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'Being normal' and self-identity: the experience of volunteering in individuals with severe mental disorders—a qualitative study

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ABSTRACT

Objective This study sought to explore the views and experiences of a group of people with severe mental disorders (SMDs) who performed volunteer services.

Design A qualitative phenomenological study.

Setting Community public mental health services of the Community of Madrid and the province of Barcelona (Spain).

Participants Purposive sampling techniques were used between September 2016 and April 2017. The inclusion criteria were: individuals aged 18–65 years who participated in volunteer activities during the performance of this study, based on the regulations of volunteer services in Spain and the community of Madrid; a diagnosis of non-organic psychotic disorder (F20.x, F21, F22, F24, F25, F28, F29, F31.x, F32.3 and F33) according to the International Classification of Diseases, 10th Revision; an evolution of ≥2 years; and a moderate to severe dysfunction of global functioning with scores ≤70 in the Global Assessment of Functioning Scale. Ultimately, 23 people with SMD participated in the study with a mean age of 47 years (SD 8.23).

Methods Data were collected through in-depth interviews and researcher field notes. A thematic analysis was performed following appropriate guidelines for qualitative research.

Results Two main themes emerged to describe the experience of participating in volunteer activities: (1) rebuilding self-identity, based on the participant's experience of volunteering, of acquiring a new role and a new perceived identity that made them feel valued and respected; and (2) being a so-called normal person with a 'normal' life, based on recovering a sense of normality, unmarked by the illness, thanks to daily responsibilities and occupations.

Conclusions Qualitative research offers insight into the way people with SMD experience volunteering and may help to improve understanding of the underlying motivations that drive these individuals. These findings may be applied to improve guidance during their process of recovery and subsequent inclusion into society.

INTRODUCTION

Currently, many health services and social programmes exist that cater towards the needs of people with severe mental disorders (SMD).[1] SMDs are characterised by three dimensions[1 2]: (A) the diagnosis of a psychotic disorder (except those that are deemed organic), (B) an evolution of the disorder equal to or of a 2-year duration and (C) a moderate to severe disorder affecting occupational, social, family and work functioning.

People with SMD often suffer high levels of stigmatisation, leading to isolation, both as an individual and in their social life.[3] For many SMD sufferers, their performance of meaningful activities is limited. This hampers their participation in the community and leads to a negative impact on their health and, ultimately, their quality of life,[4] as well as a decreased life expectancy when compared with the general population.[5] Furthermore, the appearance of the mental disorder leads to a sense of loss of identity and a decline in social roles.[6 7] As a result, people with

Strengths and limitations of this study

► The strengths of our study include the use of multiple triangulation strategies (researchers, participants, methods and collected data).

► Additionally, participant validation of the data obtained was employed to increase credibility regarding the accuracy of the findings.

► The study included 23 participants with different diagnoses. This has provided us with a much broader perspective of the volunteer experience.

► The limitations of our study include the fact that these findings cannot be extrapolated to all people with psychiatric diagnoses who participate in volunteer programmes due to the design used.

► These results may help professionals understand people who perform volunteer services and strengthen the use of community mental health service interventions as a tool to promote the recovery process for people with mental health disorders.

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SMD have difficulties leading what they consider to be a 'normal' life.[8–11]

The meta-analysis conducted by Suijkerbuijk *et al*[12] states that most people with psychotic disorders are interested in being engaged in a productive activity and participating in society. The former encompasses paid employment or volunteering.[13 14] Volunteering promotes the acquirement of meaningful roles and offers mutual benefits for volunteers and the community.[13] This is one of the main characteristics of the recovery process concerning participation in activities in community environments (normalised) outside the clinical context.[11–15] Despite these benefits, there is a limited presence of people with SMD in productive activities, such as volunteering. This is due to the low expectations placed on them and the lack of support in the access to these problems.[13] Numerous studies,[16–23] describe how people with mental disorders who perform volunteer work, refer that this has a positive effect on their mental health. According to these studies, volunteering is identified as being a meaningful, normalised occupation and as a means for developing new roles to promote their participation and inclusion in society. This, in turn, contributes towards their recovery process. Nonetheless, these studies[16–23] highlight the need to continue conducting further research in order to deepen our knowledge regarding the meaning and impact of volunteering in people with SMD.

Gaining insight into the perspective of people with mental disorders is essential in order to understand the meaning they give to healthcare and social interventions, their role in the same and how these impact their recovery process.[24 25] The recovery process is both individual and subjective, where people assign a meaning to their experience and recovery, therefore this process cannot be solely analysed using statistical criteria.[26] Prior qualitative studies[27–29] have studied the role and significance of occupation in the process of recovery of people with mental disorders, in order to describe their experience during the recovery process and their perception of their illness.

The purpose of this study was to explore the experience and perspective of a group of people with SMD who were engaged in volunteering work and to analyse how the impact of the same is perceived in both their recovery process and in their lives. Specifically, the research questions that drive this study are: what is the lived experience of people with SMD who perform volunteering? How does volunteering impact on their life and their recovery process?

METHODS

This study was conducted following the Consolidated Criteria for Reporting Qualitative Research (COREQ)[30] and the Standards for Reporting Qualitative Research (SRQR)[31] guidelines.

Design

This was a qualitative phenomenological study addressing the experiences of people with SMD who participate in volunteering programmes. In qualitative studies, phenomenology attempts to understand how individuals construct their world view; in other words, it looks through a window into other people's experiences.[24 25] Such experiences will always have meaning for the people who have lived them and, therefore, qualitative phenomenology designs use first-person narratives from participants.[24 25]

Research team

Six researchers (three men and three women) participated in this study, including four occupational therapists (JP-C, MP-d-H-T, RM-P and CS-C) and two research nurses (DP-C and PP-B). Four of these (DP-C, PP-B, JP-C and RM-P) had experience in qualitative study designs, were not involved in clinical activity and had no prior relationship with the participants taking part in the study. The remaining researchers had clinical and research experience with people with SMD (JP-C and CS-C).

Prior to the study, the positioning of the researchers (table 1) was established through two briefing sessions addressing the theoretical framework, their prior experience and their motivation for the research.[24 25]

Setting

This study took place in the community public mental health services of the Community of Madrid and the province of Barcelona (Spain). These services are managed by the following entities: Fundación El Buen Samaritano, Grupo Exter S.A., Instituto de Neuropsiquiatría y Adicciones del Parc de Salut Mar and Hermanas Hospitalarias del Sagrado Corazón de Jesús. The aim of these services is to provide structured care to people with severe and long-lasting mental disorders who present difficulties in their autonomous psychosocial functioning and their normalised social integration and to ultimately facilitate their recovery and inclusion into the community.

Participants and sampling strategies

The inclusion criteria were people: (A) aged 18–65 years, (B) participating in volunteering activities during the performance of the study, based on the regulations for volunteering activities in Spain[32] and in the Community of Madrid,[33] (C) with a diagnosis of a non-organic psychotic disorder (F20.x, F21, F22, F24, F25, F28, F29, F31.x, F32.3 and F33) according to the International Classification of Diseases, 10th Revision,[34] (D) with an evolution of ≥2 years, (E) with moderate or severe dysfunction of global functioning measured via the Global Assessment of Functioning Scale with scores ≤70,[35] (F) also, the participant had to maintain all of his or her legal rights and autonomous capacities and (G) all participants had to sign the informed consent. For the inclusion criteria, volunteering was defined as[33] the ensemble of activities of general interest developed by individuals within public or private organisations of a free and charitable nature

Table 1	The positioning of the researchers
Theoretical framework	The theoretical framework was interpretivist. From this perspective, human actions are meaningful, and the goal of interpretive inquiry is the understanding of how people interpret the meaning of this social phenomena.
Beliefs	People with severe mental disorder who exhibit functional impairment often lack a motivating life project. Volunteering can be an element that gives meaning to your life, with which you feel competent, useful and integrated in society. The acquisition of the role of volunteer can become part of their personal identity, contributing benefits to their mental health and having a positive impact on other areas of occupation.
Prior experience with volunteering	Previous work experience with people with severe mental disorders who expressed that volunteering was a rewarding activity. Interest in this phenomenon after assessing its positive effect on the recovery process and its social and community inclusion, as well as the personal interest of the researchers after carrying out an international volunteering.
Motivation for the research	To explore volunteering through participants' first-hand experience. To describe and understand their point of view to those matters they consider relevant to their lives and, thus, improve healthcare. The absence of publications in Spain on volunteering and people with severe mental disorder from a qualitative perspective, considering that it may be of interest to professionals of community mental health services.

and not prompted by a personal or legal obligation. The exclusion criteria included: (A) participants <18 years, (B) with acute psychopathological imbalance, (C) individuals with language or understanding disorders and (D) not signing the informed consent.

Purposive sampling methods based on relevance to the research question (not clinical representativeness) were used.[36] To this end, the researchers selected the individuals and sites of study as this provided them with essential insight regarding the problems of the same.[25] In this case study, the researchers included the participants who met the inclusion criteria. No other criteria were considered (such as length of voluntary activity and so on). Sampling and data collection were pursued until the researchers achieved information redundancy, at which point no new information emerged from the data analysis.[24 25] In our

study, this was achieved after the inclusion of 23 participants. There were no dropouts.

For the recruitment process, researchers were introduced to participants through the manager or professional of each community public mental health service that was included in the study.

Data collection

Data were collected over an 8-month period between September 2016 and April 2017. The first stage of data collection consisted of unstructured interviews, using the following open questions: what type of volunteering do you do? What is the experience of volunteering like for you? The second stage consisted of semistructured interviews based on a question guide (table 2), in order to obtain information regarding specific topics of

Table 2	Semi-structured interview guide
Research areas	**Questions**
The volunteer process	What are your motivations for volunteering? What does volunteering do for you? What do you contribute to volunteering?
Quality of life and time management	How does volunteering influence your daily life? How does volunteering influence your health?
Recovery process	What is the relationship between volunteering and your illness? How does one influence the other?
Personal identity	Has the performance of volunteering changed the image or the concept you have of yourself or of who you are? How? Have you ever felt different from other people because of mental illness? How does volunteering influence this?
Responsibility, obligation and commitment	Do you experience volunteering as a responsibility, an obligation and/or a commitment? How is this for you?
Social and interpersonal relationships	How is your relationship with those who receive the volunteer services? (If there are any) How is your relationship with other volunteers? What is most relevant to you? How has volunteering influenced your relationship with others: with your family, friends, partner, neighbours, people with whom you participate in other activities?
Role of professionals and the organisation	What is the role of health professionals in your volunteer work and/or what have health professionals done to support your volunteer work?

interest.[24 25] The question guide was developed based on accounts obtained from the participants.

The interviews were tape-recorded and transcribed verbatim (by JP-C, RM-P, CS-C and PP-B). A total of 23 interviews were undertaken (one per participant). Overall, 1459 min of interviews were recorded, with 729 min corresponding to the first stage and 730 min to the second stage. All the interviews were held at the community mental health services, according to the participants' preferences. Twenty-three researcher field notes were also collected. Besides the participants, no one else was present during data collection.

Data analysis

A full verbatim transcription was performed for each of the interviews and researcher field notes. The texts were collated to allow for qualitative analysis.[24 25] The field notes were used in the analysis as they provided a greater perspective and added depth to the data. The notes were used for the analysis in several ways: (A) to describe the meaning of expressions and/or terms used by participants and their non-verbal responses (gestures) when faced with questions or in their own narratives; (B) to complete and/or verify the data obtained in the interviews (triangulation); and (C) as reminders of key aspects to consider during the analysis process, such as the identification of possible relationships and/or aspects that are repeated among the interviews. The initial analysis was carried out by the same researchers who were in contact with the participants. An inductive thematic analysis was performed,[24 25] and the process began with the most descriptive content in order to obtain the meaningful units, and then went into further depth and reduction to produce thematic code groups, that is, by grouping meaningful units referring to the same point or content until the main topics emerged. Thus, the level of abstraction and complexity of the analysis increased from meaningful units to thematic code groups and, finally, themes.[24 25] The final outcome was the identification of themes that represented the participants' experiences of volunteering. As this was an inductive thematic analysis, a coding framework was not developed and applied. The themes were obtained based on the participants' narratives, via a process of coding and analysis. Three researchers (JP-C, DP-C and RM-P) performed the analysis of the qualitative data. Each interview was analysed separately, without comparing the same. Subsequently, each researcher listed the emerging themes and negotiated confluent and diverging issues. Finally, in the event of differences of opinion, theme identification was decided by consensus. No qualitative software was used on the data.

Rigour

The COREQ and SRQR guidelines[30 31] were followed. Furthermore, we used criteria by Guba and Lincoln (table 3) for establishing the trustworthiness of the data by reviewing issues concerning data credibility, transferability, dependability and confirmability.[24 37]

Ethics and dissemination

We obtained permission from Grupo Exter S.A., Fundación El Buen Samaritano, Instituto de Neuropsiquiatría y Adicciones del Parc de Salut Mar and Hermanas Hospitalarias del Sagrado Corazón de Jesús. Informed consent and permission to record the interviews was obtained in all cases.

Patient and public involvement

First, researchers informed all the participants of the study design prior to them agreeing to participate. The study

Table 3	Trustworthiness criteria
Criteria	**Techniques performed and application procedures**
Credibility	Investigator triangulation: each interview was analysed by three researchers. Thereafter, team meetings were performed in which the analyses were compared and categories were identified.
	Participant triangulation: the study included participants belonging to different diagnosis. Thus, multiple perspectives were obtained with a common link (the experience of volunteering).
	Triangulation of methods of data collection: non-structured interviews, semistructured interviews were conducted and researcher field notes were kept.
	Participant validation: this consisted of asking the participants to confirm the data obtained during the stages of data collection and analysis. All participants were offered the opportunity to review the audio or written records as well as the subsequent analysis to confirm the interpretation of their experience by the researchers. None of the participants made additional comments.
Transferability	In-depth descriptions of the study performed, providing details of the characteristics of researchers, participants, contexts, sampling strategies and the data collection and analysis procedures.
Dependability	Audit by an external researcher: an external researcher assessed the study research protocol, focusing on aspects concerning the methods applied and study design. Also, an external researcher specifically checked the description of the coding tree, the major themes, patients' quotations, quotations' identification and the descriptions of themes
Confirmability	Investigator triangulation, participant triangulation and data collection triangulation.
	Researcher reflexivity was encouraged via the performance of reflexive reports and by describing the rationale behind the study.

design was pre-established, and the participants were unable to modify the same. Second, participants involved in the study helped researchers identify the research questions in order to create a semistructured question guide. The questions of the semistructured interviews were based on unstructured previous interviews where the participants were able to describe their experience and perspective without limitations and to develop their own relevant content. Also, participants were involved in confirming the data obtained at the various stages of data collection and analysis. All participants were offered the opportunity to review the audio or written records, as well as the subsequent analysis to confirm the interpretation of their experience by the researchers. All participants were given on audio copy of the interview; however, none of the participants made additional comments. To verify the analysis performed for each interview, half of the participants were contacted, all of which confirmed the analysis performed by the researchers. The results of this study will be disseminated to participants via email by providing participants with the open access link for the study. Besides, the authors will also disseminate the results of the study via conference presentations with those entities that collaborated in the study and national and international congress.

RESULTS

Twenty-three users of mental health services (16 men and 7 women) diagnosed with an SMD, with a mean evolution of 17.91 years (SD 9.21) and a mean age of 47 years (SD 8.23) were included in the study. The mean time that they had been performing volunteer services was 3.89 years (SD 1.62). Their clinical and demographic features are shown in table 4.

Two specific themes emerged from the material analysed: (A) rebuilding self-identity, with three subthemes: acquiring roles that form a part of 'who I am', changing the perception of 'who I am' and feeling valued, appreciated and respected; and (B) being a 'normal person' with a 'normal life', with three subthemes: being a 'normal' person; acquiring responsibility and commitment; and having a 'normal' life. We reported some of the participants' narratives taken directly from the interviews regarding the two emerging themes.

Theme: rebuilding self-identity

The participants described how performing the volunteer work made them acquire a new role, that of a volunteer, which becomes a part of who they are and their identity, changing their self-perception and perceptions concerning how they are and how they feel regarding others.

Subtheme: acquiring roles that form a part of 'who I am'

Besides participating in the volunteering experience, the participants 'felt like volunteers', identifying with this as a new role, both within as well as beyond, the volunteer experience. Furthermore, the participants described how this

Table 4	Demographic and clinical features of the participants included
Participants	23 participants (16 men, 7 women).
Age, years	Mean: 47 years (SD 8.23).
Work/social situation	21 participants: absolute permanent disability for all jobs.
	2 participants: total permanent disability for your usual profession.
Duration of volunteering	Mean: 3.89 years (SD 1.62).
Periodicity	17 participants: 1 day a week.
	4 participants: 2 days a week.
	1 participant: 3 days a week.
	1 participant: 5 days a week.
Type of volunteering	7 participants: support for people with severe mental disorder in different activities (one guitar teacher, two social activities, one artistic activities, one aerobic teacher, one urban garden and one flamenco teacher).
	5 participants: animal volunteer.
	4 participants: care for elderly.
	2 participants: library assistant.
	2 participants: chess teacher with children at social risk.
	2 participants: soccer coach with children with intellectual disabilities.
	1 participant: food delivery to families at social risk.
Diagnosis	11 participants: F20.0: paranoid schizophrenia.
	3 participants: F31: bipolar disorder.
	2 participants: F20.5: residual schizophrenia.
	2 participants: F25: schizoaffective disorder.
	2 participants: F20.9: unspecified schizophrenia.
	1 participant: F20.6: simple schizophrenia.
	1 participant: F33: recurrent depressive disorder.
	1 participant: F28: other psychotic disorder.
Years since the diagnosis	Mean: 17.91 years (SD 9.21).

new role as a volunteer overrides their role as someone with an illness, which is what they identified with previously and, therefore, is like a new beginning: '*I go with my volunteer experience and I say "I am a volunteer (…) you are no longer ill"*' (participant 6, 54 years old). '*It seems as if you are no longer burdened with the illness, it seems like you are no longer ill. It is very gratifying because you completely forget that you are ill, and you feel like a different person (…) It makes you feel like a person in an important position*' (participant 11, 54 years old).

Within this new role as a volunteer, the participants performed different functions as a teacher or instructor, which reaffirmed their feelings about volunteering and helped them to identify with this new role: '*The fact they call you a teacher is amazing (…) I think it is the nicest thing that I have been told in my life, even though it is volunteering, it cures you, it cures you*' (participant 4, 43 years old). '*You are happy to know that a child aged 9 or 10 years old calls you a*

teacher or mentor (…) It is very fulfilling, being called a teacher, the fact that I am a chess teacher fills me with satisfaction' (participant 8, 44 years old).

Some participants spoke of the significance of being able to introduce themselves to other people based on their newly acquired role. Being a volunteer, a teacher or a monitor means overriding the role of a sick person as a way of introducing themselves to other people, *'You don't have to say "I am a paranoid schizophrenic", instead you can say "I am a volunteer at an NGO" (…) you have a different option, that is socially well perceived, so for me this is very important, I feel very fortunate, and lucky, I can give to others without having to say I am a schizophrenic and that is very important'* (participant 6, 54 years old).

Subtheme: changing my perception of who I am
This new role led to a change in the perception of oneself as a person, impacting on the sense of usefulness, personal worth and the ability to believe in one's own personal capacities: *'I feel better with myself. It helps to value myself as a person, the illness makes you think that you are worth nothing. It makes you demonstrate your worth to other people, to people, towards the world'* (participant 11, 54 years old). *'I have realised that I have a good heart (…) From having a completely negative life I have gone to realising, all of a sudden, that I am a totally positive person who helps many people… this is reassuring, you feel good. It gives you so much'* (participant 20, 37 years old).

Subtheme: feeling valued, appreciated and respected
The participants described how being a volunteer makes them feel more valued and appreciated by people in their environment and more respected for the work they do on a daily basis: *'They have trusted me more and more and now I lead the guitar group and workshop, I am the one who makes the decisions. You can really tell that here the people really appreciate me and when there is anything to do, they always call me (…) if they appreciate you so much it is because, ultimately, you are doing it right'* (participant 3, 43 years old). *'The instructors treat you like a person, not as an ill person'* (participant 16, 47 years old).

Theme 2: being a 'normal person' with a 'normal life'
The participants described feeling once again like a 'normal' person, unmarked by the illness, with their daily responsibilities and occupations, framed within a normal life.

Subtheme: being a 'normal' person
Most participants described how, during the process of the illness, they stopped feeling like a person and, after the volunteering, once more they felt like a 'normal' person: *'Above all, [it makes me feel] like a person because, in the end, you think about it and you don't even believe in yourself, you are afraid of everything, and so, feeling busy, feeling active, makes me feel like a person (…) you start building up from the inside, because, somehow, you don't even feel like a person (…) Seeing that I can do things on my own, believe in myself, is, well, like feeling like a person'* (participant 2, 52 years old). *'Feeling better is having more independence, feeling, like a*

"normal" person (…) it is very easy for them to say "you're ill" and to stay at home. No, you have to try to lead a normal life. If volunteering helps you to be more, 'normal', then, all the better' (participant 19, 39 years old).

Subtheme: acquiring responsibility and commitment
For most participants, feeling like a 'normal' person implies acquiring responsibilities in their daily life and establishing a commitment. The participants described how this commitment and the related responsibilities motivated them to get up in the mornings, bathe and groom themselves, get dressed, use public transport, relate with other people and, ultimately, have a satisfactory daily routine: *'Providing your commitment is like being active, not having a job, it is unpaid but it makes you feel like a person and you assume responsibility. Getting up early, taking responsibility for going and committing to the elderly so that they can feel good, or give them a pleasant time, it makes me feel active (…) When you commit to something, when you really try to be in the present, caring for the elderly the best you can, it makes you feel like a person'* (participant 2, 52 years old)'. *'An obligation, a commitment, knowing that you have to get up at a certain time, it's like a job, in other words, it gives you stability, commitment, an obligation… a sense of normality, as if you work'* (participant 9, 51 years old).

Subtheme: having a 'normal' life
Most participants acknowledged that, via commitment and by incorporating daily activities into their volunteering experience, they felt that they were leading a 'normal' life, one that all people experience, thanks to the performance of daily activities and routines, such as grooming and toileting themselves and getting out of the house: *'then you get up early, you get washed,… often you have neglected your hygiene, you are eager for everything, getting up early, cleaning up, going out, striking up conversations, putting your mind where it belongs (…) being busy means turning the illness around, you know?'* (participant 2, 52 years old). *'For me, leading a normal life means having a routine, having a routine of getting up and working for four hours or whatever I can. For me, leading a normal life means doing what most people do'* (participant 14, 40 years old).

DISCUSSION
Our results display how the participants perceive the experience of volunteering, thanks to the performance of meaningful occupations. These experiences had a positive effect on the reconstruction of their identity, of feeling 'normal' and of leading a 'normal' life.

In mental health, recovery is understood as a process of personal growth that involves hope, a sense of personal identity, leading a life of meaning and assuming responsibilities.[38] The loss of identity and social roles is observed from the very first psychotic episodes.[26] The search for meaning within the recovery process is related to the performance of recreational activities, work or volunteer duties and the ability to connect with other people during

these activities,[39] in a community context (normalised contexts) and outside the clinical context.[11] The identity of people with SMD is affected by the psychiatric diagnosis and the evolution of the disorder, in part, due to the loss of social roles[7 28 40] and also because the patients acquire the role of an ill person.[10 40 41] As a result, people with mental disorders feel that the possibility of fulfilling a 'normal life' is remote. Previous studies[6 42 43] recommend community interventions targeted at maintaining a positive identity,[6] which is related to decreasing the negative effects associated with self-stigma, such as low self-esteem, a lack of hope, lower compliance to treatment and a decrease in the quality of life.[42] Within the recommended interventions,[6 42 43] the development of meaningful occupations provides new opportunities for constructing alternative identities to that of the illness.[16 40 44] Identities that are linked to work contexts have shown to facilitate the acquirement of a new self-concept that is different to the disorder, integrating the same into their personal and social identity.[45]

Our findings support previous studies,[16 18–21] where the performance of volunteering, via the engagement in meaningful occupations, contributes to the construction and maintenance of a new personal or occupational identity. This does not mean that there are no obstacles during the volunteer process. In this sense, adverse effects have been identified in people with mental disorders who perform volunteering work. These include feelings of vulnerability, stress, stigma or discrimination on behalf of other volunteering colleagues.[17 22] Regarding 'normality', previous studies[8–11] have described how, for a person with a mental disorder there is the quality of life factor that decreases the perceived stigma, namely feeling like a 'normal' person, and doing 'normalised activities', such as self-care or participating in society.[3] Furthermore, people with mental disorders express difficulties for perceiving themselves (and being perceived by other people) as being 'normal'.[8–11] It would therefore be advantageous to develop educational and vocational activities in normalised environments in order to provide these individuals with social contacts and help them to structure their daily life.[10 11 46] It is striking how the participants in this study displayed a motivation to help others through volunteering, in a search for their own recovery and embrace a sense of 'normality'. Different studies[20 23] display how helping others provides them with the necessary 'sense of normality' to be accepted by other people and find a place in society.[45]

The strengths of our study include the use of multiple triangulation strategies and participant validation to ensure confidence in the validity of the findings. Additionally, the inclusion of 23 participants with different diagnoses has allowed us to have a far broader perspective of the volunteer experience. Limitations of our study include the fact that these results cannot be extrapolated to all people with psychiatric diagnoses who participated in a volunteer programme. However, these results may help professionals understand volunteers and strengthen

this intervention in the community mental health services as a tool to promote recovery processes. Further research is necessary with regards the experiences of people with SMDs who participate in volunteer programmes in order to understand the impact that volunteering has on their daily care management. Studies in this field would also be valuable in order to explore the impact of the paths of recovery on people with SMD, the experience of performing other meaningful occupations in their life and the process of empowerment and community inclusion. Considering future lines of research, we feel that studies on the impact of volunteering with animals or 'peer support' interventions may be of considerable interest.

In conclusion, our results provide insight regarding how volunteering is experienced and may be helpful during recovery processes and thereafter as a way to support inclusion into the community. Our study provides a basis to guide further studies, addressing the impact of volunteer activity on the lives of people with SMD, as well as on their recovery.

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