Article

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Socio-Educational Involvement of Families in the Leisure Time of Individuals With Severe Mental Disorders: The Perceptions of Professionals

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Abstract

Background: Leisure practices that involve satisfying experiences and meaningful moments contribute to human development and enable individuals to discover interests, fulfill needs, and promote personal well-being. However, certain social groups may have difficulty in engaging in rewarding leisure activities. For people with severe mental disorder (SMD), leisure activities considered valuable require specific forms of support to ensure meaningful experiences.

Methods: The aim of this article is to examine family involvement in leisure activities of individuals with SMD from the perspective of professionals. An open-ended, online questionnaire was administered to 29 participants from various rehabilitation services in the Community of Madrid, Spain, as well as family associations involved in the recovery process of individuals with SMD. Data were examined using an inductive thematic analysis informed by open and axial coding procedures.

Results: Family involvement in valuable leisure activities for people with SMD remains low, despite these activities being highlighted as a socio-emotional need for this group. Professionals indicated that low levels of involvement are the result of socioeconomic, family-related, or symptom-related factors associated with this population.

Conclusions: Strategies are needed to facilitate and promote greater family involvement and participation in leisure activities for people with SMD.

Keywords

mental health; mental disorder; leisure; free time; family support

Introduction

Leisure is one of the many ways human beings manifest and express themselves, as it allows them to engage in practices that offer meaningful experiences and moments [1,2]. Valuable leisure is understood as the scientific evolution of humanistic leisure and consists of activities with positive value for people and communities, which recognize the importance of satisfying experiences and their potential for social development [3]. According to Iso-Ashola and Baumeister [4], leisure encompasses recreational, creative, and solidarity-based dimensions and is grounded in freedom of choice, personal satisfaction, and autotelism [5]. Furthermore, as it is associated with quality of life, leisure should be adapted to individual interests [6].

In today's society, shaped by liquid modernity [7], the changing nature of social life has made the appropriate use of leisure time increasingly important from a socio-educational perspective [8–11]. In this context, leisure should foster social inclusion and respond to the needs of particularly vulnerable groups, including people with severe mental disorder (SMD).

For individuals with SMD, leisure activities acquire particular relevance, as they contribute to reducing anxiety and improving stress management [12]. This is highlighted by the Asociación Vizcaína de Familiares y Personas con

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Enfermedad Mental [13] in its report Leisure and mental health: Projecting the future, which emphasizes the impact of these activities on the development of social and relational skills, as well as on the creation of opportunities for social participation for people with SMD.

From an international perspective, studies such as those by Bian and Xiang [14] and Iwasaki *et al*. [15] demonstrate that participation in leisure activities helps people with SMD alleviate psychiatric symptoms, lead more active and participatory lives, and reduce boredom. Similarly, Fortune and Leighton [16] argue that leisure plays a rehabilitative role by contributing to psychiatric stability, helping to overcome isolation, and facilitating normalized integration into the community environment. Likewise, Dubreucq *et al*. [17] reported that leisure can challenge the notion that mental illness is inherently disabling or degenerative; a perception that may hinder the development of rehabilitation pathways that seek to promote autonomy and the assumption of responsibilities.

Indeed, social networks of people with SMD constitute a fundamental element in enabling participation in rewarding activities and making appropriate use of free and leisure time [18]. Families are key agents in the recovery process, supporting individuals in their daily lives and playing an essential role in fostering and optimizing these processes [19]. They are often the primary source of support for people with SMD, offering emotional support, guidance, and assistance across multiple areas of daily life, particularly in situations of greater vulnerability. Their involvement contributes significantly to the individual's well-being by promoting stability and providing emotional support [20]. This is especially relevant because living with SMD may also foster strengths, learning experiences, and adaptation processes among family members [21]. In some cases, however, prior intervention is necessary to identify specific tools and strategies that foster more adaptive family dynamics and ensure that this process of support and learning is meaningful. Despite the importance attributed in the literature to both leisure and the role of families in recovery processes, scientific evidence regarding family involvement in the leisure activities of people with SMD remains limited. Furthermore, few studies have examined this issue from the perspective of professionals working in psychosocial rehabilitation settings, thus highlighting the need for further research in this field.

Materials and Methods

Participants

A total of 29 participants were recruited using intentional non-probabilistic sampling from psychosocial rehabilitation services and family associations involved in the recovery process of people with SMD in the Community of Madrid. The aim of the study was to examine family involvement in the leisure activities of people with SMD from the perspective of professionals. For the purposes of this study, SMD was understood as a long-term mental health condition associated with significant functional impairment requiring sustained psychosocial and/or clinical support [22]. Informants were selected based on their ongoing contact with people with SMD and their families throughout different rehabilitation processes. This experience provided them with a broad understanding of family dynamics and of factors that facilitate or hinder family participation in leisure activities.

The sample was intentionally composed of participants with direct knowledge of the rehabilitation and support processes of people with SMD. Nevertheless, it should be noted that most participants were professionals from various types of services and with different professional profiles. This heterogeneity was considered analytically valuable because it allowed the study to capture diverse perspectives on family involvement in leisure activities. However, it may also have influenced the interpretation of the data, since the findings mainly reflect professional and institutional viewpoints rather than the direct voices of people with SMD or their relatives. Therefore, the results should be interpreted as an exploratory approximation to the phenomenon grounded primarily in the perspectives of professionals working in psychosocial rehabilitation contexts.

Instruments

An ad hoc questionnaire structured into two sections was used. The first section collected sociodemographic data, while the second section addressed the subject of the study. Five expert assessors, all university lecturers with extensive research experience working with people with SMD, validated the instrument. To strengthen the reliability of the ad hoc questionnaire, the items were reviewed by the expert panel to ensure their clarity, representativeness, and relevance to the study. Items were revised according to the experts' assessments before final administration. To measure assessor agreement, the content validity index (CVI) was used and the degree of consensus for each item was calculated mathematically. Items with a CVI $\leq$ 0.99 were

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discarded. Of the 15 initial items, 2 were removed as they had a CVI = 0.71.

The final structure of the questionnaire is as follows:

1. Sociodemographic data (6 items): gender; age; work context; if applicable, what type of psychosocial rehabilitation resource; professional category; and years of experience.

2. Family involvement in the leisure activities of people with SMD (7 items):

Open-ended questions

a. Do you think the level of family involvement in the leisure activities of people with SMD is appropriate for the needs of the users of the resource or association where you work.

b. How often does the person with SMD take part in leisure activities together with their family.

c. What sort of leisure activities does the person with SMD take part in together with their family.

d. Are leisure activities mutually agreed upon by the person with SMD and their family.

e. Which family member or members are most involved in sharing leisure activities with the person with SMD.

f. What factors do you think influence the degree of participation in shared leisure activities between the family and the person with SMD.

g. What role do professionals and rehabilitation services/associations play in promoting leisure activities between the family and the person with SMD.

Procedure

A group of potential participants was initially selected. After being informed about the objectives of the research, they were invited to participate voluntarily. The confidentiality of the responses was guaranteed in accordance with the principles and protocols established by the Declaration of Helsinki (64th World Medical Association General Assembly, Brazil, October 2013).

Following approval by the Ethics Committee of the Spanish National University of Distance Education (UNED) (Reference: 15-SISH-EDU-2024), the instrument was administered individually in digital format to each participant from January 2025 to June 2025. Participants completed an online questionnaire developed through Google Forms, which included the items outlined in the survey instrument. Before given access to the questionnaire, participants received information about the study aims, confidentiality, voluntary participation, and data protection. Informed consent was obtained electronically from all participants before completing the questionnaire.

Following the data collection phase, responses were coded, organized, and analyzed. The resulting database was securely safeguarded by the study authors.

Data Analysis

This qualitative study employed an inductive thematic analysis informed by analytical procedures commonly associated with grounded theory [23]. Given the exploratory nature of the study and the specific characteristics of the data, the aim was not to develop a formal substantive theory. Instead, the analysis sought to identify and organize the primary meanings emerging from participants' responses regarding family involvement in the leisure activities of individuals with SMD. Therefore, the methodological approach is most accurately described as an inductive qualitative analysis supported by open and axial coding procedures [24].

The analysis was conducted in several stages. First, all responses were read in full in order to become familiar with the content and identify preliminary meanings. Second, open coding was performed by segmenting responses into meaningful textual units and assigning initial descriptive labels to them. Third, codes with conceptual proximity were compared and grouped into broader categories. Fourth, an axial coding process was conducted to explore relationships between codes and subcodes, particularly those referring to the level of family involvement, the family figures involved, the importance people with SMD attribute to leisure, consensus in decision-making, frequency of shared leisure activities, types of activities, and factors facilitating or limiting participation.

Two members of the research team performed the coding process. After an initial independent coding phase, the researchers compared the codes assigned to the textual units and discussed discrepancies until consensus was reached. When disagreements arose, they were resolved through discussion and by returning to the original responses to preserve the meaning expressed by the participants. Although no formal inter-coder agreement coefficient was calculated,

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Table 1. Codes and subcodes derived from data analysis.

Codes	Subcodes
Family involvement in leisure activities of people with SMD	Level of involvement
	People involved
	Importance for the person involved
	Consensus and promotion of leisure activities
Participation in leisure activities of family members and people with SMD	Frequency
	Types of activities
	Factors influencing shared leisure participation

SMD, severe mental disorder.

researcher triangulation was used throughout the analytical process to enhance the consistency and credibility of the interpretation.

As a result, a system comprising two main codes and seven subcodes was identified. The system aligned with the research objective and enabled the analysis of the questionnaire responses (see Table 1). The coding system was refined progressively during the analysis until no new relevant categories emerged from the available material. This was interpreted as thematic saturation within the limits of the sample and the data collection strategy. However, given the small sample size and the predominance of professional participants, saturation should be understood cautiously and in relation to the specific analytical objective of this study. Data processing was carried out using MAXQDA Analytics Pro 2024 software (Windows 10 version, VERBI, Berlin, Germany).

The codes were analyzed to identify any relationships. A relational map was created using the MAXMaps tool in MAXQDA Analytics Pro 2024 software (Windows 10). The model showed the relationships between the sub-codes through shared textual units.

Results

Sample Characteristics

A total of 29 individuals participated in the study. Of these, 62.1% ($n = 18$) were women and 37.9% ($n = 11$) were men. Participants ranged from 20 to 52 years of age ($M = 36.43$; $SD = 8.81$).

Of the 29 participants, 26 were professionals working in rehabilitation services for people with SMD, while three were involved through family support organizations. Mean professional experience was 10.59 years ($SD = 4.42$). The professional characteristics of the 26 participants who worked in rehabilitation services for people with SMD are shown in Table 2.

Distribution of Citations and Relationship Between Codes and Subcodes

A total of 241 excerpts were collected. Table 3 shows the distribution of the excerpts.

As regards the relationship between the codes and subcodes that emerged from the data analysis, Fig. 1 presents a relational map based on the information processed within the code and sub-code system. The relationships are represented by arrows. The direction of the arrows indicates the influence between codes and sub-codes, as described in the testimonies. The thickness of the arrows reflects the number of textual units referring to each relationship.

Analysis by Codes and Sub-Codes

Family Involvement in Leisure Activities of People With SMD

The code uses different factors to reflect the dynamics of family involvement in the leisure activities of people with SMD.

Level of Involvement: This subcode compiled 29 testimonies indicating the level of family involvement in leisure activities for people with SMD and how well these activities met the needs of these service users. Most participants (75.9%; $n = 22$) reported low family involvement in leisure activities. Half of the statements referred to factors influencing this lack of involvement. For example, these included "a lack of understanding of the condition," "the strain involved in caring for a person with SMD," or the limited importance families attach to leisure, as suggested by the following educator: "There are still protective tendencies that do not regard leisure as being an essential and fundamental element."

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Table 2. Professional characteristics of the sample subgroup of professionals.

Professional characteristics	Distribution
Type of service	Small nursing care homes [53.9%; *n* = 14]
	Community social support teams [26.9%; *n* = 7]
	Day centers [11.4%; *n* = 3]
	Psychosocial rehabilitation centers [3.9%; *n* = 1]
	Vocational rehabilitation centers [3.9%; *n* = 1]
Professional role	Educator [46.2%; *n* = 12]
	Psychologist [30.7%; *n* = 8]
	Held management or coordination positions [15.3%; *n* = 4]
	Occupational therapist [3.9%; *n* = 1]
	Social worker [3.9%; *n* = 1]

Table 3. Distribution of textual units by codes and sub-codes.

Codes	Subcodes
Family involvement in leisure activities of people with SMD [55.6%; *N* = 134]	Level of involvement [21.6%; *n* = 29]
	Figures involved [22.4%; *n* = 30]
	Importance for the person involved [22.4%; *n* = 30]
	Consensus and promotion of leisure activities [33.6%; *n* = 45]
Participation in leisure activities of family members and people with SMD [44.4%; *N* = 107]	Frequency [27.1%; *n* = 29]
	Type of activity [27.1%; *n* = 29]
	Factors influencing shared participation in leisure [45.8%; *n* = 49]

SMD, severe mental disorder.

Conflictual family relationships or family breakdown were other prominent causes. These barriers can be exacerbated by economic factors, as reflected in the following statement: "Furthermore, if these leisure activities involve a financial cost and depend on the families, the lack of involvement becomes even more pronounced." The advanced age of many service users' families was another factor contributing to the perception of low family involvement: "The average age of our residents is 55, which means that their main family references, primarily parents, are very elderly (around 80 years old)."

However, not all testimonies identified causes related to the family–service user relationship. Two statements indicated that the services themselves consider it appropriate to limit joint leisure activities, as reflected by the following coordinator: "The service does not usually promote family participation in leisure activities, except on specific occasions such as celebrations or birthdays."

A total of 17.2% (*n* = 5) of the statements indicated that there was such a high degree of heterogeneity that it was difficult for them to have a clear opinion, as reflected by this educator:

> It depends. There are families who are involved and engage in leisure activities together. There are service users who, despite having a good family relationship and being willing, prefer to engage in leisure activities individually. It doesn't depend so much on the service, but rather on the individual, the family, and the relationship between them.

Finally, 6.9% (*n* = 2) considered the level of family involvement to be high.

The people involved: Thirty statements related to family involvement in shared leisure activities were identified in the subcode. Most (63.3%; *n* = 19) referred to the immediate family as the core unit of support, without designating a specific individual. Notably, six statements excluded the father from this involvement, while four referred exclusively to the parents. A total of 20% (*n* = 6) suggested that siblings show the greatest involvement due to their proximity in age, as reflected in the following testimony: "Our current reality is that it is the brothers and sisters who most encourage service users to engage in activities, mainly due to their closer age and vitality, according to what they report." The mother followed as the next most frequent figure at 16.7% (*n* = 5).

Importance for the person involved: Under this subcode, 30 references described the degree of importance the person with SMD attributes to engaging in leisure activities

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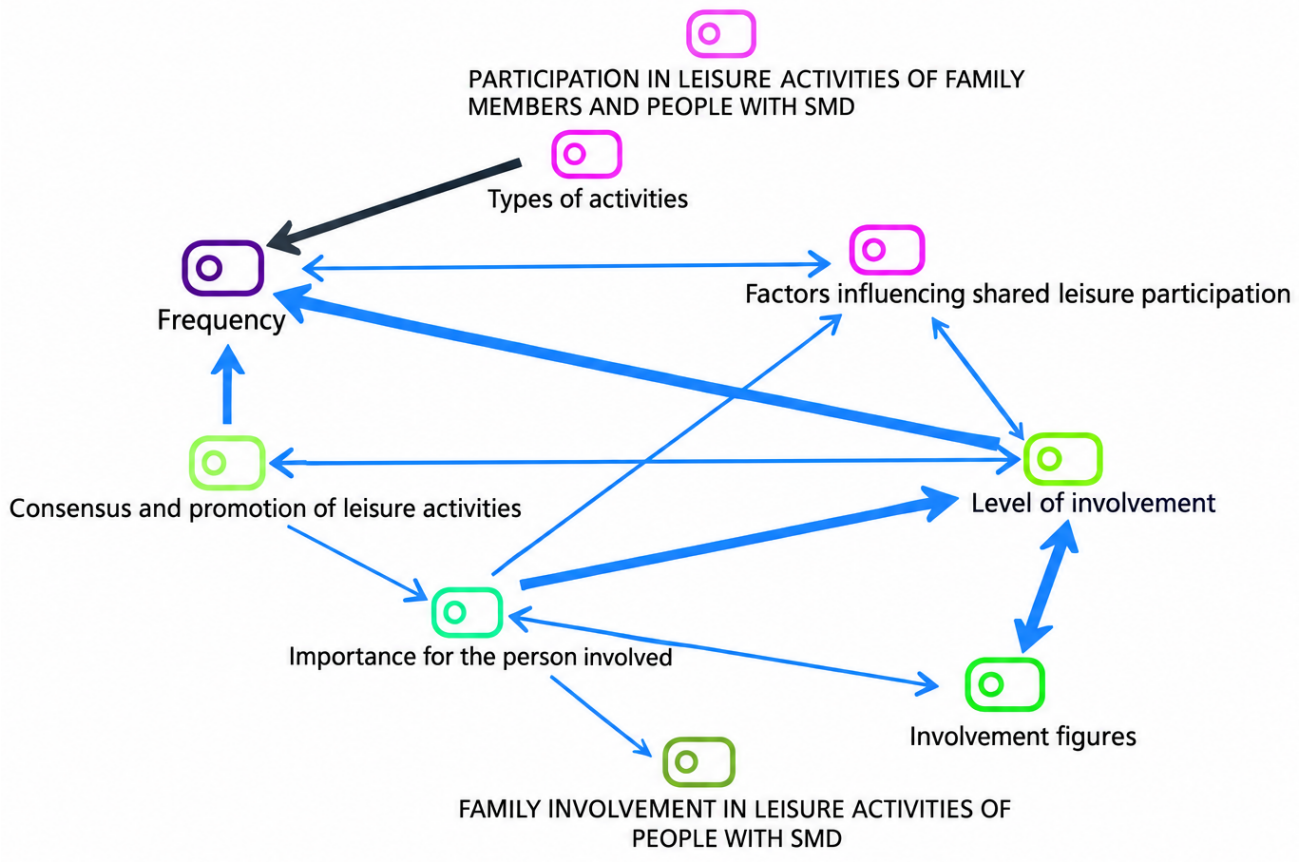


Fig. 1. Codes and subcodes co-occurrence map. Note: Map generated by the authors in MAXQDA Analytics Pro 2024 based on responses of the professionals.

with their family. Of these, 46.7% (n = 14) indicated that service users needed family involvement in their leisure activities, as the following statement indicates: "It matters to them a great deal; some express it explicitly and others implicitly, but they seem to miss connecting with their family through leisure."

The positive effect that family acceptance has on their self-esteem was the most frequently highlighted factor motivating this need, as reflected in the following statement by a psychologist:

> They attach great importance to it, since leisure takes place in relaxed environments, and being able to enjoy leisure time with the family is very important. Self-esteem and self-love are closely related to inclusion within the family and a sense of belonging.

However, the relevance service users attributed to family involvement in their leisure activities was not unconditional, as four of the verbal segments linked it to having a stable and positive relationship with their family. A third of responses reflected considerable variability among users and could therefore not make a firm statement.

Finally, 23.3% (n = 7) believed service users do not attach much importance to family involvement in their leisure activities. They noted that shared free-time spaces with family tend to focus more on maintaining a necessary interpersonal relationship rather than being mediated by a specific leisure activity. For the latter, users rely more on peers within the services themselves or engage in leisure individually, as illustrated in the following statement:

> They prefer to engage in leisure activities individually or with other peers, and even in mainstream community settings. To spend leisure time with their family, they choose activities such as going for a walk or having a drink, which they consider very important for developing interpersonal relationships in other contexts that support their coexistence.

Consensus and promotion of leisure activities: This subcode included 45 units of analysis, making it possible to identify the degree of consensus between family members and patients with SMD regarding leisure activities and self-

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management.

As concerns the degree of consensus, most of the 25 references (72%; *n* = 18) stated that there was no or very low consensus on decisions about engaging in joint leisure activities. All of these statements emphasized that it is the family who decides on and plans the activities. According to the participants who included a reason in their response, this was due to the difficulties that service users have in taking initiative, as illustrated in the following testimony:

> It [the activity] is chosen by the family. The people with SMD at my center do not have the initiative to propose leisure activities or even stick to their daily routine and they find it difficult to engage in activities outside of it.

The other reason cited was family imposition without considering the person's symptomatic state or personal interest: "On the other hand, there is the imposition by relatives who, in events such as a baptism, demand the family member's presence despite the person with SMD not wanting to attend." Conversely, 8% (*n* = 2) of statements showed a high degree of consensus. Finally, 20% (*n* = 5) considered that there was so much variability across cases that they could not provide a firm response as to the existence of consensus in planning joint leisure activities.

The remaining 20 statements in this subcode addressed the promotion of leisure self-management among individuals with SMD. Of these, 75% (*n* = 15) indicated that independent leisure was seldom promoted, with leisure responsibilities being delegated to specialized services or external organizations. As one educator noted: "In general, very little; they tend to delegate it more to services and associations rather than encouraging the person to seek out their own leisure activities." In contrast, 25% (*n* = 5) indicated that families actively support the individuals' leisure self-management.

Participation in Leisure Activities by Family Members and Individuals With SMD

Frequency: A total of 29 responses described how often individuals with SMD and their families participate in leisure activities together. A total of 37.9% (*n* = 11) of respondents indicated infrequent participation only on special occasions or at events such as Christmas holidays or birthdays once every three months or never in some cases. Other respondents (13.9%; *n* = 4) of participants reported a monthly frequency, with one or two joint activities per month. A further 24.1% (*n* = 7) indicated a high frequency or weekly activities, although family involvement was highlighted as a determining factor in this higher frequency. Finally, 24.1% (*n* = 7) stated that it was not possible to establish a general frequency due to the heterogeneity of the cases.

Types of activities: A large proportion of the 29 accounts in this sub-code (65.5%; *n* = 19) described activities that were not open to wider social contexts, were routine-based, and lacked any recreational, cultural, social, or sporting component. As one participant put it, "The most common activities I have experienced were non-productive; ones like going for walks, visiting Madrid's basic cultural offerings (many services), and the occasional workshop linked to community groups and local initiatives." These activities mostly consisted of taking short walks near the care home, going shopping for items the service user needed, spending a few hours at the family home, having a drink in a café near the care home, or going out for a meal.

Seven analysis units considered that families undertook a wider range of activities, such as visits to exhibitions, sporting activities, short trips, excursions, etc. However, as a teacher pointed out, these types of activities were organized far too often: "Celebrating holidays. Family birthdays. Going out for lunch or dinner with the family. Rarely any leisure activities or cultural outings such as going to the theatre, cinema, museums, etc." Finally, 10.4% (*n* = 3) stated that the only leisure activities families and service users did together were held in the care homes themselves.

Factors influencing shared leisure participation: Across 49 responses, participants highlighted the multiple factors driving greater or lesser participation in shared leisure activities between family members and people with SMD.

The most frequently mentioned factors were related to family dynamics and circumstances (46.9%; *n* = 23). Aspects such as family burden, breakdown of ties, or dysfunctional family structures predisposed lower involvement and participation in the leisure activities of people with SMD.

A generational imbalance and lack of knowledge about family members' leisure activities due to particular living arrangements or household composition were also noted, as stated by this psychologist:

> The longer a person has been disconnected from the leisure opportunities available in their environment or from the leisure activities practiced by their family, the more difficult it will be for them to resume them, and for their family to motivate them to do so. The generational gap present in some families also influ-

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ences tastes and preferences when it comes to enjoying leisure and free time.

One participant stated that greater involvement or motivation is usually perceived when the family presents the following characteristics: "a good relationship, paternalism, feelings of guilt, not wanting them to feel abandoned in the supported residences, wanting to help their family member, recovering pleasant moments together as a family (…)."

Individual characteristics specific to service users (14.3%; n = 7) and socioeconomic factors (14.3%; n = 7) were the second most frequently mentioned factors. As for the first, five testimonies highlighted that service users' symptomatology was a determining element, while the two remaining testimonies referred to the importance service users attach to meaningful leisure activities. Lack of family involvement, without specifying its origin, was the fourth most frequently mentioned factor (10.2%; n = 5).

Another aspect, mentioned in 8.2% (n = 4) of the statements, was the stigmatization of these individuals. This may make families reluctant to try out new activities or expose the family member to diverse social contexts, especially if they have previously had negative experiences, as reflected in the following testimony:

> Family members experience such stigma that they aren't able to accompany their relative to engage in "mainstream" activities; they don't share leisure time with their relative and others. They may be "afraid" of certain behaviors their relative might display, or they may think that the person does not need leisure activities simply because they have SMD.

Finally, other factors have also been suggested to influence the degree of family involvement in leisure activities with people with SMD: availability of time (4.1%; n = 2), and the lack of appropriate programs (n = 1).

Discussion

Professionals' testimonies indicate that, in general, family involvement in the leisure activities of people with SMD does not adequately meet service users' needs. Nevertheless, when the relationship is positive, individuals attach great importance to these encounters, highlighting benefits that impact their symptomatology, self-esteem, and the strengthening of their bonds. These findings are consistent with studies conducted by [25], which have shown that meaningful leisure experiences exert a positive impact on people living with mental illness. Additionally, along the same lines, leisure experiences are emphasized as tools for promoting a more active life among people with SMD, where leisure serves as a means of coping with stress and boredom and of reducing other psychiatric symptoms [26,27].

According to the testimonies of professionals, individuals with SMD and their families infrequently engage in shared leisure activities, with these encounters tending to occur only on specific occasions, such as holidays or special celebrations. This may be influenced by contemporary lifestyles characterized by what Giurge *et al*. [28] define as "time poverty" or the feeling of having too much to do and too little time to do it. As these authors note, the phenomenon has become commonplace in contemporary life and affects individuals' well-being, health, social engagement, and both the quantity and quality of time available for leisure [29]. Furthermore, symptomatology associated with SMD and family burden are factors that may hinder these encounters, as aspects such as social isolation, lack of motivation, and difficulties in taking initiative can negatively affect participation in leisure activities [30]. Nevertheless, this situation should also be interpreted in light of the circumstances many families face as they find themselves having to cope with significant emotional, organizational, and caregiving demands. Therefore, the lower frequency of shared leisure activities does not necessarily reflect a lack of family involvement, but rather a complex reality shaped by the needs and limitations experienced by both parties.

The advanced age of many service users' family members constitutes another factor contributing to the perception of low involvement in leisure activities. Scientific literature has linked age, among other factors, to the quality of family leisure, indicating that psychophysical condition and intergenerational distance influence both the types of activities carried out together and the time and space devoted to them. From this perspective, the lower level of participation observed should also be understood as a result of limitations associated with the ageing process, rather than solely as a lack of family involvement, thereby helping to better contextualize and understand this reality [31].

Regarding leisure between service users and their families, the participating professionals describe them as basic or routine activities (short walks, spending a few hours at home, family meals, eating out at a restaurant, etc.) that are primarily shared with mothers or siblings. Although these activities may appear to be of limited significance, they can form part of what is known as therapeutic leisure [32]. This type of leisure aims to support rehabilitation and strengthen

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bonds with the immediate environment, thus maintaining the social support network that plays a key role in recovery [33,34].

As for leisure self-management by families so that individuals with mental illness can participate in other settings and with people outside the family context, professionals generally report a lack of concern regarding this issue, as these responsibilities are usually delegated to services or associations. One possible explanation may be families' trust in psychosocial rehabilitation professionals, who are assumed to be better equipped to address each user's specific needs.

Finally, two professionals indicated in their testimonies that the services and leisure activities these individuals are provided do not encourage family participation, except on very specific occasions. This underlines the role of professionals in creating spaces and moments that can enhance one of the most valuable characteristics of family leisure: its potential for improvement through educational interventions [35,36]. Indeed, families, professionals, and researchers must understand leisure as a socio-educational tool of action that can help transform the social reality of people facing greater difficulties and, in turn, promote their autonomy and community participation [12].

The sample intentionally included participants with direct knowledge of the rehabilitation and support processes of people with SMD. Although the diversity of services and professional profiles allowed collecting different perspectives on family involvement in leisure activities, the findings mainly reflect professional and institutional viewpoints rather than the direct experiences of people with SMD or their relatives. In addition, the use of an online, open-ended questionnaire may have limited the depth and richness of the information obtained, potentially affecting data saturation. It may have also prevented direct interaction between researchers and participants to clarify responses or ask follow-up questions. Therefore, the findings should be interpreted as an exploratory approach to the phenomenon from the perspective of professionals working in psychosocial rehabilitation settings.

Conclusions

From the perspective of professionals in the field, the results indicate a limited level of family involvement in the leisure activities of people with SMD, which is further conditioned by factors such as family burden, symptomatology, economic difficulties, stigma, and the advanced age of relatives. This situation reduces opportunities for shared leisure experiences and underlines the need to promote socio-educational interventions that support families, foster the autonomy of people with SMD, and create accessible spaces for participation and social inclusion.

Availability of Data and Materials

The datasets generated for this study are available on request to the corresponding author.

Author Contributions

DGC, ÁDJO and FJGC coordinated the project; DGC set up the database; JDE completed the qualitative analysis. The four authors wrote the initial version of the article. DGC and FJGC prepared the Introduction and Theoretical Framework; DGC and ÁDJO drafted the Discussion Section. All authors read and approved the final manuscript. All authors have participated sufficiently in the work and agreed to be accountable for all aspects of the work

Ethics Approval and Consent to Participate

The study was conducted in accordance with the Declaration of Helsinki and approved by the ethics committee of the National University of Distance Education under reference 15-SISH-EDU-2024. Informed consent was obtained from all subjects involved in the study.

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Conflict of Interest

The authors declare that the research was performed without any commercial or financial relationships that could be interpreted as potential conflict of interest.

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