

“An Ongoing Struggle With the Self and Illness”: A Meta-Synthesis of the Studies of the Lived Experience of Severe Mental Illness

Charis P. Kaite^{*}, Maria Karanikola, Anastasios Merkouris, Elizabeth D.E. Papathanassoglou

Cyprus University of Technology Department of Nursing, School of Health Sciences, Vragadinou, 3041-Limassol, Cyprus

ABSTRACT

The diverse experiences of severely mentally ill persons, most of the times, have not been taken into account, or integrated to the treatment procedures. This meta-synthesis aimed to examine what is like to live with severe mental illness narratives by employing a meta-ethnographic synthesis of seventeen published peer reviewed qualitative studies. Third order analysis revealed as core theme “An ongoing struggle for reconciliation with the self and the illness”. Other themes included amongst others: loss of identity, pain of having had one's life stolen, being an outcast. The identification of the importance of the alterations of self-identity throughout the continuum of the severe mental disorder may be the focus of targeted psychosocial interventions.

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BACKGROUND

Despite the plethora of available treatment options for the management of severe mental illness (SMI), many are still in some point weakly associated with the lived experience of mentally ill people (Kent, 2003; Million, 2004; Thompson, 2007). Moreover, the treatment methods of mental disorders have not been developed in accordance to the special needs and wishes of mentally ill individuals (Barker & Buchanan-Barker, 2011; Jacobson, 2001; Warne & McAndrew, 2010). Thus, issues linked to quality of life and adherences to therapy are very often raised (Corring & Cook, 2007; Fleck, Keck, Corey, & Strakowski, 2005; Gale, Baldwin, Staples, Montague, & Waldram, 2012; Gee, Pearce, & Jackson, 2003; Haddad, Brain, & Scott, 2014; Manwani et al., 2007; Piat et al., 2009).

In relation to the lived experience of a situation, although many would argue that only an objective reality exists, according to Rogers (1959), what shapes a person's behavior is not necessarily what is true, but “what the individuals thinks is true” (Nestoros & Vallianatou, 1996, p. 280). As a result, the person tries to perceive and conceptualize oneself in accordance with his/her perception of reality (Rogers, 1959). Under this scope, the way a person behaves in health and in illness issues, may also be influenced by his/her perception of the reality (Beck, 1991). Thus, the way one may react in relation to the therapy may be relevant to the way he/she interprets his/her illness and the treatment methods implemented (Beck, 1991).

Taking the above into consideration, one may assume that there are various contexts of reference in which to understand an individual's lived experience of mental illness and its treatment. Indeed, previous literature focuses on specific aspects of mental disorder experience and from diverse backgrounds (Baker, Procter, & Gibbons, 2009; Green, Hayes, Dickinson, Whittaker, & Gilheany, 2003; Mauritz & van Meijel, 2009). In particular, a number of studies look at the lived experience of involuntary hospitalizations during the acute phase of the disease (Williams, 2008; Wood & Pistrang, 2008). In contrast, a vast amount of literature explores solely the lived experience of the recovery process (Aston & Coffey, 2012; Dilks, Takser, & Wren, 2010; Jensen & Wadkins, 2007; Turton et al., 2011), or the coping mechanisms used to combat mental illness (Green, Hayes, Dickinson, Whittaker, & Gilheany, 2002; Webb, Charbonneau, McCann, & Gayle, 2011; Yangarber-Hicks, 2004), whilst others investigate the ambivalent relationship between medication and quality of life (Gale et al., 2012; Piat et al., 2009; Sajatovic & Jenkins, 2007). Furthermore, some other studies describe the relationship between mentally ill people and health care professionals (Borg & Krinstiansen, 2004; Cleary, Hunt, Horsfall, & Deacon, 2012; Gahnström-Strandqvist, Josephsson, & Tham, 2004; McCloughen, Gillies, & O'Brien, 2011; Schroeder, 2012).

Despite the diverse objectives of studies on lived experience of mental illness, it is revealed that in most of them severely mentally ill people experience their disease as “a descent to hell” (Noiseux & Ricard, 2008, p. 1152), describing enormous suffering and exclusion from friends and families (Andersen & Larsen, 2012). The emotions frequently reported are shame, isolation (Liu, Ma, & Zhao, 2012) and powerlessness (Borg & Davidson, 2008). However, most of these studies do not shed light on the core of these experiences, and help us further understand the phenomenon of severe mental illness (SMI) and suffering in its essence (Andersen & Larsen, 2012; Borg & Davidson, 2008; De Maynard, 2007; Hirschfeld, Smith, Trower, & Griffin, 2005; Jönsson et al., 2008; Lee,

^{*} Corresponding Author: Charis P. Kaite, PhD, Cyprus University of Technology Department of Nursing, School of Health Sciences, Vragadinou 15, 3041-Limassol, Cyprus.

E-mail addresses: charis.kaite@cut.ac.cy (C.P. Kaite), maria.karanikola@cut.ac.cy (M. Karanikola), anastasios.merkouris@cut.ac.cy (A. Merkouris), e.papathanassoglou@cut.ac.cy (E.D.E. Papathanassoglou).

Kleinman, & Kleinman, 2007; Liu et al., 2012; McCann & Clark, 2004; Moreira & Coelho, 2003; Nyström, Dahlberg, & Segesten, 2002; Nyström & Nyström, 2007; Pollack & Aponte, 2001; Sanseeha, Chontawan, Sethabouppha, Disayavanish, & Turale, 2009; Schön, 2009; Thompson et al., 2008; Wang, 2011; Ward, 2011). Overall, prior literature, theoretical explanations and historical perspectives present a variety of data regarding the lived experience of mental disorders, depending on the diverse study objectives, culture and backgrounds and structures of the health care systems (Andersen & Larsen, 2012; Borg & Davidson, 2008; De Maynard, 2007; Hirschfeld et al., 2005; Jönsson et al., 2008; Lee et al., 2007; Liu et al., 2012; McCann & Clark, 2004; Moreira & Coelho, 2003; Nyström & Nyström, 2007; Nyström et al., 2002; Pollack & Aponte, 2001; Sanseeha et al., 2009; Schön, 2009; Thompson et al., 2008; Wang, 2011; Ward, 2011). Moreover, it is through meta-synthesis that we can achieve greater understanding of the core of these experiences and shed some light on the phenomenon of SMI and suffering in its fundamental nature (Allen, Carpenter, Sheets, Miccio, & Ross, 2003; Barker & Buchanan-Barker, 2011; Barkham, 2002; Davies, 2014; Day et al., 2005; Deegan & Drake, 2006; Happell, Manias, & Roper, 2004; Hewitt & Coffey, 2005; Kieft, de Brouwer, Francke, & Delnoij, 2014; Kopelowicz & Liberman, 2003; Määttä, 2006; Malins, Oades, Viney, & Aspdén, 2006; McCabe, 2004; Mueser et al., 2002; Yu & Kirk, 2008).

Although, a number of reviews on the subject of the lived experience of SMI exist in international literature, however, most of these studies have certain limitations. These are: inclusion of studies of solely one type of design i.e. phenomenology, focus on a particular aspect of the experience of SMI excluding others, inclusion of participants other than mentally ill people (family members or health care professionals), or no application of inclusion criteria or quality appraisal tools for the estimation of the rigour of the studies included in their sample (Andersen, Oades, & Caputi, 2003; Davidson, O'Connell, Tondora, Lawless, & Evans, 2005; Dundon, 2006; Holt & Tickle, 2014; Leamy, Bird, Le Boutillier, Williams, & Slade, 2011; Sells et al., 2004; Silverstein & Bellack, 2008; Warner, 2009; Wisdom, Bruce, Saeedi, Weis, & Green, 2008; Zolneriek, 2011).

This paper aims to synthesize qualitative research findings that explore the lived experience of SMI in order to understand the phenomenon from a different angle compared to that of a single study's (Dixon-Woods & Fitzpatrick, 2001; Paterson, Thorne, Canam, & Jillings, 2001; Walsh & Downe, 2005). A novel synthesis of already given data has been attempted.

To the best of our knowledge this is the first study to synthesize studies that used a variety of qualitative methodologies in order to understand how people with SMI experience their disease.

METHODS

The present meta-synthesis encompassed three distinct phases: a) a systematic literature search, b) critical assessment of the selected papers, and c) a meta-ethnographic synthesis, according to Noblit and Hare (1988).

Search, inclusion and exclusion criteria

A comprehensive literature search was undertaken between May 2014 and January 2015 in the following Databases: CINAHL, MEDLINE, PubMed, Psych Info, Psychology and Behavioral Science Collection. The following search terms were used singularly and in combination in each database:

"mental illness" OR "mental disorders" OR "mental health" OR "serious mental illness" OR "severe and persistent mental illness" OR "chronic mental illness" OR "schizophrenia" OR "schizoaffective" OR "bipolar" OR "depression" AND "lived experience" OR "narrative" OR "self-stories" OR "life-history methods" OR "phenomenological hermeneutics" OR "autobiography" OR "ethnography" OR "interpretative phenomenological analysis" OR "subjective experience" OR "hermeneutic

phenomenology" OR "in depth interview" OR "qualitative research" OR "focus groups" OR "grounded theory" OR "open ended" OR "narratives" OR "perception of illness" OR "illness experience" OR "experiences and expressions" AND "service user" OR "client" OR "psychiatric consumer" OR "mental health consumer"

The studies included in the sample of the present meta-synthesis:

- 1) had been published i) from 2000 to present, ii) in the English language, and iii) in a peer-reviewed journal,
- 2) had a qualitative design,
- 3) were aiming to explore the lived experience or interpretation of severe mental disorder, including the process of recovery in their objectives, mainly bipolar disorder or psychosis,
- 4) were based on data that had been collected solely from individuals with severe mental disorders.

The studies that were excluded from the sample of the present meta-synthesis had the following characteristics:

- 1) The sample was limited: i) to people who were suffering from different types of severe mental disorder than psychosis or bipolar disease, such as OCD, substance abuse, postpartum depression, personality disorders or other types of DSM Axis II mental disorder, ii) to people who were homeless.
- 2) The samples were single person case-studies or included the life history of one person, due to certain limitations following these study designs, such as: a) the fact that the perspective regarding a particular phenomenon is limited and the results deriving from such study designs are difficult to be replicated, b) there is a greater risk, for "research bias", compared to other types of qualitative study designs, since there are limited opportunities for assessing the rigorous of the results.
- 3) The aim was to investigate specific aspects of mental disorder experience, such as stigma, loss, grief, or specific aspects of recovery such as work, housing, medication management, as well as solely pre-diagnosis of first episode experiences, thus "recovery" was not included in search term.
- 4) studies that were evaluating the effectiveness of interventions e.g. art programmes, self-help programmes or clubhouse support
- 5) Data were based on narratives different than patients' perspective of the lived experience of severe mental illness (e.g. family members, mental health professionals or other therapists).
- 6) Dissertations because of the unavailability of data

The combined search strategies returned 1679 records. The titles, the abstracts, as well as the full texts were studied and 1568 papers were excluded. The remaining 111 papers, as well as 25 papers added after citation searching, were further examined in detail. After taking into consideration the inclusion and exclusion criteria, as well as the quality appraisal standards, 17 papers remained for the sample of the present meta-synthesis (Fig. 1).

Quality appraisal of retrieved papers

All the papers that were considered for inclusion in the sample of the present meta-synthesis were assessed in terms of methodological adequacy and rigor by the standardized tool Critical Appraisal Skills Programme (CASP). This is a form instrument that has been developed, tested and recommended by the National Health System of the United Kingdom (Schön, 2010).

The CASP tool provides classification of scholar papers according to their methodological adequacy. It consists of 10 items, each of them stating a question about a particular methodological feature. The first two items are screening questions and, if they are answered positively, the researcher is able to proceed with the remaining eight items, classifying the study in one of two quality categories. The questions can be answered with "yes", "no" or "can't tell".

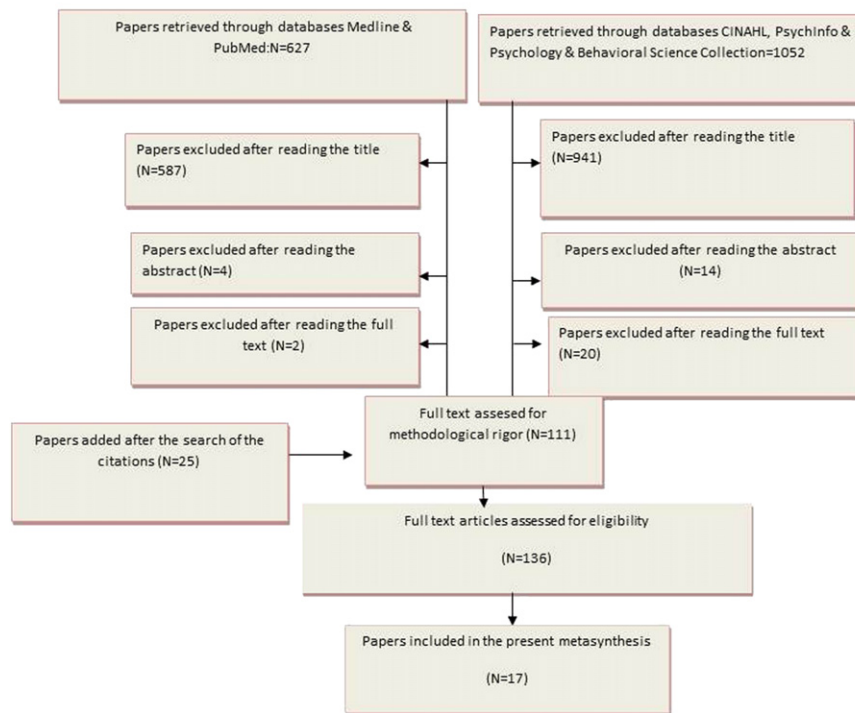


Fig. 1. Process of data collection.

Specifically, according to the answers given, scholar papers are classified in two categories. Studies in category A are characterized by a low risk of type I or II error, as they meet at least 9 of the 10 items proposed. Studies in category B meet more than 5 but less than 9 of the 10 items proposed. Assignment of studies to category B status means that they partially meet adopted criteria, presenting a moderate risk of bias, mainly of type II. Case studies and studies with convenience samples belong to this category.

All papers were assessed by three reviewers (1st, 2nd, 4th author), independently to address inter-rater reliability. The first author is a PhD psychologist, familiar with qualitative research as she has been a research assistant for qualitative studies for several years. The first author, also has a number of publications on qualitative research. The second author is an Assistant Professor in Mental Health Nursing, has been the supervisor of numerous PhD students on qualitative studies, since has a substantial education and experience in qualitative analysis, as well as a number of qualitative publications. Lastly, the 4th author, is a Professor in Nursing, has been a principal investigator in many qualitative studies, a member or leader of both qualitative and quantitative research teams and her strong area of interest focuses on the phenomenological investigation of the lived experience.

At first, each of the three aforementioned authors read single papers and used a separate copy of CASP checklist in order to assess each paper. When each researcher completed his own assessment, a meeting was held with all three researchers (1st, 2nd, 4th author), in order to document identification of key issues and come to an agreement. As there was no disagreement between the three researchers as to which studies were fulfilling the inclusion criteria, only one meeting was held. At this point, it is worth mentioning that the initial screening questions were of significant importance in identifying papers as suitable for inclusion in the present synthesis. If answers to the summary questions were all positive then assessment continued.

More specifically, according to the ten items of the CASP tool, all studies included in the present meta-synthesis were classified in category A. In particular, in all studies 1) the aim was clearly stated, 2) the qualitative methodology that was used was the appropriate one for the phenomenon under study, 3) the methodological qualitative design that was implemented was the appropriate one according to the objectives of the study, 4) the recruitment strategy was the appropriate one according to the aims of the study, 5) data were collected in a way that assured adequate coverage of the topic under study, 6) the relationship between the researchers and the participants had been adequately considered, 7) the ethical issues had been taken under consideration, 8) data analysis was sufficiently rigorous, 9) there was clear report of findings and 10) the contribution and the implications of the findings generated by the study, as well as the limitations, were adequately discussed.

There were no disagreements between the three researchers as to which studies fulfilled the criteria of the CASP tool.

Meta-ethnographic synthesis of data

Meta-ethnography was chosen as the most appropriate method of synthesizing the data in the present study since it i) has its underpinnings in the interpretive paradigm from which qualitative methodology stems, ii) provides a higher level of analysis and interpretation, iii) generates new research questions, and iv) reduces duplication of research (Britten, Campbell, Pope, Donovan, & Myfanwy, 2002). Moreover, this method is the most widely cited in the healthcare research of qualitative data synthesis, and in particular with regard to patients' experiences of illness (Campbell et al., 2003; Pound et al., 2005). Furthermore, meta-ethnography as suggested by Noblit and Hare (1988) is more suitable for meta-synthesis involving a small number of studies.

Noblit and Hare (1988) suggested seven stages for conducting a meta-ethnographic synthesis. These were followed in the present

study in the adopted version for health research by Britten et al. (2002). These steps are:

1. Getting started, which involves the writing of the research question
2. Deciding what is relevant to the initial interest, which involves the search and selection of the studies of the sample based on certain criteria
3. Reading the studies, which involves an in-depth study of the included papers in order to identify the main themes (concepts) in each of them
4. Determining how the studies are related, which involves identification of the common themes across the included studies, as well as how these themes are presented in each paper (first-order interpretation)
5. Translating the studies into one another, which includes the interpretation of the relationship between the common themes in each study (second-order interpretation)
6. Synthesizing translations, which include the interpretation of the way in which second order interpretations are related to one another (third-order analysis)
7. Expressing the synthesis, which includes illumination and writing of the synthesis

More specifically, we applied first, second and third level analysis of data (Schutz, 1962). First order analysis involved i) the identification of the main themes in each included study, as a summary of the original findings of each study, ii) the search of the common themes across all included studies, and iii) the interpretation of the common themes across all included studies. We have constructed a matrix to compare all the constructs emerged, with lines and arrows to indicate possible relationships between constructs and subsequent themes across the different studies of the meta-synthesis (Britten et al., 2002; Campbell et al., 2003). Then, we searched for a theory that could integrate the expressions of the common themes in each paper in a meaningful way. This was our second order analysis. Then we developed our third order analysis by writing our views and interpretations which in turn revealed a possible relationship among all included studies, in terms of the themes and concepts that had been illuminated in the second order analysis (Dixon-Woods & Fitzpatrick, 2001; Paterson et al., 2001).

Lastly, consensus was achieved in a second meeting with all three aforementioned authors that contributed to the assessment of the included paper. More specifically, during the second meeting, the researchers first read all the second order interpretations independently, then all three of them met to discuss the third order analysis by revisiting second order analysis and the quotes associated with it. After that, they reached a consensus by discussing all the study differences and similarities for each single paper in detail, in order to produce an integrated scheme and a new interpretative context that was derived from the key concepts and the second order interpretations.

RESULTS

Search results and initial assessment

The current meta-synthesis integrated the findings from seventeen papers regarding 242 subjects of the papers, the majority of them being women, aged from 18 to 64 years old. The included studies were conducted in the following countries: one in Canada, one in Norway, three in Sweden, two in Australia, one in Brazil and Chile, one in Thailand, one in the UK, four in the USA, two in Taiwan and one in Turkey. Most of the researchers used in-depth, semi-structured interviews. One study was based on interpretations of pictures and photos selected by the participants in order to represent what it has been like to live with chronic mental illness (photo-voice), whilst in another one it was used a combination of data collection methods (visual diaries, in depth interviews, observation notes, sketches and designs, artwork). All studies were published after 2000.

The participants in five studies were recruited from inpatient facilities (university or public hospitals), in three studies from a non-governmental organization, in one study from a group of music therapy, whilst in four studies the participants had chosen themselves the place of interview (e.g. home, cafes, private room etc.). Moreover, in two studies the participants had been recruited from the community, in one study through flyers and in another study from an annual art exhibition hosted by Mental Illness Fellowship Queensland (MIFQ).

The main features of the included studies are presented in Table 1.

INTERPRETATION OF FINDINGS

The third order interpretation, which included the synthesis of second order translations (Holt & Tickle, 2014), revealed as the core theme of the lived experience of severe mental illness the “ongoing struggle for reconciliation with the self and illness”.

Severely mentally ill patients seemed to experience a harsh encounter with the illness and its consequences. In particular, they seemed to experience a continuous suffering, mainly arising from stigma, loss of their credibility and social status, isolation, powerlessness and hopelessness.

“It would have been best if I could have stayed feeling OK, but there is this kind of feeling that drags you down until you feel bad, a feeling that you can't do much about...” (Jönsson et al., 2008, p. 1226).

“I wish the rest of the world could see that seeking help for mental health (problems) is not a bad thing or something to joke about or judge me” (Thompson et al., 2008, pp. 17–18).

“I've even tried committing suicide once [...]. It is very hard to see a future with this illness.” (McCann & Clark, 2004, p. 789).

Additionally, severely mentally ill patients stated their need to be accepted by society, and further gain back and maintain a normal life.

“[...] (telling about the illness) I don't know how it would sound to them what they would think of me after I told them, so I think it's unnecessary. Why should they be informed? As long as I behave normally, or they consider that I behave normally, there's no need to run around and tell them that I've been like this or that.” (Jönsson et al., 2008, p. 1226).

Their need to be accepted by themselves, in terms of normality, was also evident:

“I want to get married and have children and live a good life. I want to work. I don't want to receive social welfare payments [...] I want to live a normal life [...].” (Jönsson et al., 2008, p. 1230).

More importantly, the need for self-acceptance was perceived as an essential step towards recovery:

“I also feel rejected by my family, they are indifferent. That hurts. It also affects me in my bodily and mental development, let's say, to carry on a more normal activity” (Moreira & Coelho, 2003, p. 82).

Overall, the effort to accept the illness was perceived as an ongoing struggle through the different phases of the disease, evoking subsequent feelings of denial, anger and hopelessness. Furthermore, this procedure was described as a continuous fluctuation between acceptance and non-acceptance.

With regard to the results of the first and second order analysis, the translation of the concepts identified in the first order analysis (Table 2) led to six themes produced in the second order analysis, which are presented below (Table 3). Moreover, Fig. 2 depicts the association between the core theme and the concepts produced in the first and second order analysis.

Table 1
Main Features of the Studies in the Current met Synthesis.

Author/Date	Aim	Methodology	Core theme/Main themes
1. Borg & Davidson, 2008	To explore how the challenges of severe mental illness are experienced within the context of everyday life	-Existential phenomenology & participatory research -13 people with severe mental illness & reference group of 5 persons -Open-ended questions focused on existential, social, material, health & illness issues	Core theme: Striving for recovery & normality Main themes • The importance of having a normal life: spending time in ordinary environments where normality is expected from individuals (vs. psychiatric settings) -housekeeping, paying bills etc. -fulfilling social & family roles -having a job • Just doing it: doing something concrete to improve one's situation: finding sources of hope & inspiration despite the limitations stemming from the illness • Acquiring helpful people/situations/strategies towards making life easier: -the contribution of mental health care practitioners -a stable income & having a home -being occupied with meaningful & pleasurable activities • The value of being good to yourself -a healthy lifestyle -being good to others -offering to one's self pleasurable activities
2. Güner, 2014	To determine the illness perceptions of patients with schizophrenia in remission	-Descriptive exploratory design -9 patients with schizophrenia (8 males and 1 female) -semi-structured interviews	Main themes: •Schizophrenia is a complicated illness that causes indescribable pain and fear •Schizophrenia is a mystery, patients lacking an understanding of the causes of schizophrenia speculate on numerous reasons [genetic, brain not releasing sufficient dopamine, blows to the head and subsequent seizure, loneliness, an act of God, poor family relationships, academic failure, economic hardship and/or stress, excessive studying during childhood, not placing importance on one's social life, obsessing with certain things, personality traits (introversion), depressive and oppressive settings, working in difficult jobs, being subjected to ill-treatment, loss of loved ones and combination of those factors] •Loss of life: life goes by without having lived and there was nothing in their lives but schizophrenia. Emotions: hurtful feelings and exasperation. •A dynamic journey toward recovery, varying from patient to patient and defined as the cessation of symptoms and the disappearance of all negative consequences of the illness - Factors facilitating recovery: supporting family attitudes, drug therapy as important in order to prevent relapses, personal responsibility (engage in activities, hobbies etc.) - Spirituality & positive relationship with God - Helping relationships with doctors that could educate family & listen to their concerns - Factors that Hinder Recovery (family attitudes, stigmatization, fear of being deprived of certain rights, the quality of health care and financial/social security issues) •A process of recovery (1. Changes in perception of schizophrenia, first fear now came familiar and accepted, 2. Learning to live with illness, able to take medications, 3. Deriving meaning from illness, giving positive meaning to schizophrenia) •Optimistic view of illness: Schizophrenia as a means of protection from negative experiences. Core theme: The sense of personhood inclusive in mental illness Main themes: •To know who me is (beyond the label of mental illness, the identity of artist as a sense of accomplishment and self-respect). •I can't separate it (Perception of the sufferer's self in relation to illness as a supplement of oneself) •Meaning of recovery (recovery as a fluctuating process) •Systems (descriptions in relation to clinical interventions, normality and functioning in order to meet conventions prescribed in mental health)
3. Gwinner, Knox, & Brough, 2013	To share the complexities of illness and recovery as a full human experience derived through a collaborative process aimed at improving and understanding the lives of each person living in the community.	-Participatory Action Research (PAR) -Eight adults identified as artists and diagnosed with mental illness -Visual diaries, three in-depth interviews with each of eight artists, observation notes of the notes and planning and exhibiting processes, the artists sketches/designs and finished artwork	Core theme: The sense of personhood inclusive in mental illness Main themes: •To know who me is (beyond the label of mental illness, the identity of artist as a sense of accomplishment and self-respect). •I can't separate it (Perception of the sufferer's self in relation to illness as a supplement of oneself) •Meaning of recovery (recovery as a fluctuating process) •Systems (descriptions in relation to clinical interventions, normality and functioning in order to meet conventions prescribed in mental health)

Table 1 (continued)

Author/Date	Aim	Methodology	Core theme/Main themes
4. Hirschfeld et al., 2005	To explore the experiences and meanings of young men with psychosis.	-Grounded theory -6 men with schizophrenia -Semi-structured interviews with open-ended questions	•A Bit more better (recovery as an ongoing aspect and the development of coping strategies) •Layered Identity (the persons identity as an artist is luminous over the mental illness identity) Core theme: Personal and Interpersonal changes Main themes • Experience of psychosis: suicidal and depressive feelings, as well as insecurity and fear. • Development and use of coping strategies • Personal and Interpersonal changes: feelings of loss, loneliness and alienation leading to alterations in young men's perception of themselves and their relationships • Personal explanations regarding the onset of psychosis: the contribution of i) self-perception prior to psychosis onset, ii) stressors associated with the quality of relationships with women.
5. Jönsson et al., 2008	To explore the meaning of living with Bipolar Disorder, focusing on individuals' perceptions about the illness and the future	-Content analysis -18 participants -structured interviews	Core theme: Moving back and forth towards acceptance of illness Main themes • Perceptions regarding the illness -Accepting the illness -Being insecure in ones' self, stemming from the fear of becoming ill again or due to discrimination -Striving to understand the causes and course of the illness -Managing the illness through the development of coping strategies, such as the expression of feelings, medication and positive thinking • Perception of the future -An uncertain future due to limitations set by the illness -A hopeful future based on expectations about being part of a society.
6. Ko, Smith, Liao, & Chiang, 2014	To explore illness experiences of people living with schizophrenia within Taiwanese culture	-Interpretative Phenomenological Approach -15 participants with schizophrenia -Sharing experiences on events in the participant's personal lives or family life, participant's personal diaries, informal interviews, repeat observations and one in-depth face to face interview	Core theme: Searching for re-integration Main themes: •Reflecting on illness experiences -Loss of self-control (losing one's mind, unable to control one's behavior) -Sense of unbearable suffering (unbearable suffering and a feeling that no one understands them) -Connecting with spiritual world (causes of illness as possession by spirits or punishment and repayment of sins connected to previous life) •Living with illness experience -Regaining control (coping mechanisms: supporting families, medication controlling symptoms, professional relationships based on trust, involving the patient in treatment by considering the patient's own opinion, as well as ones feeling of engagement in therapeutic relationships) -Searching for inner peace (religion and strong belief in god as coping mechanisms) •Learning from illness experience -Reframing self-expectations (considering one's own health as a priority in contrast to one's career goals that are hindered by illness) -Redefining the value of life (family bonds as supporting and empowering to continue fighting mental illness. Core theme: The journey between illness and health Main themes: •The Destinations (illness and health) -Illness as time spent in jail, as a rushing flood or a nightmare, a constant battle, hell, a black hole, or a black death vs health as freedom, peace, embracing life and light. •Identity (lost vs restored identity) •Control (no perceived control vs taking control) •Social Engagement (social isolation vs social connection) Core theme: Illness as a catastrophic experience Main themes
7. Kooij, 2009	To understand what the songs written by adult music therapy participants diagnosed with SMI reveal about their lived experience of mental illness	-Hermeneutic Phenomenology -3 participants (2 female and 1 male) who had written substantial body of songs diagnosed with schizophrenia, major depression, bipolar disorder and anxiety disorder -Open-ended interviews	Core theme: The journey between illness and health Main themes: •The Destinations (illness and health) -Illness as time spent in jail, as a rushing flood or a nightmare, a constant battle, hell, a black hole, or a black death vs health as freedom, peace, embracing life and light. •Identity (lost vs restored identity) •Control (no perceived control vs taking control) •Social Engagement (social isolation vs social connection) Core theme: Illness as a catastrophic experience Main themes
8. McCann & Clark, 2004	To explore how young people with schizophrenia experience their illness, and find meaning into it.	-Existential Phenomenology -Husserl and Merleau Ponty approach -9 adults with schizophrenia -Semi-structured interviews -Giorgi analysis	Core theme: Illness as a catastrophic experience Main themes

(continued on next page)

Table 1 (continued)

Author/Date	Aim	Methodology	Core theme/Main themes
9. Moreira & Coelho, 2003	To explore the lived experience of schizophrenia in Brazil-Chile people.	-Existential Phenomenology -Merleau Ponty approach -50 individuals (20 in Brazil and 30 in Chile) -Semi-structured interviews -Giorgi's analysis adapted by Moreira (2001)	• Embodied temporality: Illness as a catastrophic experience • Embodied relationality: illness as a mediator of social relationships • Embodied treatment: medications side effects as burdensome Core theme: An experience of oppression and powerlessness Main themes
10. Nyström et al., 2002	To explore the existential meaning of living with severe mental illness	Phenomenology of hermeneutics -Gadamer approach -7 individuals with psychosis -Open-ended questions	• An experience of oppression and powerlessness: emotionally and somatically tired and weak • Feeling trapped in psychiatric hospitals: lack of freedom • Taking strong medication constantly: ambivalent feelings about medication • Loneliness and suffering from the stigma of mental illness: rejection and loneliness • The relation between persecutory hallucinations and political and cultural history: possession of spirits Core theme: inability for personal & emotional development Main themes • Avoidance/unwillingness to personal development/change • Being an outsider during childhood/lack of emotional support • Constant unmet needs (search of feelings) of secure & positive self-esteem • Existential loneliness • Dysfunctional social relationships
11. Nyström & Nyström, 2007	To explore the lived experience of individuals who are suffering from recurrent depression	-Phenomenological method of Giorgi -10 participants with depression -Unstructured interviews	Core theme: Paralysis Main themes • Feeling alienated from oneself and others: loss of sense of being a holistic person • Difficulty in understanding and making oneself understood: difficulties in understanding depressive symptoms and in communicating one's suffering • Feelings as if being behind an invisible screen in a state of paralysis: being locked up and excluded from ordinary life • Unbearable pain: the person can neither live nor die • A struggle with and against perpetual limitations: medication adherence • Unable to be with oneself or others: inability to be present in one's own life and difficulty in maintaining social relationships, leading to a sense of meaningless life • Sense of indignity: self-hatred and low self-esteem, as well as feelings of guilt • A need to vanish with dignity, without strain on others: suicidal thinking due to guilt of being a burden to the family.
12. Pollack & Aponte, 2001	To explore the perceptions of illness in people being treated for bipolar disorder in a public hospital	-Exploratory study -15 patients with bipolar disorder -Structured interviews -Content analysis	Core theme: Struggling to accept illness Main themes • Facing the diagnosis: chronic struggle for identifying and accepting Bipolar Disorder • The importance of personal metaphors: development of personal metaphors in order to explain their illness. Personal metaphors seem to influence the acceptance of the illness • Dealing with the medical model: treatment focused on medication
13. Sanseea et al., 2009	To explore how people diagnosed with schizophrenia perceive themselves in relation to their illness in north-eastern Thailand	-Hermeneutic phenomenology -Heideggerian approach -In-depth interviews and observations -18 participants	Core theme: Schizophrenia as a supernatural experience Main themes • Perception of mental illness: chronic conditions that require continuous medication and treatment • Perceptions of causes of illness: cultural and spiritual beliefs attributed to supernatural powers • Perceptions of discrimination: perceived as different from others, isolated from society, rejected and distrusted by society

Table 1 (continued)

Author/Date	Aim	Methodology	Core theme/Main themes
14. Schön, 2009	To explore the differences in interpretation of severe mental illness between men and women, and how this meaning-making influences the recovery	-Grounded theory -30 patients with severe mental illness -In-depth interviews	- Attempting to live with schizophrenia: developing coping strategies, such as practicing mindfulness or positive concentration, meditation and praying Core theme: Reason for illness. The stressed brain & soul Main themes - Causes of the illness: (men) loss of love from mother, separation from a parent, heredity, personal insecurity arising from childhood experiences, (women) vulnerability, biological illness, heredity and stressful childhood - Categorizing the illness: “the illness”, “the psychosis”, as oppression in terms of sexual abuse, physical abuse, or self-oppression during childhood or adulthood - Gendered illness triggers: (men) professional and financial responsibilities, (women) emotional stress - Illness values: (men) “illness as attack”, “illness as an enemy”, “illness as vulnerability”, “total lack of defense against emotions”, (women) “illness as a mean for creativity”, “painful but also freeing and contributing to who one really is”. - Personal responsibility: (men) active agents in developing the illness, (women) receptors of the stress to which they had been exposed - Recovery goal: (men) prevention of relapse and control of symptoms, (women) psychosocial adjustments to a perceived lifelong vulnerability
15. Thompson et al., 2008	To explore what it is like to live with chronic mental illness.	-Qualitative Descriptive method -7 patients with chronic mental illness -Interviews based on photos selected by the participants in order to represent what it has been like to them to live with chronic illness -Content analysis	Core theme: Feeling misunderstood and invisible Main themes - Need to be seen as individuals and not solely as mentally ill persons - Attempting to gain control and be safe through various actions and activities - Making an ongoing effort to repair injured self-esteem - Using various coping skills, positive such as humour, or negative, such as withdrawal
16. Ward, 2011	To explore what it is like to live with bipolar disorder and comorbid substance used disorder	-Phenomenology -13 patients with Bipolar Disorder -in -depth interviews -Colaizzi's method for data analysis	Core theme: trying to escape Main themes - Life is hard due to the negative impact of BD (confinement in a mental hospital, emotional instability, problems in social relationships) - Feeling the effects: loss of the job, home, children and the respect of others - Trying to escape, through self-medicating - Spiritual support, as a coping mechanism - Being pushed beyond the limits: having suicidal thoughts due to the unbearable pain and intense symptoms - A negative connotation: stigma of being diagnosed with BD, as well as negative meanings such as “crazy” or “crack head”, resulting in rejection from society
17. Wang, 2011	To explore the personal illness experience and views of mental healthcare of people with mental illness	-Qualitative study -10 voluntary research participants with schizophrenia, bipolar or major depression -semi-structured in depth interviews -Thematic analysis	Core theme: The denial of being ill Main Themes: -Mental health service users roles and identities -Perceptions of mental illness -Personal experience of psychiatric stigma

A. Loss of identity and the pain of having one's life stolen

The meaning of mental illness as it was revealed through the experiences of people with severe mental illness encompassed a sense of a titanic disruption in one's life.

“[...] An interruption of life”, ‘like having your poles reversed’ (Pollack & Aponte, 2001, pp. 173–174).

“It is an elusive suffering, consisting of opposites, paradoxes and complexity” (Nyström & Nyström, 2007, p. 679).

The consequences that follow the onset of the illness seemed to include particular alterations in one's personal and social life. These changes maybe integrated in a process of transformation of the self-identity prior to illness to a new identity, the “sick identity” that followed the onset of the illness. In some cases this was described as alienation from the self and others.

“I am being alienated from myself and others” (Nyström et al., 2002, p. 679).

Table 2

The Concepts Identified and their Frequency Across the Studies Which are Included in the Present Meta-Synthesis (First Order Interpretation).

	Borg & Davidson, 2008	Güner, 2014	Gwinner et al., 2013	Hirschfeld et al., 2005	Jönsson et al., 2008	Ko et al., 2014	Kooij, 2009	McCann & Clark, 2004	Moreira & Coelho, 2003	Nyström et al., 2002	Nyström & Nyström, 2007	Pollack & Aponte, 2001	Sanseea et al., 2009	Schön, 2009	Thompson et al., 2008	Wang, 2011	Ward, 2011
Concepts																	
<i>The meaning of mental illness: an interruption of life</i>																	
Interruption of life/Catastrophic experience/Attack from enemy							X	X				X		X			
Chronic illness/Complexity		X											X				
Uncontrollable/Unpredictable situation		X				X	X	X					X				
Suffering/Painful experience		X				X	X				X			X			X
An asset/A special gift from God												X		X			
Paradoxes (Opposites)												X					
A supplement in one's self			X														
<i>Feelings/Perceptions</i>																	
Fear of relapse/Insecurity/ Frustration		X		X	X			X									
Loss of self-confidence					X												
Alienation from self																	
Feeling invisible								X							X		
Suspiciousness/Altered thinking												X	X				
Alienated from others/Isolation										X							
Loss (job/home)								X									X
<i>Social consequences</i>																	
Stigmatized					X				X				X				X
Labeling					X								X			X	
Rejection/Loneliness								X	X								
Interrupted family relations								X									X
<i>Causes of illness</i>																	
Traumatic events during childhood/Lack of love/Loss				X						X							

Furthermore, the loss of the prior to the illness self-identity seemed to cause an enormous confusion to participants regarding who they are now, and why they are differentiated from others (Kooij, 2009). This loss of identity and related roles seemed to be the main source of suffering and pain since their previous life had been taken away once and for all.

B. Being an outcast

A plethora of feelings were described by the people with severe mental illness. Most of these were connected with experiences of suffering. Anger, pain, sadness, helplessness, hopelessness and denial were some of them.

"My wife would probably tell you that I won't admit it and I think it's like that with many forms of mental illness, you don't want to admit that you have such an illness . . . that's my opinion" (Jönsson et al., 2008, p. 1225).

[...] "I had a brief period of time were I used to get angry because of the symptoms starting to show, at an early stage, when my mental illness was developing. I did not really want to be experiencing them, and showing anger was one way of, I don't know, asking for help in a way, or just earn reinforcing, [...]. I was not happy about the things in my mind at the time" (Hirschfeld et al., 2005, p. 258).

"[...] help me or I'm going to kill myself, because I don't want to live like this anymore." (Ward, 2011, p. 24).

Moreover, feelings of constant fear of becoming ill again and subsequent insecurity caused to the majority of participants further feelings of powerlessness:

"The worst aspect of it is not being confident with your own mind. Knowing that you can lose it, as it happened before. I am conscious of the fact that it can happen again . . . For me, that is the worst thing." (McCann & Clark, 2004, p. 788).

"I am worried and fearful of becoming psychotic again" (Nyström et al., 2002, p. 129).

[...] "But there is always that chance of slipping back into depression, but you have just to find another way to avoid that" (Hirschfeld et al., 2005, p. 257).

Overall, the sense of being an outsider to life was evident in people's narratives. Loneliness and feelings of being isolated, even rejected, were described in a dramatic way. Additionally, a feeling of meaninglessness seemed to be evident in the majority of the descriptions reviewed.

"I feel bad [...], why am I going to lie to you. . . I feel bad, I feel lonely . . . you feel as if you are empty, as if no one wants you, no one has any interest in you. There's very little motivation to make you carry on" (Moreira & Coelho, 2003, p. 82).

C. Loss of social status and admitting defeat

With regard to the social consequences of the illness, experiences of loss of ties with the family and friends were mainly described. Most of the times, that seemed to be irreversible and somehow to symbolize a case of defeat from the mental illness, mainly in terms of loss of social status and respect from others.

"They backed off. They did not want anything to do with me. Most of my friends disappeared" (McCann & Clark, 2004, p. 791).

"It destroyed the relationship I had with my family, including my son. It destroyed every element of it over the years [...]" (McCann & Clark, 2004, p. 791).

[...] "We'd fought with each other a few times. I lost my daughter. But, I'm gonna' get her back. I'm still beating myself up about that. My son, I have a 24-year-old boy, and he just wouldn't have anything to do with me" (Ward, 2011, p. 24).

Furthermore, participants disclosed long, vivid descriptions regarding social stigma and labeling.

"[...] that's the way it is with mental illness. They say that there are no prejudices anymore, because people are so enlightened, but that isn't true" (Jönsson et al., 2008, p. 1225).

"From my feelings, society does not trust people who are "phee-bha" (insane)" (Sanseeheha et al., 2009, p. 309).

More importantly, social stigma and labeling were revealed as factors inhibiting any effort to accept mental illness:

"[...] They look askance at you and think "Hmm she's mentally ill and her behavior is different [...]"...and that may be the reason why I find it difficult to accept the illness" (Jönsson et al., 2008, p. 1225).

D. Misfortunes that lead to tribulations

Participants shared their need to understand the causes of their illness. They talked about stressful life events, such as economic burden, work pressure, drug misuse and traumatic events during childhood. Additionally, supernatural powers, brain damages and heredity were also identified as factors associated with the onset of the mental disease.

Overall, despite the different types of mental disorder contributors, these factors were perceived as the milestones of the suffering experience of severely mentally ill persons.

"Bipolar disorder is a condition caused by stress. A lack of rest, a lack of eating and a lack of economic support" (Pollack & Aponte, 2001, p. 173).

"Well I am not sure, but it might have been the drugs I was taking" (Hirschfeld et al., 2005, p. 261).

"My illness [was] caused by black magic. I believed that someone disliked me and envied me" (Sanseeheha et al., 2009 p. 308).

"It's related to genetics, that's why I am ill. My grandmother's and grandfather's." (Sanseeheha et al., 2009, p. 309).

"I lacked basic love and care during childhood" (Nyström et al., 2002, p. 126).

E. Pharmacotherapy as oppression and the burden of it

The side effects of pharmacotherapy were acknowledged as huge limitations to the struggle of reconciliation with the illness. In particular, psychotropic medicines seemed to be an obstacle in participants' social and romantic life. Overall, medication was perceived as a heavy weight, dragging down the body and mind, as well as an intense, bearing load that needs to be carried all the way through the illness.

"I asked, and also begged, my doctor to stop prescribing them [...]. I can take it for my whole life as long as there are no side-effects" (Sanseeheha et al., 2009, p. 307).

"[...] because I intend to get married [...]. The medicine was making me physically weak [...]. A man's physical part. So I said, let's stop" (Moreira & Coelho, 2003, p. 82).

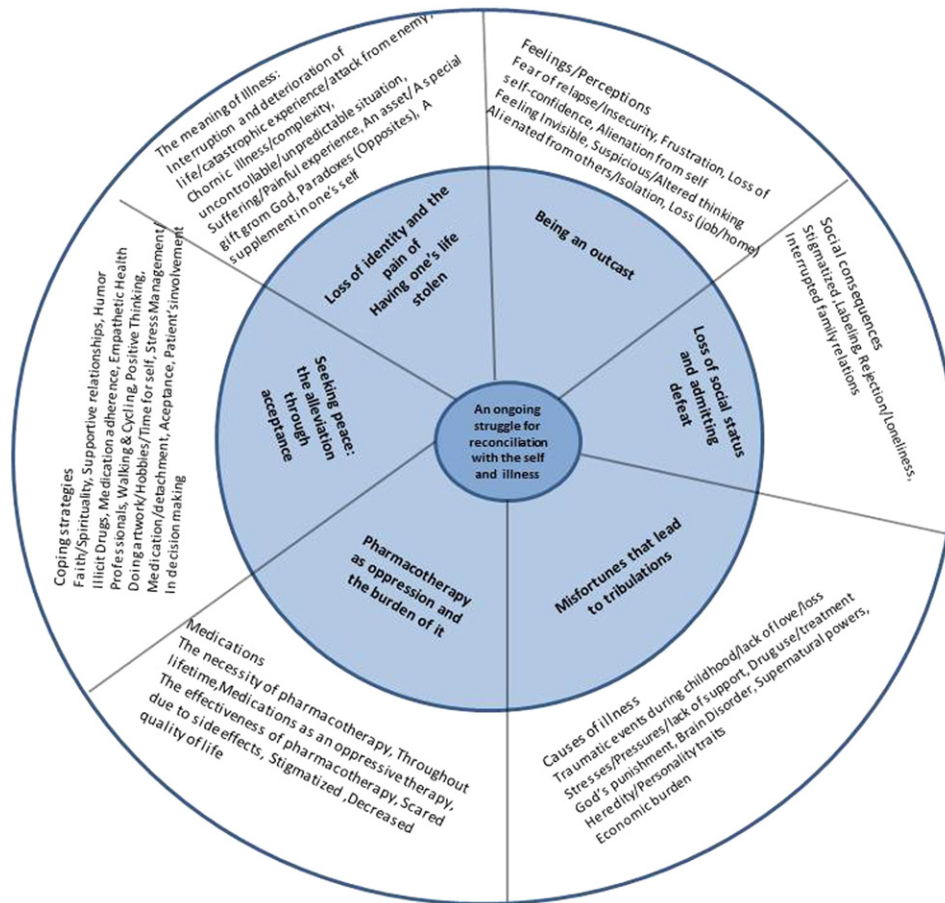


Fig. 2. Depiction of the association between the core theme and the themes and constructs revealed in the second and first order analysis.

"Sexually, my medication affects my ability to ejaculate ..." (McCann & Clark, 2004, p. 793).

In some cases, medication was also described as necessary, since it controlled the illness and its symptoms. Thus, despite the negative effects of pharmacotherapy in mentally ill patients' personal and social life, many of them acknowledged the therapeutic effect of psychotropic medicines:

"[...] my head is fine because of the medicines, if it weren't for the medicines, I'd be crazy" (Moreira & Coelho, 2003, p. 82).

"[...] I feel better when I take drugs, but if I stop taking it, I will feel dizzy after a while. So it is necessary to rely on drugs to control the illness" (Wang, 2011, p. 5).

F. Seeking peace: The alleviation through acceptance

During the ongoing effort to manage the limitations of the illness, participants seemed to develop various coping strategies. Towards reconciliation, participants appeared to have articulated a new identity of their selves in order to accept the illness. More importantly, they seemed willing to embrace their new identity posed by the illness and integrate the limitations into it.

Spirituality and a positive relationship with religion seemed to be a valuable way of finding peace in one's life under the scope of illness.

"A lot of people have religion, but that's not it. [...] Since I had this relationship with Jesus, it has really come good [life now looks more promising]...."

I find that, where it all matters, is in the spirit. If I've got my spirit alive, then everything else comes in." (McCann & Clark, 2004, p. 790).

"Praying helps improve the quality of my mind. My mind is more peaceful." (Sanseeheha et al., 2009, p. 309).

"[...] Anytime I get in a tight situation or whatever, I can go to God. It helps me for some reason; it calms me down where I can be able to function." (Ward, 2011, p. 25).

Overall, reconciliation with the self and illness seemed to be the ultimate prerequisite of finding peace in one's life. This process of acceptance of the limitations of the illness seemed to be mediated by the endeavor to build a new identity through the ill health.

"you know I have matured a lot more. You become aware of what is around you, and you understand illnesses and all the ins and outs. So obviously, yah you change a lot" (Hirschfeld et al., 2005, p. 260).

"I have perhaps been able to come to terms with and accept some things, but it's difficult. Probably it doesn't matter what illness it is. It'll perhaps become a suffering for people with diabetes to not be able to eat chocolate. And then perhaps, finally you realize that, perhaps I don't need that chocolate any longer and then you don't suffer any more" (Nyström et al., 2002, p. 682).

Table 3
Synthesis of Second Order Interpretations into Third Order Interpretations.

Concepts	Second order interpretations	Third order interpretations
<i>The meaning of mental illness: An interruption of life</i>	Loss of identity and the pain of having one's life stolen	Ongoing struggle for reconciliation with the self and illness
Interruption and deterioration of life/Catastrophic experience/Attack from enemy		
Chronic illness/Complexity		
Uncontrollable/Unpredictable situation		
Suffering/Painful experience		
An asset/A special gift from God		
Paradoxes (Opposites)		
A supplement in one's self		
<i>Feelings/Perceptions</i>	Being an outcast	
Fear of relapse/Insecurity/Frustration		
Loss of self-confidence		
Alienation from self		
Feeling invisible		
Suspiciousness/Altered thinking		
Alienated from others/Isolation		
Loss (job/home)		
<i>Social consequences</i>	Loss of social status and admitting defeat	
Stigmatized		
Labeling		
Rejection/Loneliness		
Interrupted family relations		
<i>Causes of illness</i>	Misfortunes that lead to tribulations	
Traumatic events during childhood/Lack of love/Loss		
Stresses/Pressures/lack of support		
Drug use		
God's punishment		
Brain disorder		
Supernatural powers		
Heredity/Personality traits		
<i>Medication</i>	Pharmacotherapy as oppression, and the burden of it	
The necessity of pharmacotherapy throughout lifetime		
Medications as an oppressive therapy		
The effectiveness of pharmacotherapy		
Scared due to side effects		
Stigmatized		
Decreased quality of life		
<i>Coping Strategies</i>	Seeking peace: The alleviation through acceptance	
Faith/Spirituality		
Supportive relationships		
Humor		
Illicit Drugs		
Medication adherence		
Empathetic Health Professionals		
Walking & Cycling		
Positive thinking		
Doing artwork/Hobbies/Time for self		
Stress management/Meditation/Detachment		
Acceptance/Patient's involvement in decision making		

DISCUSSION

This meta-synthesis aimed to appraise and synthesize current qualitative research data on the lived experience of SMI. Although several studies have been conducted in order to investigate the lived experience of SMI, this is the first meta-synthesis on the subject to our knowledge. The majority of the participants in the studies reviewed disclosed their continuous suffering due to the symptoms of the illness, as well as their perception of loss of self-identity and life previous to illness. Thus, in this meta-synthesis we enlightened the need for reconciliation with the new identity of self, as posed by the limitations and challenges of the illness. The ongoing struggle towards this equilibrium was revealed as the inner essence of the experience of the ill health. Moreover, this dynamic development seemed to involve a re-conceptualization of mental illness as one aspect of one's multi-dimensional identity, instead of capturing his/her entire personal perception, leading to the formation of the "mental patient" self-identity.

In more detail, in the current meta-synthesis the perception of participants that their life history had been disrupted was highlighted as

a central element of their experience. Suffering, seemed to result from patients' awareness of the losses following the onset of the symptoms; the first and foremost of them was associated with an unfamiliar sense of the self. This alteration of the perception of the self was followed by other losses, such as loss of social relationships and roles, control over one's life or esteem from self and others. Overall, the need to rebuild one's self identity was revealed as essential for accepting the limitations of the illness. When this procedure was perceived as a challenge, mentally ill persons were able to achieve alleviation.

Thus, the issue of self-identity throughout the continuum of ill health appears to be crucial with regards to adjustment to the new conditions caused by the symptoms of severe mental disorders. Based on this finding, further research is needed in order to explore the way mentally ill people perceive their self-image through the different phases of the illness. Moreover, interventions aiming to enhance a positive self-perception through the different stages of the illness may also be useful.

Furthermore, the effect of medication towards alleviation from the symptoms of SMI was revealed as a main theme in the present meta-synthesis. Although adherence to pharmacotherapy was widely

perceived as a necessary and essential means for control of the symptoms and prevention of relapse (Liberman, Kopelowicz, Ventura, & Gutkind, 2002; Mansell, Powell, Pedley, Thomas, & Jones, 2010; McKay, 2010; Piat et al., 2009; Ridge & Ziebland, 2006; Schön, 2010; Shea, 2009), the way in which medication facilitates transformation of self-identity, and further acceptance of the limitations following SMI was not enlightened in the present study (Noiseux & Ricard, 2008; Spaniol, Wewiorski, Gagne, & Anthony, 2002). Thus, it may also be interesting to explore whether or not exists any relationship between self-perception during different phases of the illness and adherence to pharmacotherapy.

In relation to other effective means for the management of SMI it was found that spirituality and a positive relationship with religion had a major impact towards this goal. Previous studies (Makdisi et al., 2013) have described coping strategies for relieve from SMI as internal and external. Internal factors are related to one's effort for self-determination and initiatives taken for independence, such as spirituality or engagement in positive thinking. On the other hand, medication adherence (Liberman et al., 2002; Mansell et al., 2010; McKay, 2010; Piat et al., 2009; Ridge & Ziebland, 2006; Shea, 2009; Schön, 2010) and religiosity (Mizock, Russinova, & Shani, 2014), are identified as external factors.

Another main theme that was addressed in the present study involved the social consequences of SMI. The social consequences of mental illness regarded damaged family, social and romantic relationships, and were highlighted as really painful. Indeed, there are data supporting that severely mentally ill persons experience difficulty in creating and maintaining interpersonal relationships (Forrester-Jones & Barnes, 2008; Hirschfeld et al., 2005; Linz & Sturm, 2013; McCann & Clark, 2004; Nyström & Nyström, 2007; Nyström et al., 2002). The reasons for that lie not only in the pathophysiology of severe mental illness but in the stigma and labeling as well. In particular, the isolation following the symptoms of SMI may be further enlarged by the effects of stigma and labeling, which frequently lead to the loss of self-esteem (McCann & Clark, 2004; Moreira & Coelho, 2003; Sanseeha et al., 2009) and subsequently to withdrawal. However, interpersonal relationships and connectedness to others are necessary throughout a person's life, since the ability to develop and maintain interpersonal relationships is a key component of mental health (Liberman et al., 2002). Thus, recovery encompasses the capacity of creating social relationships. Indeed, the need of acceptance of mental ill people from society, together with mutual relationships, was highlighted as a precondition for recovery (Jönsson et al., 2008; Thompson et al., 2008).

Based on this, interventions aiming to social rehabilitation may need to transform their philosophy and adopt a more genuine towards social acceptance character (Drake & Whitley, 2014; Linz & Sturm, 2013; Mizock et al., 2014; Scheyett, DeLuca, & Morgan, 2013). This means that mental health care professionals need to enhance their empathic understanding and subsequently unconditional acceptance of mentally ill individuals, liberated from their preconceptions regarding mental illness (Cleary et al., 2012; Dilks et al., 2010). Indeed, there is evidence which shows that mental health care professionals, in accordance with the wider society, still hold strong stereotypes regarding mental disorders (Ben-Zeev, Young, & Corrigan, 2010; Corrigan, 2000; Schulze & Angermeyer, 2003). Nevertheless, the quality of the therapeutic relationship between mental health care professionals and patient is important for optimal clinical outcomes (Hogan & Shattell, 2007; Wheeler, 2004). Thus, strengthening this relationship, as well as lives of mentally ill individuals within society, need to be the focus of mental health care policies, including the elimination of stigma.

LIMITATIONS

Despite that this is the first meta-synthesis concerning the experience of people with severe mental illness, there are particular limitations which have to be taken under consideration. The first one

stems from the fact that the studies included were solely in English language. As a result, contradictory findings published in other languages might have not been taken into consideration. Moreover, the fact that there were included studies following all kinds of qualitative design many have caused some degree of heterogeneity in the data produced in the second order analysis. In particular, one has to mention that the aforementioned results derive from a number of studies reviewed, which followed diverse methodological approaches and consequently were influenced by various theoretical and philosophical underpinnings. Thus, one may deduce that the special theoretical and philosophical background may affect the analysis in a subtle way, and therefore the interpretation of data reviewed. For example in the study of Borg and Davidson (2008), researchers used a combination of phenomenology and participatory research. Participatory research by definition, considers participants as active members of the research team. Thus, it is not surprising that the interpretation of the data by the researchers themselves is possessed by "optimism", noting how close to "normalcy" the participants are. On the other hand, the study of Nyström et al. (2002), which seems to follow a rather psychoanalytical background, presents a more "pessimistic" approach to the interpretation of the results, or rather seems to adopt an interpretation that wants mentally ill individuals passive and unable to escape from the limitations of the illness. However, we performed second order analysis based on participants' narratives, rather than on researchers' interpretations. Thus, we proposed a novel interpretation of the reviewed data.

Another limitation is associated with the fact that the studies that were aiming to explore solely the process of recovery from SMI were not included. This may have influenced the interpretation of our data since such studies include important information regarding a vital period in the continuum of ill-health, and therefore associated with the experience of the illness. However, we decided not to include these studies because the scope of the present metanalysis was to reveal the essence of the entire experience of SMI, and not to focus on a particular phase of it. Thus, our results may be more pertinent to the acute rather than to the recovery phase of SMI.

CONCLUSIONS

The present study shed some light on different aspects of the lived experience of SMI, and identified the importance of self-identity throughout the continuum of the illness and in particular how the altered self-identity may become a means for reconciliation between the self and the demands of the illness. This issue might be the focus of targeted psychosocial interventions, aiming to alleviate experiences of suffering of the mentally ill people.

Additionally, the present findings might usefully contribute to the knowledge of health professionals working with SMI persons in order to help strengthen their empathy in relation to the SMI persons' individual needs. Furthermore, researches are required to learn more about both sexes needs, whilst future studies aiming to synthesize qualitative data solely on the subject of recovery from SMI may be of great interest providing insight to the main themes of this particular period during the illness.

Abbreviations

CASP	Critical Appraisal Skills Programme
DSM	Diagnostic and Statistical Manual of Mental Disorders
SMI	Severe mental Illness

COMPETING INTERESTS

Authors declare that there are no conflicts of interest.

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