. As problems you mean? **INT.** That either keep you well or pose a problem. Depends on how you view them?	
More secure in self, trust and more friendships	**D.** I don't really consider social networks as an issue now. I am just getting on with things now. I've no problems with finance and no problems with family. **INT.** What does this represent? **D.** I am secure financially. That is good. **INT.** So you don't have to worry about it.	Just focusing on the good things, keeping going, things are going well.
Friendship and financial support are important too.	**D.** Oh I see nothing to worry about for finances, nothing to worry about for family. I've got lots of friends now. **INT.** Is that all right now? **D.** Yes I am done.	Financially I am fine. This has improved since I have got better, more secure in self, trust and more friendships and meeting up with others.

Appendix 8 Sample of Participant Kawa Maps

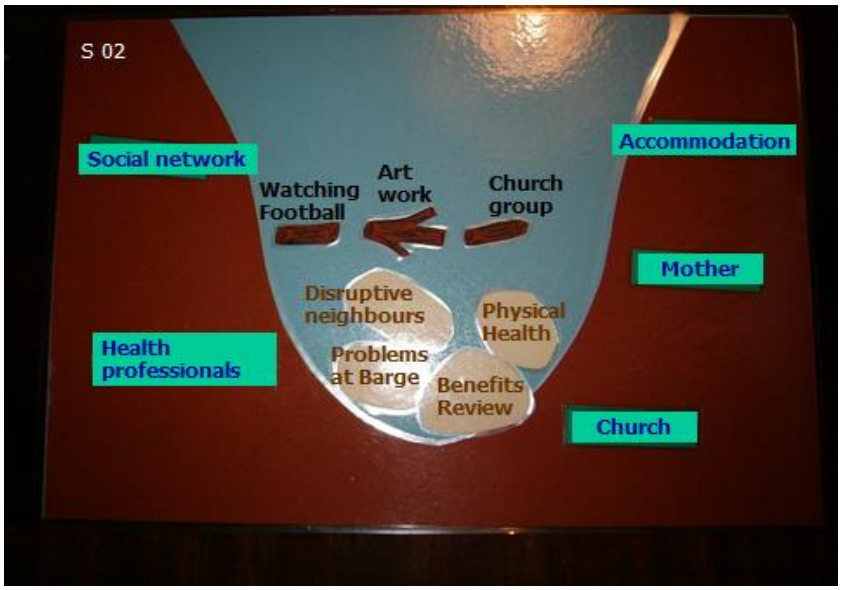
Bert's Kawa Map 1



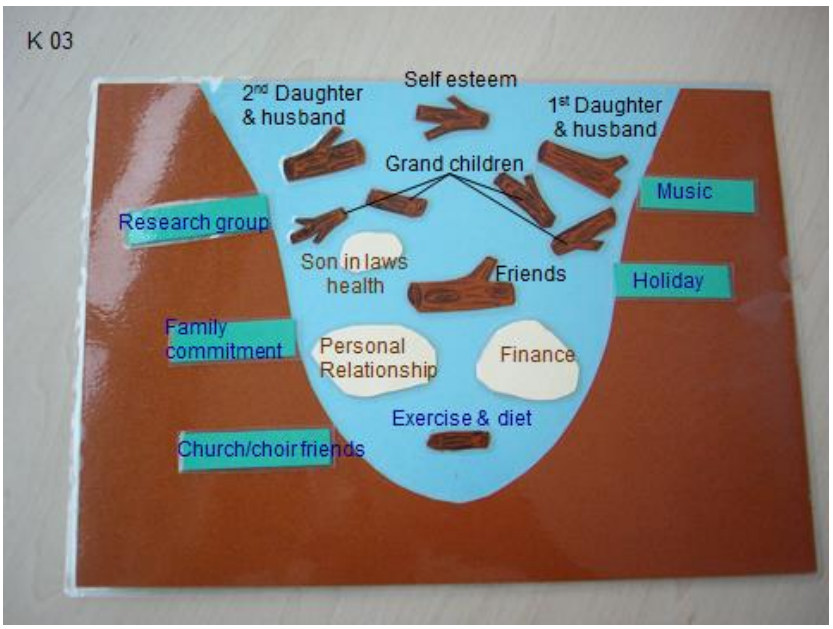
Maggi's Kawa Map 2



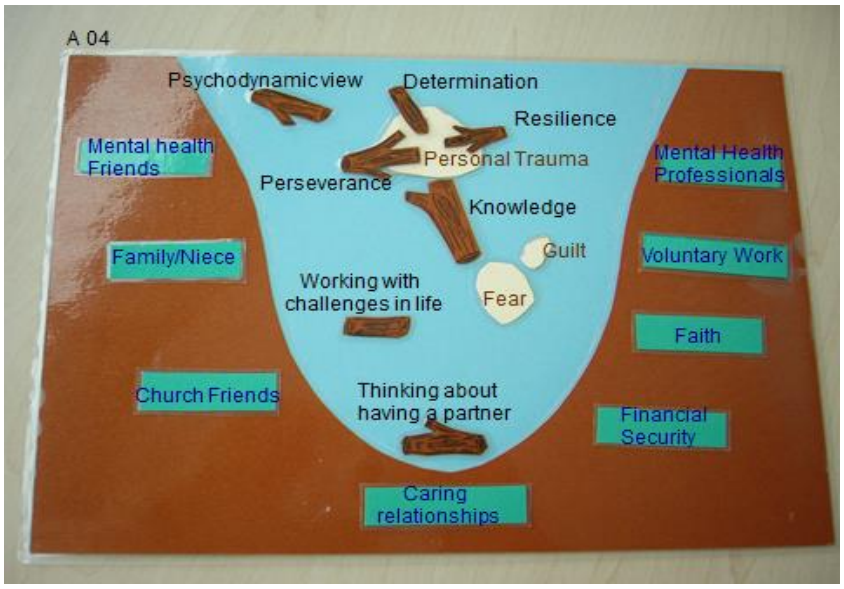
Stewart's Kawa Map 2



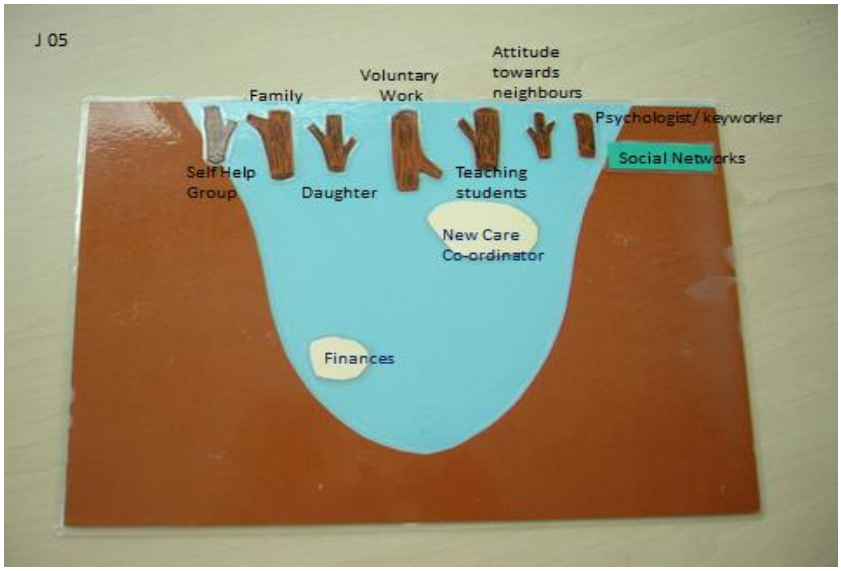
Kim's Kawa Map 3



Anne's Kawa Map 4



Jill's Kawa Map 5



Appendix 9 Individual Kawa Model Framework Index

Overview of factors within Diane's Kawa Maps

Personal Maps	Map 1	Map 2	Map 3	Map 4	Map 5
Challenges/Life difficulties/ Concerns (Rocks)					
Marriage Issues	X	X	X		
Lack of confidence	X				
Relationships	X				
Family relationships		X			
Assets or Liabilities (Driftwood)					
Singing/ singing lessons	X	X	X	X	X
Music /guitar	X				
Poetry/ writing poetry	X	X	X	X	X
Music group		X			
Being on the Radio		X			X
Involvement in Voluntary work	X	X	X	X	X
Outings	X	X			
Relating to others	X				
Husband					X
Involvement in Sports			X	X	
Improved Health					X
Friends					X
Environmental Factors (River sides & base)					
Social Networks	X	X	X	X	X
Noisy/stressful environment	X				
Family	X	X			
Holiday				X	X
Finance		X	X		

Appendix 10 Determining Salient Value

Identifying the salient value of each element/component
• Regularity of factor being represented within personal maps.
• Importance reinforced by supporting interview responses.
• Level of emotional conviction when discussing the factor.

Appendix 11 Cohort Kawa Model Framework Index

Factors highlighted by all Participants

Personal Kawa Maps	Annie	Bert	Diane	Jill	Kim	Maggi	Peter	Stewart
Challenges/Life difficulties/ Concerns (Rocks)								
Marriage Issues			X					
Lack of confidence			X					
General Relationships & Interactions			X	X	X			X
Family relationships (Partner, Siblings, Children)			X	X	X	X	X	
Concerns about brother							X	
Concerns about flatmate							X	
Running out of meaningful occupation/ activities (Walking)							X	
Coping with change				X			X	X
Change in Health Professionals				X			X	X
Mental Health Condition and Related symptoms	X					X		X
Health, Exercise and Diet		X		X	X	X		X
Benefits/ Pension/ Finances					X			X
World Events						X		
Counselling					X			
Accommodation					X			X
Seasonal pressures (Christmas)				X	X			
Poor Self-esteem/Image					X			
Concentration					X			
Stress	X			X				X
Trauma	X							
Guilt	X							

Assets (A) or Liabilities (L) (Driftwood)								
Creative Engagement/ Occupations:								
Singing/ singing lessons			A					
Music /guitar			A					
Poetry/ writing poetry			A			A		
Music & drama group		A	A					
Art/ Art Group						A		A
Watching football								A
Being on the Radio			A					
Walking							A	
Outings			A			A		
Self-esteem/ positive attitude	A	A			A			
Relating and relationships (Partner, Sibling, Children)			A	A	A		A	
Involvement in Sports			L		A			
General Health			L		A			
Friends	A		A	A	A			
Mental health support/ user involvement		A		A		A	A	
Welfare Benefits & Finances					L	L	L	
Housing							A	
Knowledge & Information	A							
Medication		A					A	A
Professional help		A		A	A		A	
Social support	A				A			A
Family				A	A			A
World Events					L			
Positive Experiences		A						A
Determination	A							
Mental Health & Insight	A	A						
Resilience and perseverance	A							
Faith		A						A
Voluntary work	A	A	A	A	A	A		

Environmental Factors (River sides & base)								
Social Networks	E	E	E	E	E	E		E
Noisy/stressful environment			E					
Family	E	E	E	E	E	E		E
Holiday			E		E			
Finance	E	E	E		E			
Supportive Relationships	E	E		E	E		E	E
Mental Health charity	E				E	E	E	
Housing					E		E	E
Freedom Pass							E	
Professional Support/ Help	E			E	E		E	E
Beliefs & Faith groups	E	E			E	E		E
Employment/ Work					E			

Appendix 12 Summary of the participants' view of the value of the Kawa Model/ Maps

	Anne	Bert	Diane	Jill	Kim	Maggi	Peter	Stewart
Strengths								
Clarity & empowerment	X	X	X	X	X	X	X	X
Reviewing changes in life and recovery	X	X	X	X	X	X	X	X
Self-discovery & personal growth	X	X	X	X	X	X	X	X
Ease with identifying with the Kawa concepts	X	X	X	X	X	X		X
Limitations								
Not remembering the components				X		X		
Jargon & Terminology							X	

Appendix 13 Themes: Criticism of the Kawa Model

Main and Sub Themes	Issues	Author	Year
Identification and Assurance with using the Kawa model			
Researcher or clinicians perspectives and confidence	Researcher level of anxiety and confidence with Kawa model concepts.	Cardomy *et al.*	2007
	Clear explanation of the Kawa model concepts and using such an unconventional model of practice.	Paxson et al	2012
	Therapist confidence in explaining, interpreting and adapting the Kawa model. Working with the unconventional nature of the Kawa model.	Owen, A.	2014
	Getting more familiar with the Kawa model and its less conventional concepts. Also explaining and adopting the Kawa model within interviews.	Humbert et al	2014
Participant or patient perspectives and confidence	Understanding and remembering the different Kawa model components. Feeling anxious about accurately representing their circumstance.	Cardomy *et al.*	2007
	Participants at times felt self-conscious about having to draw their Kawa maps and worried about the quality of the drawings.	Richardson *et al.*	2010
	Requiring more guidance when using the Kawa model and managing their anxiety.	Owen, A.	2014
	Wanting more structure and guidance in constructing their own maps.	Bai and Paxton	2015
Comfort with symbolism and metaphors	Some participants were unsure what each component piece represented.	Nelson, A.	2007

	Participants who did not feel comfortable or relate to symbolism and metaphors preferred not to use the Kawa model. Whilst those who were not visual learners found it more difficult to use the Kawa model for self-reflection.	Renton, L.	2010
	Participants who were less familiar with using more projective techniques or the use of metaphor were not as positive about using the Kawa model.	Owen, A.	2014
Structure and guidance in working with personal narrative	Exploring personal narratives from the Kawa maps created is a skill and guielines.	Renton, L.	2010
	Although it promoted the examination of personal narratives, specific guidance on how to explore the narratives were required.	Humbert et al	2014
	Not being sure of how to effectively elicit or work with the person's narrative from the Kawa maps created. Guidance needed	Bai and Paxton	2015
Lack of an occupational perspective			
Occupational perspective	The Kawa model did not focus on the occupations of the participants, but on their lived experienced.	Nelson, A.	2007
	Need for occupation focused models of practice.	Kielhofner, G.	2008 2011
	Clearer focus on occupational involvement promoting belonging. Occupation is not explicitly articulated as a component of the individuals' river.	Wada, M.	2010
	The use of the Kawa model did not focus on occupation but rather the lived experience of the individual and what was meaningful to them.	Teoh, J.	2013
	Existing Occupational therapy models place consider occupation as a discrete	Owen, A.	2014

	entity, whilst the Kawa model considers occupation as an integral part of self through which the person and the environment.		
Kawa model does not have an assessment measure	Models of practice need to support gathering of evidence and clinical effectiveness.	Kielhofner, G.	2008, 2011
	Increased focus on evidence, practitioners may select MOHO because of its significant evidence base. Second,MOHO is the first model proposed to guide occupation-focused practice in the field.	Lee et al S.W.	2012
	Kawa model has no assessment tool therefore does not measure clinical effectiveness.	Owen, A.	2014
	Model of practice benefit from assessments that evidence effectiveness.	Wong, S.R. and Fisher, G.	2015
Contextual Applicability of the Kawa model			
Contextual differences	The Kawa model is a departure from a euro-centric focus which some found more difficult to relate to (Westerners looking at the model may be concerned about where the 'self' is located in the Kawa model.	Cardomy *et al.*	2007
	Value of personal motivation, autonomy and an ego-centric focus of existing models which is not emphasised within the Kawa model.	Kielhofner, G.	2008 2011
	The Kawa model is unique because it treats a person as not being discretely located but depicts the self as both present and integrated in nature, this may make it difficult to comprehend for those situated in a western context.	Wada, M.	2010
	Participants become aware of how the wider context influenced their learning on placement.	Bai and Paxton	2015

Absence of the Inner self and personal goals	The Kawa model does not depict the 'inner self', acknowledges the interactional self exclusively. Unfortunately, those inner aspects are not depicted in the model, which therefore limits the extent to which conflicts between the inner self and the context can be addressed.	Wada, M.	2010
	The conflict between inner and collective desires are not so clearly present within the Kawa model	Wada, M.	2010
	Emphasis was not only on the individual but the wider contextual, which may have shifted focus away from the 'inner self'	Humbert et al	2013 2014
Level of insight and cognitive function	Level of insight of the participants could impact upon the usability of the Kawa model and maps, especially those with a cognitive impairment.	Ostyn	2013
	Using the Kawa model with those with impaired cognition and limited insight might post limitations.	Owen, A.	2014

Appendix 14 Royal College of Occupational Therapists Grant Confirmation Letter

UK Occupational Therapy Research Foundation
Building the evidence – creating the future

106-114 Borough High Street
London SE1 1LB
t: 020 7450 2323
f: 020 7450 2349
e: researchfoundation@cot.co.uk
w: www.cot.org.uk/researchfoundation

Mr Kee Hean Lim
Division of Occupational Therapy
Brunel University
Mary Seacole Building
Uxbridge
Middlesex
UB8 3PH

26 March 2009

Dear Mr Lim

United Kingdom Occupational Therapy Research Foundation: Research Career Development Grant

Longitudinal study exploring the value of occupation in the recovery of mental health service users within the Kawa Model framework

Thank you very much for submitting a proposal to the 2009 round of funding opportunities from the United Kingdom Occupational Therapy Research Foundation. The College was pleased with the overall response to this call for proposals, and I'm delighted to inform you that you have been awarded a 2009 Research Career Development Grant.

The reviewers noted that you have a good track record in the area of your research interest, and strong professional links in the field. Your project is methodologically sound and well-planned, although you have not made any acknowledgement of ethical issues that may arise from research with this particular group of service users. It was noted that this is a small study with a limited number of participants and the impact of the findings may therefore not be great, but it was considered that the extent of your research undertaking was appropriate at PhD level.

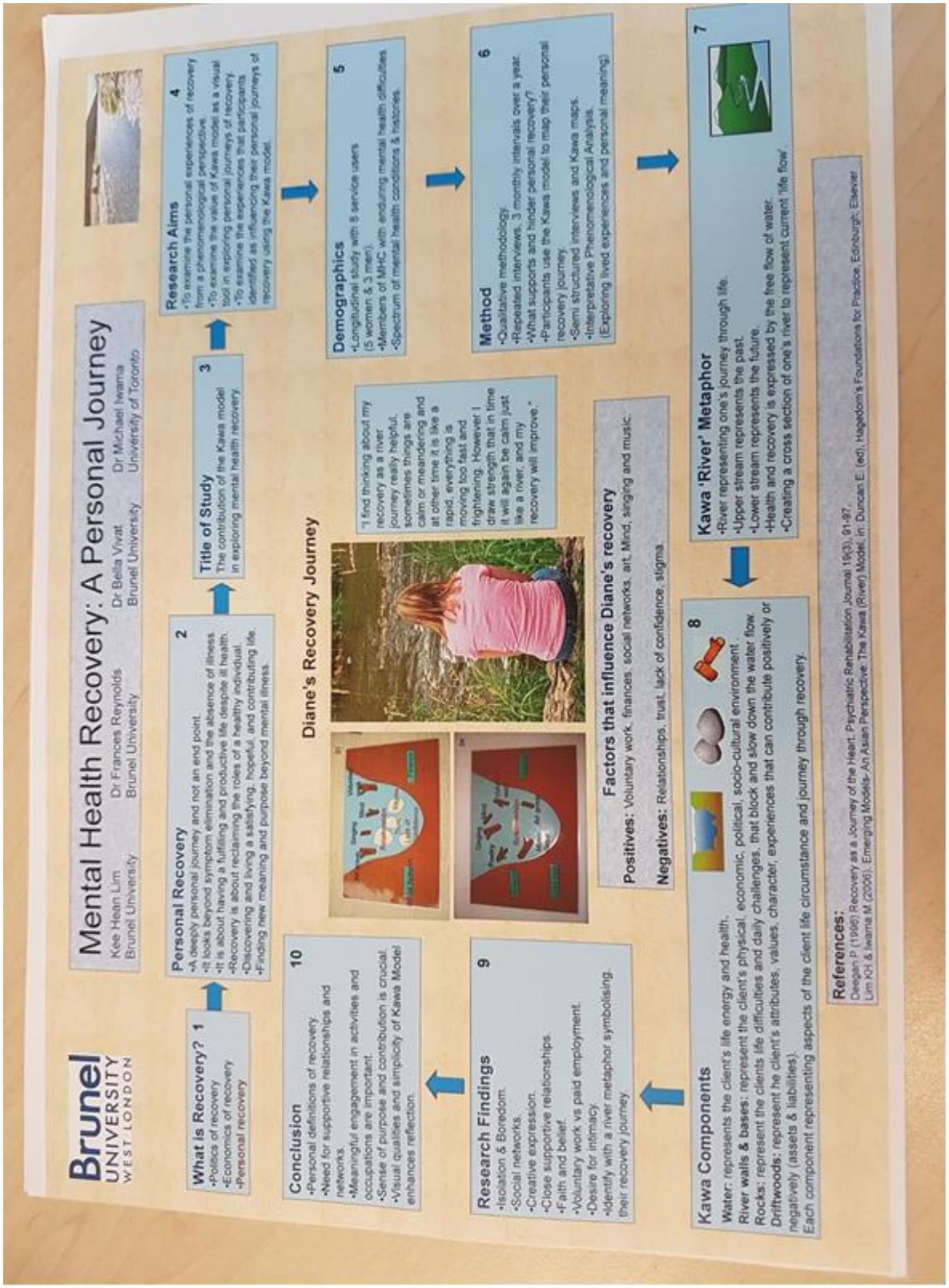
As the recipient of a 2009 UKOTRF grant, you will receive formal recognition of your success at a special UKOTRF lunch to be held on Thursday 25 June at the College's annual conference in Brighton. During the lunch, guest speakers Professor Florence Clark and Professor Gail Mountain will discuss 'Using research evidence to support occupation-focused interventions - examples from practice settings'. Further details will be provided shortly and you may wish to note this date in your diary, in the meantime.

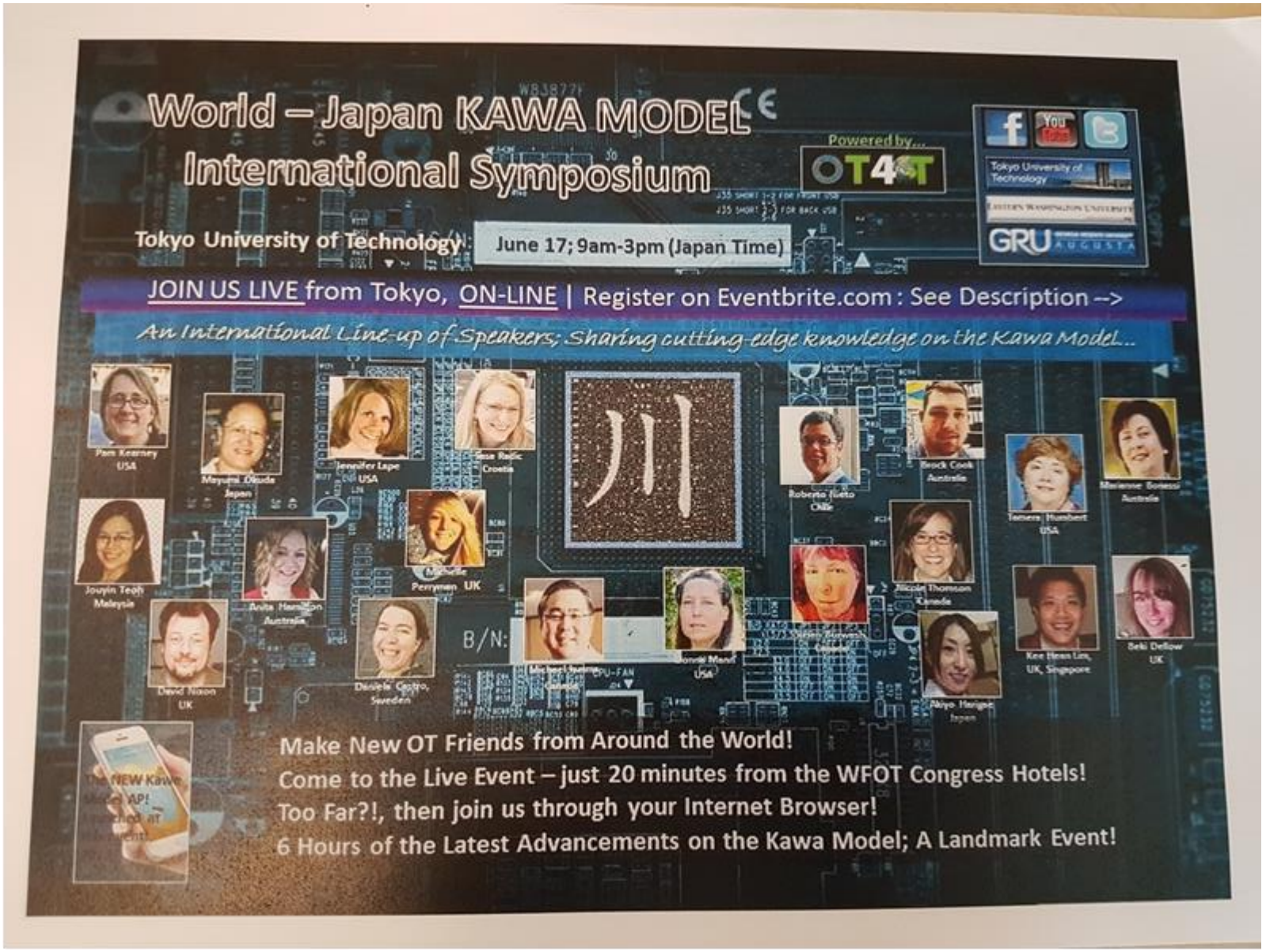
Yours sincerely

Elizabeth White

Dr Elizabeth White
Head of Research and Development

Appendix 15 Posters




World – Japan KAWA MODEL
International Symposium
Powered by...
OT4T
Tokyo University of Technology
June 17; 9am-3pm (Japan Time)
JOIN US LIVE from Tokyo, ON-LINE | Register on Eventbrite.com : See Description –>
An International Line-up of Speakers; Sharing cutting-edge knowledge on the Kawa Model...
Make New OT Friends from Around the World!
Come to the Live Event – just 20 minutes from the WFOT Congress Hotels!
Too Far?!, then join us through your Internet Browser!
6 Hours of the Latest Advancements on the Kawa Model; A Landmark Event!