

# **Mental health recovery narratives and their impact on recipients: systematic review and narrative synthesis**

Stefan Rennick-Egglestone <sup>a\*</sup>, Kate Morgan <sup>a</sup>, Joy Llewellyn-Beardsley <sup>a</sup>, Amy Ramsay <sup>b</sup>, Rose McGranahan <sup>c</sup>, Steve Gillard <sup>d</sup>, Ada Hui <sup>a</sup>, Fiona Ng <sup>a</sup>, Justine Schneider <sup>e</sup>, Susie Booth <sup>f</sup>, Vanessa Pinfold <sup>g</sup>, Larry Davidson <sup>h</sup>, Donna Franklin <sup>f</sup>, Simon Bradstreet <sup>i</sup>, Simone Arbour <sup>j</sup>, Mike Slade <sup>a</sup>

<sup>a</sup> School of Health Sciences, Institute of Mental Health, University of Nottingham

<sup>b</sup> Health Service and Population Research Department, Institute of Psychiatry, Psychology and Neuroscience, King's College London

<sup>c</sup> Unit of Social and Community Psychiatry, Blizard Institute, Barts and the London School of Medicine and Dentistry, Queen Mary University of London

<sup>d</sup> Population Health Research Institute, St. George's University of London

<sup>e</sup> School of Sociology and Social Policy, University of Nottingham

<sup>f</sup> NEON Lived Experience Advisory Panel

<sup>g</sup> McPin Foundation

<sup>h</sup> Yale School of Medicine, Yale University

<sup>i</sup> Institute of Health and Wellbeing, University of Glasgow

<sup>j</sup> Ontario Shores Centre for Mental Health Science

\* Rennick-Egglestone is the corresponding author.

Institute of Mental Health, Triumph Road, Nottingham, NG7 2TU, United Kingdom.

[stefan.egglestone@nottingham.ac.uk](mailto:stefan.egglestone@nottingham.ac.uk) +44 115 30926

## **Abstract**

**Objective.** Mental health recovery narratives are often shared in peer support work and anti-stigma campaigns. Internet technology provides access to an almost unlimited number of narratives, and yet little is known about how they impact on recipients. The aim of this study was to develop a conceptual framework characterising the impact of recovery narratives on recipients.

**Method.** A systematic review of evidence about the impact of mental health recovery narratives was conducted. Searches used electronic databases (n=9), reference tracking, hand-searching of selected journals (n=2), grey literature searching and expert consultation (n=7). A conceptual framework was generated through a thematic analysis of included papers, augmented by consultation with a Lived Experience Advisory Panel.

**Results.** 8,137 articles were screened. Five papers were included. Forms of impact were: Connectedness; Understanding of recovery; Reduction in stigma; Validation of personal experience; Affective responses. Behavioural responses. Impact is moderated by characteristics of the recipient, context and narrative. Increases in eating disorder behaviours was identified as a harmful response specific to recipients with eating disorders.

**Conclusions.** Mental health recovery narratives can promote recovery. Recovery narratives might be useful for clients with limited access to peers, and in on-line interventions targeted at reducing social isolation in rural or remote locations, but support is needed for the processing of the strong emotions which can arise. Caution is needed for use with specific clinical populations.

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**Keywords.** Mental health; Recovery narratives; Recovery stories; Memoirs; Impact

## Introduction

Mental health recovery narratives are first-person accounts of recovery from mental health problems which refer to events or actions over a period of time.<sup>1</sup> They are referred to as 'recovery narratives' throughout the remainder of this paper, whilst recognising that this term is used elsewhere in healthcare research and practice, e.g. in narratives of recovery post-stroke.<sup>2</sup>

Recovery narratives can be live (given in the context of a real-world or online relationship) or recorded (presented in invariant text, video or audio). Live recovery narratives feature in peer work, where professional training typically encourages the selective disclosure of personal experiences, as part of an ongoing relationship with a client. A USA national survey has identified helping others through the narrating of recovery narratives as a feature of the work of peer specialists,<sup>3</sup> and Davidson, et al. <sup>4</sup> have argued that the disclosure by a peer worker of their own transition to a "hero of their own self-journey" (p.124) can instil hope in others.

Substantial numbers of recovery narratives are publicly available, distributed through books<sup>5,6</sup>, on-line collections<sup>7</sup> and digital media hosting services.<sup>8</sup> Creating narratives can provide benefits for narrators,<sup>9</sup> who might be motivated by sending messages of "hope, courage and survival" (p. 68),<sup>10</sup> a form of indirect emotional support provision.<sup>11</sup> Campaigns which aim to reduce stigma<sup>12,13</sup>, such as Bell Let's Talk<sup>14</sup>, have used recorded recovery narratives<sup>15</sup> as a mechanism for creating social contact<sup>16,17</sup> between people with experience of mental health problems and others. Narratives used for anti-stigma purposes can also have a beneficial impact on help-seeking behaviour,<sup>18</sup> and organisations such as Here to Help<sup>19</sup> and the Scottish Recovery Network<sup>20</sup> have created on-line collections with the explicit intent of supporting recovery in recipients. These might be seen as a specific initiatives within a larger effort to incorporate information and communication technologies into mental health practice, motivated by challenges

such as limited access to in-person mental health treatment in rural<sup>21,22</sup> and First Nations<sup>23</sup> communities, and for people with social anxiety disorders.<sup>24</sup>

Despite widespread interest, a knowledge gap exists about how live and recorded recovery narratives make an impact. No systematic review has been conducted on this topic. A realist review considered the broader question of how sharing experiences of health conditions on the Internet might affect the health of those sharing and receiving material; it identified mechanisms such as (1) the recipient finding useful information in the experiences of others with similar health difficulties, or (2) feeling supported through an understanding that others have encountered and overcome related challenges.<sup>25</sup> This review drew on a range of empirical and non-empirical sources. Its authors note a need to strengthen the scientific evidence base, given an “*explosion of web resources that feature experiences posted by patients themselves*” (p. 219). The authors note that receiving experiences had the potential for positive and negative impact.

Other studies have identified specific harms that can be associated with receiving on-line health material, especially in the case of conditions that are isolating or stigmatised.<sup>26</sup> Examples include “pro-ana” websites, which enable on-line inter-person interaction that sustains anorexic behaviours and beliefs.<sup>26</sup> An experimental study of 235 female undergraduates showed that viewing a pro-anorexia website increased negative affect and lowered social self-esteem relative to a comparison website.<sup>27</sup> A qualitative study demonstrated that pro-anorexia sites can sustain anorexic behaviour by enabling the sharing of hints and tips.<sup>28</sup> Neither study was specific to narratives, but included websites utilising narrative material.

Mental health recovery narratives are becoming more widely available, so an evidence-based understanding of how they make an impact on recipients is needed, especially given known harms associated with on-line health material. The aim of this review was to develop a conceptual framework characterising the impact of live or recorded recovery narratives on recipients.

## Method

A systematic review of documents providing empirical evidence for the impact of recovery narratives on recipients was conducted. The systematic review protocol was registered:

[http://www.crd.york.ac.uk/PROSPERO/display\\_record.php?ID=CRD42018090923](http://www.crd.york.ac.uk/PROSPERO/display_record.php?ID=CRD42018090923).

Recovery narratives were defined as first-person non-fiction accounts of recovery from mental health problems, including (1) elements of adversity/struggle and (2) self-defined strengths/successes/survival, and which (3) refer to events or actions over a period of time.<sup>1</sup>

“Receiving a narrative” was defined as viewing, reading or listening to someone else’s recovery narrative. “Impact” was defined as the processes by which receiving recovery narratives causes benefits or harms to the recipient and the outcomes generated by these.

Inclusion criteria: (1) presents empirical research, with at least five participants as recipients of recovery narratives; (2) presents evidence relating to the impact of recovery narratives on participants, including evidence of no impact; (3) draws on non-fictional narratives with a clear mental health and recovery component; (4) the full text of the publication was available in English.

Exclusion criteria: (1) narratives were told second-hand, e.g. by a healthcare professional or carer (2) narrative were a component of a complex intervention and it was not clear whether the impact was due to the narrative or to other components of the intervention. The latter was included due to scoping searches locating papers in which recovery narratives were just one part of a multi-component intervention evaluated as a whole, and where the impact of individual components could not be disambiguated. An example was a two-component anti-stigma campaign<sup>29</sup> which utilised recovery narratives and educational workshops.

## *Search strategy*

### **Electronic databases**

Research into recovery narratives is multidisciplinary, and hence searches were conducted across a broad range of publication databases. Selection was informed by scoping searches. Selected databases were: AMED, EMBASE, MEDLINE, PSYCINFO (all via OVID). ASSIA, MLA, PILOTS, CINAHL, Web of Science. To avoid a risk of omitting relevant material, scoping searches identified a range of terms that might be loosely synonymous for “recovery narrative”, including “memoirs” and “autobiographies”.

Database search terms were piloted and then defined against AMED (via OVID), to generate a reference search strategy presented in the digital supplement. This was specialised to each database. Publications were included from inception until 31 August 2018.

Publications were filtered by title and abstract by KM, with concordance checking by SRE on a sample of 10% of titles and 20% of abstracts. Concordance was 96% for title filtering, and 95% for abstract filtering. Remaining papers were retrieved. Inclusion was decided by KM and SRE, with disagreements resolved by discussion with other authors. If a candidate publication did not use the term “recovery narrative”, it was included if definitive evidence could be assembled from the abstract or full text that the narratives it considered were recovery narratives. This involved inspecting specific narratives listed in publications for mental health and recovery content.

### **Hand searching of journals**

The two journals containing papers included through database searches (*Advances in Eating Disorders: Theory, Research and Practice* and *Journal of Nervous and Mental Disease*) were hand-searched from inception to 31 August 2018.

### **Grey literature searching**

Google and Google Scholar were searched using the terms “Impact of mental health recovery narratives” and “Impact of mental health recovery stories”. The first 100 hits were hand-searched.

### **Expert consultation**

Seven researchers with expertise in mental health recovery were sent the list of included papers and asked to identify additional candidates for inclusion.

### **Citation tracking**

References lists of all included papers and of a relevant review<sup>13</sup>, were hand-searched. Forward citation tracking of included papers and this review was conducted using Google Scholar.

### ***Data abstraction***

A data abstraction table (DAT) was designed and piloted, and is presented in the digital supplement. The DAT presents details of each included study: country of lead author, design of study, characteristics of narratives, characteristics of participants, time of impact assessment, social interaction around the narrative. It also presents knowledge about the impact of recovery narratives generated by each study, grouped by categories refined through the piloting process: form of impact, consequences of impact, facilitators to impact and barriers to impact. Included qualitative papers presented rich narrative descriptions of impact. This meant that the work of data abstraction involved producing short textual summaries of narrative descriptions. Summaries were agreed by the two lead authors, and lead by the language of the source publication.

### *Quality assessment*

Included studies were critically appraised. Results are included in the Data Abstraction Table. The Critical Appraisal Skills Programme Qualitative Checklist<sup>30</sup> was used for qualitative studies, using established thresholds to indicate high, moderate or low rated quality<sup>31</sup>. Quantitative studies were assessed using the 15-element McMaster Critical Review Form for Quantitative Studies<sup>32</sup>, with bespoke labels: high (13-15), moderate (11-12), low (0-10).

### *Narrative synthesis*

A narrative synthesis was conducted following an established methodology<sup>33</sup>. This consisted of (1) a preliminary synthesis of abstracted material on forms, consequences, facilitators and barriers to impact (2) refinement of the synthesis through discussion in a multi-disciplinary research team (3) refinement of the synthesis through consultation with a Lived Experience Advisory Panel and (4) sub-group analysis. The goal of the synthesis process was to generate a framework describing broad forms of impact, but which retained essential details of how impact occurred as presented in included papers.

The preliminary synthesis began by classifying knowledge about impact presented in the DAT as (1) transdiagnostic or (2) diagnostically specific. Example: "Feeling connected to the narrator" was classified as transdiagnostic, whilst "greater effort put into avoidance of ED behaviours" was classified as specific to an eating disorder diagnosis. Classifications were by SRE, and were reviewed by clinically-qualified authors.

A preliminary synthesis was generated by SRE, who conducted an inductive thematic analysis on items classified as transdiagnostic. Items were grouped into named themes, which were selected (1) to describe a meaningful form of impact (2) for orthogonality. Similar items grouped within a



theme were combined. To raise quality, the preliminary synthesis was discussed in a team comprising analysts from multi-professional backgrounds (mental health nursing, social psychiatry, clinical psychology, community development, design research) and including qualitative expertise. Closely related items were further combined, and names of themes and items were refined for clarity. 'Moderators' was introduced to encompass facilitators and barriers.

The updated synthesis was presented to a Lived Experience Advisory Panel (LEAP), comprising ten members with prior experience of mental health problems and of recovery. Three had published their own recovery narrative. A final version was produced based on their input. The principle change was identification of items to add existing themes to add depth. These items have been labelled as LEAP contributions to distinguish them from items sourced from included publications. During this consultation, LEAP members raised questions relevant to future research, and these are considered in the Discussion.

Items labelled as diagnostically specific to a clinical population were examined. To document forms of impact specific to that population, processes, outcomes and moderators were tabulated.

## **Results**

The PROSPERO flow diagram for this review is shown in Figure 1.

*Insert Figure 1 here*

Five papers were included (#1,#2,#3,#4,#5). Featured narratives were characterised as “recovery stories” (#1,#5), “memoirs” (#2, #3) and “lived experience videos” (#4). All narratives present in #2, #3 and #4 were inspected, and found to meet the study definition of a recovery narrative.

Key characteristics of included studies are in Table 1. Further detail is provided in the DAT.

*Insert Table 1 here*

All included papers were studies of the impact of recorded recovery narratives, and were of moderate or high quality. The single included quantitative study, #2, failed to find evidence for impact of an eating disorder memoir on participants who were female undergraduates, and not selected for membership of a clinical population. As this paper provided no evidence for impact, facilitators or barriers, then it has not informed the narrative synthesis.

The four included qualitative studies (#1, #3, #4, #5) were conducted recently. Collectively, these papers included 93 participants, 70 female and 23 male, and hence there is a clear gender bias across included qualitative research. Papers #1, #3 and #4 were conducted by research teams based in Australia, but with no overlap in authorship. #1, #3 and #4 note a lack of existing empirical evidence about the impact of recovery narratives on recipients.

Specific items were identified that provided insights into the impact of mental health recovery narratives on individuals experiencing eating disorders, and a subgroup analysis was conducted on these. Despite the inclusion of a paper whose participants had been diagnosed with a psychotic condition, no knowledge about impact specific to psychosis was identified.

### *Framework for transdiagnostic impact*

Table 2 presents a framework describing transdiagnostic impact, synthesised from forms and consequences identified in the DAT. This table includes the six themes identified through thematic analysis, which are our proposed forms of impact, and the items grouped within each theme, which provide more specific detail about how they occur.

*Insert Table 2 here*

Impact described in this table has not been categorised as helpful or harmful, due to the possible influence of contextual factors, e.g. “initiating personal disclosure to a researcher” might be

helpful if the researcher has the required competence to engage, but harmful if not.

Connectedness, Understanding, Reduction in Stigma and Validation might be thought of as more cognitive forms of impact, alongside the broad range of more affective responses listed in table 2, and a limited range of behavioural responses.

Table 3 presents moderators identified through the synthesis, identified from facilitators and barriers listed in the DAT.

*Insert Table 3 here*

Items included in the categories of recipient and narrator/narrative characteristics appeared to facilitate or block a recipient in forming a connection with the narrator or narrative, suggesting an important role for connection forming in enabling impact to occur.

### *Forms of impact specific to eating disorders*

Table 4 summarises processes and impact identified as specific to eating disorders.

*Insert Table 4 here*

All identified processes can generate harmful behavioural responses, though for the first process this only occurred if the recipient did not identify as being “in recovery” at the time of receiving the narrative; if the participant did identify as being “in recovery” or “recovered” a helpful behavioural outcome was generated. These terms were participant-defined in the source paper, e.g. there was no usage of a standardised measure to assess recovery stage.

Paper 3 identifies a *narrator/narrative characteristic* that facilitates harmful behavioural outcomes - the inclusion of particular details of eating disorder behaviours engaged in by the narrator, such as dangerously low daily calorie counts or specific patterns of disordered eating.

## Discussion

This review has presented a conceptual framework consisting of nine superordinate themes, comprising six types of impact and three moderators of impact. A sub-group analysis identified types of impact specific to eating disorders. The inclusion of only five papers, despite widespread interest in the use of recovery narratives, suggests a knowledge gap which might be filled through further empirical work, and identification of this knowledge gap is a key contribution of this paper. These findings will inform a future trial (ISRCTN11152837).

### *Relationship to existing frameworks*

A prior review<sup>25</sup> has considered the impacts of sharing and receiving health material online, and identified four domains in which positive and negative impact can occur for recipients: (1) finding information (2) feeling supported (3) experiencing health services (4) affecting behaviour. *Feeling supported* has similarities with *Validation of personal experiences*, whilst *finding information* has similarities with *Understanding of mental illness and how to recover* (with the latter being more specific to recovery narratives). Impact on behaviour occurs in both.

Our review has a stronger emphasis on factors that moderate impact, only briefly mentioned in the previous review. It also emphasises forms of impact distinctive to recovery narratives, such as connection with and empathy for the narrator. Our review does not consider issues around unbalanced or misleading material, considered extensively in the previous review. Learning that an influential narrative might not be authentic can lead to anger in recipients<sup>34</sup>, and LEAP members wondered whether recipients could be harmed by deliberately misleading narratives.

Some on-line collections of recovery narratives are predicated on a belief that receiving narratives can encourage personal recovery. A systematic review has identified Connectedness, Hope;

Identity; Meaning in life; and Empowerment (CHIME) as processes that underpin personal recovery<sup>35</sup>. Elements of all five CHIME process are present in our conceptual framework. Connectedness appears in both frameworks. The CHIME notion of Hope appears under Affective responses, whilst the CHIME notion of Identity incorporates “Overcoming stigma”, present as an impact in our conceptual framework. This provides some validation that receiving recovery narratives can promote recovery. The inclusion of “Reduction in stigma” as an outcome provides validation for the use of recovery narratives in anti-stigma campaigns.

### *Strengths and limitations*

A strength of the review is the identification, through scoping searches, of a broad range of terms that might be synonymous of “recovery narrative”, important as no included paper used this term directly. Other strengths include the use of a wide range of publication databases and grey literature sources, double rating at each stage of sifting to maximise reliability, and the use of an established methodology for narrative synthesis. Limitations include a narrow focus on mental health recovery narratives, given that the impact of narratives produced by other clinical populations may also be relevant in mental health practice, the non-use of some potential sources such as conference proceedings, and the restriction of the search strategy to English, meaning that some French-language publications could have been excluded.

### *Implications for clinical practice and mental health interventions*

Should recovery narratives be used as a resource in clinical practice and mental health interventions? The general clinical evidence is supportive for the former. A survey of 138 psychologists in the USA found a belief that mental health biographies can be helpful in therapy sessions<sup>36</sup>, and a review of case reports has demonstrated mechanisms for integrating

autobiographies into psychotherapy sessions<sup>37</sup>. A range of publications have shown acceptability of bibliotherapy and self-help texts as a form of treatment across a range of conditions<sup>38,39</sup>. Biographical material used in these studies was typically in the form of recovery narratives.

The ready availability of mental health recovery narratives on-line may support usage with younger people, who are known to be heavy users of on-line health information.<sup>40</sup> This is important given recent arguments that youth mental health should be a priority area in Canada,<sup>41</sup> and known challenges around extremely high suicide rates in Canadian Aboriginal youth.<sup>42</sup> Best practice guidelines on Canadian youth suicide reduction<sup>43</sup> include ensuring accessibility of services in rural and remote locations and enhancing engagement with marginalised individuals. Interventions drawing on on-line material are known to have particular relevance to areas with low population densities<sup>22</sup>, where access to both mental health care and to peers with experience of similar mental health problems may be difficult otherwise<sup>44</sup>. Although limited, internet access in rural and remote areas of Canada is improving,<sup>45</sup> including through enhancements to cellular networks,<sup>46</sup> and initiatives such as the Indigenous Connectivity Summit.<sup>47</sup>

Our review highlights potential mental health uses and considerations that are relatively specific to recovery narratives. People experiencing high anticipated discrimination may benefit from stigma reduction by encountering role models through narratives, who may not be available in everyday life. People experiencing high levels of social isolation, a known risk factor for youth suicide<sup>48</sup>, may experience enhanced connectedness and more validation of personal experiences. People who are early in their recovery journey may encounter relevant knowledge about how to recover. Knowledge presented in recovery narratives might enable people to cope more readily with the challenges of recovery, with coping being one source of resilience<sup>49</sup>.

The review found that recovery narratives can engender strong affective responses, sometimes through empathy to the narrator, including emotions perceived as positive (hopefulness, gratitude

for life) and others that are more distressing. LEAP members queried whether secondary traumatisation might be one outcome of excessive exposure to distressing elements of recovery narratives, potentially through mechanisms similar to those known in relation to mental healthcare providers<sup>50</sup>. When available, clinicians should monitor and support processing of emotional responses by clients, given that empathy is known to be significant risk factor for secondary traumatisation<sup>51</sup>. Alternative approaches are needed when recovery narratives are used in on-line mental health interventions. These might include moderated discussion forums or on-line support groups, which can offer emotional and instrumental<sup>11</sup> support to members.<sup>52</sup>

Our review found no material specific to psychosis, despite inclusion of a paper with participants diagnosed with a psychotic condition, and hence does not provide any argument against the use of recovery narratives in the psychosis treatment– in the context of a debate around the appropriateness of using on-line material in the treatment of psychotic disorders<sup>53</sup>.

A lack of connectedness to the narrator of recovery narrative is identified as a significant barrier to impact in Table 3, and is also indicated as a potential cause of distress. This suggests a need for further research to identify factors that might disrupt connection, of broader importance given the perceived importance of personal connection in peer support work. It also highlights the need for clinicians to attend to a client's capacity to connect as part of the decision-making process around whether to use introduce recovery narratives, and when making a selection.

In keeping with prior research into on-line material and eating disorders, this review supports an understanding of harms that can be caused by engaging with recovery narratives, through processes linked to the elements of recovery narrative presenting adversity and struggle. LEAP members queried whether similar mechanisms might be seen in consumers with prior experience of self-harm, consistent with prior research which suggests that on-line material can in fact trigger instances of self-harm<sup>54</sup>. In keeping with Whitlock, et al. <sup>55</sup>, we would argue that regular

assessment of narrative usage might enable the amelioration of harms. Alternative mechanisms are needed in the case of on-line interventions.

The findings of our review accord with prior work which suggests that the dissemination of specific details of harmful behaviours in on-line material is one mechanism of harm<sup>56</sup>. This might impact on processes for selecting recovery narratives for use in mental health practice, through tactics such as avoiding recovery narratives that include specific details of harmful behaviours.

## **Conclusions**

Mental health recovery narratives can impact on cognition, affect and behaviour, and this impact is moderated by a range of factors. Mental health recovery narratives can promote recovery in recipients, but care might be needed for use with specific clinical populations.

## **Data Access**

The complete Data Abstraction Table for this work is included as an on-line supplement.

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The Authors declares that there is no conflict of interest.

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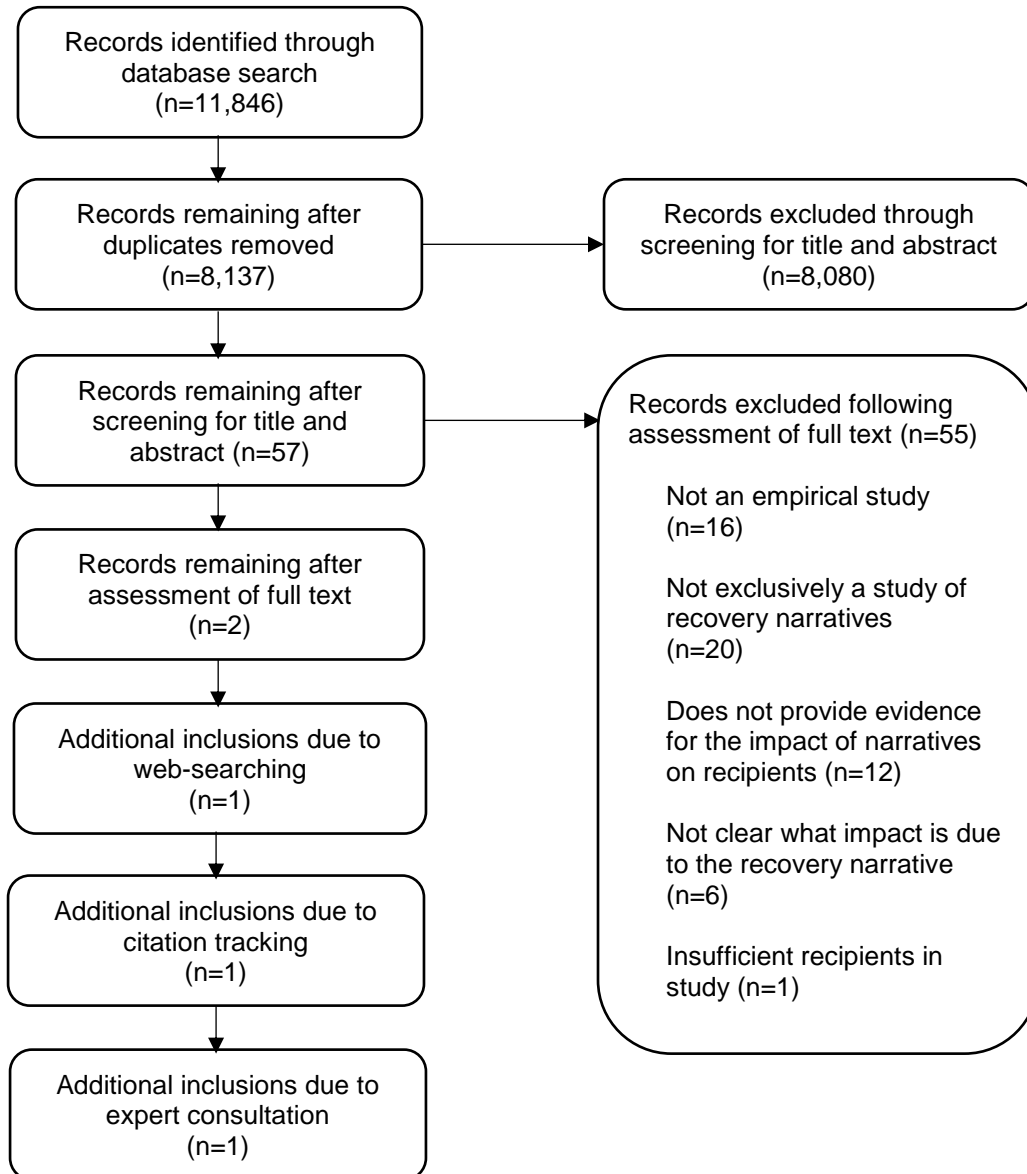
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## Figures and tables

Figure 1: Flow diagram



**Table 1 Summary of included publications (n=5)**

<b>#</b>	<b>Year</b>	<b>Design</b>	<b>Ref</b>	<b>Description</b>	<b>Time of impact assessment</b>	<b>Quality rating</b>
1	2016	Qual (n=25)	<sup>57</sup>	Thematic analysis of semi-structured interviews with first year psychology students who listened to an Anorexia Nervosa recovery narrative.	Immediately after hearing the story	Moderate
2	2006	Quant (n=54)	<sup>58</sup>	Study of the impact of a written eating disorder recovery narrative on female undergraduate Psychology students. Impact assessed using the Eating Attitudes Test (EAT-26), the Eating Disorders Inventory (EDI) Drive for Thinness subscale, a measure of perceived ED symptom prevalence, and an Implicit Association Test (IAT) measuring associations between anorexia and glamour/danger	Within one week of reading the story	Moderate
3	2015	Qual (n=24)	<sup>59</sup>	Qualitative analysis of questionnaires completed by participants who consumed eating disorder recovery narratives as part of their own recovery	Undefined	Moderate

4	2018	Qual (n=36)	<sup>60</sup>	Interviews with participants who have been diagnosed with a psychotic disorder, and who have engaged with used video-based recovery narratives presented on a website as part of their recovery.	At least three months after initial contact with website	High
5	2018	Qual (n=8)	<sup>61</sup>	Interpretive Phenomenological Analysis of interviews with attendees of a Telling My Story course.	Within one year of taking the course	High

**Table 2: Impact and associated processes of recovery narratives on recipients**

<b>Impact</b>	<b>Associated processes</b>	<b>Source</b>
Connectedness to the narrator or to others	The recipient feels connected to the narrator of a recovery narrative	1,4
	The narrative provides companionship at times of social isolation	3
	The narrative helps the recipient to feel that they belong	4
Understanding of mental illness and how to recover	The recipient's understanding of the severity, intensity and complexity of the mental health condition experienced by the narrator is deepened	1
	The recipient's understanding of how personal recovery might happen is deepened	1,4
	The recipient identifies personal behaviours that they wish to reconsider	4
	The recipient learns from a narrator who has experienced more profound difficulties than them	LEAP
Reduction in stigma (including self-stigma)	The recipient experiences a reduction in their stigmatic views about the mental health condition described by the narrator	1
	The recipient feels less ashamed about having a mental illness	4
	The recipient feels reassured that others have experienced similar distress	1



Validation of self and of personal experiences	The recipient hears hidden views about illness, and recognises themselves in these	4
	The recipient recognises some of their deepest fears in the narrative	LEAP
	The recipient compares themselves to the narrator, and finds that they are doing well	5
Affective responses	The recipient feels empathy for the narrator, and this initiates strongly-felt emotional responses (feeling moved, sad, distressed, heartbroken, inspired, admiring)	1,4 LEAP
	The recipient feels an increased gratitude for positive aspects of their life	1
	The recipient feels uncomfortable due to recall of difficult memories	LEAP
	The recipient feels increased hope that recovery is possible (and this hope provides comfort at times of distress)	3,4
	The recipient feels angry or out of place, as they have experienced significant distress, and the problems of the narrator feel insignificant	LEAP, 5
	The recipient feels pressured, as the narrative is of recovery achievements that the recipient cannot match	LEAP

	The recipient feels compelled to make personal changes after hearing a recovery narrative from someone they could relate to	5
Behavioural responses	The recipient initiates personal disclosure to the researcher	1
	The recipient initiates deeper discussion with a support worker	4
	The recipient becomes more forceful when talking about medication with medical practitioners	4

**Table 3: Moderators of impact**

<b>Moderator</b>	<b>Description</b>	<b>Facilitator or Barrier</b>	<b>Source</b>
<b>Recipient characteristics</b>	Life circumstances and events in the narrative matched those of the recipient	Facilitator	3,4,5
	The recipient reports a short-term or long-term inability to connect with others	Barrier	1
	The recipient is not able to relate to the narrator's journey of recovery, leading to feelings of alienation and despair		3,4
	The recipient has strongly held personal beliefs that contradict with those of the narrator		1
	The recipient avoids some recovery narratives due to the content being excessively challenging		4
	The recipient has an empathic response to video-based recovery stories, making consumption tiring		4
	The recipient is not at the right stage of recovery for a particular narrative to be beneficial		LEAP
	The recipient feels significantly worse off than the narrators, and holds back from connection		5

<b>Contextual</b> characteristics	The recipient had a support worker who helps with use of the technology	Facilitator	4
	The recipient had a choice of physical location to consume narratives		4
	Lack of access to internet technology at home	Barrier	4
<b>Narrator and narrative</b> characteristics	The narrator presents specific details of their own behaviours or life events	Either	3
	The narrator appears to find it hard to express emotions or be authentic	Barrier	LEAP

**Table 4: Processes and impact specific to eating disorders narratives**

<b>Process</b>	<b>Impact</b>	<b>Source</b>
Receiving a narrative enhances the recipient's understanding of the possible dangers of eating-disorder behaviours	[Recipient self-identifies as "in recovery" or "recovered"] Greater effort put into avoidance of eating disorder behaviours  [Recipient self-identifies as not in recovery] Increases in belief that others are worse off, and hence change not necessary	3
Receiving a narrative encourages emulation of eating disorder behaviours enacted by the narrator	Increase in eating disorder behaviours	3
Receiving a narrative triggers prior eating disorder behaviours matching those of the narrator	Increase in eating disorder behaviours	3
Receiving a narrative leads to unhelpful social comparison with narrator	Increase in eating disorder behaviours	3