e.g. Spencer, Matt (2013) An ecological exploration of personal recovery in the context of severe mental illness. D.Clin.Psych. thesis, Canterbury Christ Church University.

Matt Spencer BA Hons Grad Dip

AN ECOLOGICAL EXPLORATION OF PERSONAL RECOVERY IN THE CONTEXT OF SEVERE MENTAL ILLNESS

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Summary of this major research project

Section A reviews the current state of recovery research and provides a systematic and ecologically-informed consideration of empirical literature published since 2007. Studies considering individual and social elements of recovery, peer-led and statutory services, and community and societal aspects of recovery are reviewed with conclusions drawn regarding further research.

Section B reports the findings of an empirical study investigating the discovery of hope and meaning, and relevant helping and hindering factors, in the context of recovery from severe mental illness. An emergent grounded theory model is provided, and key theoretical, clinical and research implications are discussed.

Section C provides the opportunity for critical reflection on this project. Four questions are considered regarding what has been learnt through carrying out this study, what might have been done differently, implications for the author’s clinical practice, and possible directions of future research.

Section D contains all appendices for this project, for the readers’ optional reference.

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Major Research Project

Section A: Literature review

Personal recovery in the context of severe mental illness: What do we now know?

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Abstract

This review has two aims. First, the current state of recovery research is clarified. This finds that whilst consensus may have been reached on the commonalities of the journeys and stages of recovery, further research into the processes of recovery and their helping and hindering factors remains prudent. This has been seen to require an ecological approach. As a consequence the second aim of this review is to provide a systematic and ecologically-informed consideration of published literature pertaining to recovery following the only previous review of this type. Thirty nine empirical studies, published since 2007, are found to cluster into six categories including; individual and social elements of recovery, peer-led and statutory services, and community and societal aspects of recovery. This review concludes that the processes of recovery (e.g. hope and meaning in life) and their helping and hindering factors remain to be fully explored, requiring further UK-based qualitative and ecologically-oriented studies.

Introduction

Purpose of this review

Interest in recovery from severe mental illness (SMI) has intensified to the extent that a conceptual understanding may have been reached. Critics have however suggested that its basis on personal narratives may perpetuate the individualistic discourse that predominates the western approach to mental health. This has led to calls for a reconsideration of ‘personal recovery’ from an ecological perspective. With its roots in systems theory (Bateson, 1972) and community psychology (Nelson & Prilleltensky, 2005), the ecological approach provides a framework that allows for the consideration not only of the individual perspective, but also of the surrounding context and any interaction between the two. This review therefore aims to summarise the current conceptual understanding of ‘personal recovery’ and to provide a systematic review (Centre for Reviews and Dissemination; CRD, 2008; Grant & Booth, 2009) of current empirical literature relating to the domain of ‘personal recovery’. The review concludes with the identification of further research.

Recovery: Definition

Recovery has been described as an idea “whose time has come” (Shepherd, Boardman, & Slade, 2008, p. 3), finding itself “at the heart of a debate about the raison d'être of mental health services” (Slade, 2009, p. 35). Three identified usages of the phrase ‘recovery’ (Ralph & Corrigan, 2005) have been found to include; a spontaneous alleviation of difficulties without professional intervention, (2) the outcome of effective treatment, and (3) the recovery of hope, purpose and meaning, whatever the circumstances, in the context of continuing ‘symptoms’. Accepting those experiencing ‘spontaneous’ recovery may fall outside of the remit of mental health services, Slade (2009) suggests that it is the latter two usages that have received most interest, referring to them respectively as ‘clinical’ and ‘personal recovery’.

The professional-oriented concept of ‘clinical recovery’ has faced two criticisms. First of all its assumption, on little evidence, that experiences associated with ‘illness’ are best made sense of through a biomedical approach to SMI, leading to an assumption of deterioration over time (e.g. Bentall, 2009). This assumption has been undermined by evidence from longitudinal studies of individuals with ‘schizophrenia’ (e.g. Harrison et al., 2001), leading to the conclusion that “bad outcome is not a necessary component of the natural history of schizophrenia; it is a consequence of the interaction between the individual and his or her social and economic world” (Warner, 2007, p. 1444-1445). Whilst much attention has been paid to recovery from ‘schizophrenia’ previous reviews have highlighted (Silverstein & Bellack, 2008) that, as a result of the problematic nature of mental health diagnoses (Boyle, 2002), much of this discussion is applicable to people with SMI in general.

A second critique has come from the publication of personal narratives of people with lived experience of mental health problems (Coleman, 1999; Davidson, & Strauss, 1992; Fisher, 1994; O’Hagan, 1996; Ridgeway, 2001), leading to a call for the alternative definition of recovery referred to by Slade (2009) as ‘personal recovery’. Highlighting the importance of uniqueness, individuality and constructivism to personal recovery a plethora of meaningful alternatives to Slade’s (2009) dichotomy are identified in the literature including being ‘in’ recovery versus recovery ‘from’ (Davidson, Schmutte, Dinzeo, & Andres-Hyman, 2008) and ‘social’ versus ‘clinical recovery’ (Secker, Membrey, Grove, & Seebohm, 2002). However, whilst privileging subjectivity, one definition of ‘personal recovery’ has reached wide acceptance among service users and professionals:

> "Recovery is a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness. Recovery involves the development of the new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness" (Anthony, 1993, p. 527).

It is in reference to this definition that this review will apply the terms personal recovery and recovery interchangeably.

UK policy context

Personal recovery has been a consistent feature of UK policy and clinical guidance throughout the 21st century (Department of Health; DH, 1999; 2006; 2009; National Institute for Clinical and Healthcare Excellence; NICE, 2002; 2009) leading to a recent collaboration between the National Health Service (NHS) Confederation and Centre for Mental Health (HM Government, 2011) to support the establishment of principles of personal recovery within statutory services (Shepherd, Boardman, & Burns, 2010). Despite this, and elucidating the current debate over their raison d'être (Slade, 2009), policy makers and statutory services have been criticised for the appropriation of recovery in order to reduce costs (Perkins & Slade, 2012).

Clinical psychology training context

At a time of significant restructuring of the NHS and in the context of the increasing dominance of the evidence-based practice the British Psychological Society (BPS; 2013) has sought consultation on the nature of clinical psychology training. In doing so the BPS has 'marketed' the knowledge and skills that distinguish those that qualify as clinical psychologists in contrast to other mental health clinicians and psychological therapists. Specifically, clinical psychology training is found to produce clinicians with broad therapeutic skills and knowledge in a manner that is highly cost-effective. As a consequence of this breadth of knowledge, clinical psychology is seen to occupy a relatively creative role within an otherwise solipsistic mental health care system that has been criticised for its apparent tendency towards the production of specific “NICE-approved technicians” (McCusker, 2013, p. 10).

It has been suggested that the paradigm shift implied by personal recovery offers clinical psychology, with its unique ability to consider an ecological frame and multiple levels of analysis, an opportunity to facilitate meaningful and lasting systemic change (Cohen, Abraham, Burk, & Stein, 2012) whilst also justify the discipline within an increasingly competitive market place of caring professions. Significantly this may not be the case in the US where the discipline is criticised for a lack of experience and representation in work with SMI (Mueser, Silverstein, & Farkas, 2013).

Current empirical conceptualisation of recovery

Personal recovery: Conceptual clarity

Previous reviews of the personal recovery literature have identified needs develop an operational definition, to identify reliable methods of measurement, and to focus on the factors facilitating and inhibiting recovery (Bellack, 2006; Liberman & Kopelowicz, 2005; Silverstein & Bellack, 2008; Slade & Hayward, 2007). Studies by Leamy and colleagues (2011), Slade et al. (2012) and Williams et al. (2012) have sought to meet this need.

Through a narrative synthesis of existing conceptualisations of recovery (97 studies), Leamy and colleagues identified a conceptual framework of three inter-linking categories including; (1) characteristics of the recovery journey (Appendix 4), (2) recovery stages (Appendix 5), and (3) recovery processes. Identifying that stage models of recovery map reliably onto the trans-theoretical model of change (Prochaska & DiClemente, 1982) Leamy and colleagues concluded that further clarification of the journey and stages of recovery may present limited benefit. Conversely, the identification of five recovery processes, including Connectedness, Hope, Identity, Meaning, and Empowerment (acronym 'CHIME'), represented a significant development. A subsequent review (Slade et al., 2012) further validated these findings. Regarding measures of recovery-orientation, Williams and colleagues (2012) concluded that a gold standard measure is yet to emerge and that no available measure should be applied outside of the context in which it was developed. Leamy and colleagues, and others, have continued to critique this body of literature for its focus on first-person narratives, recommending that the investigation of recovery processes may require a broadening of focus to include an ecological perspective which "while critical…has…not been a focus of mental health clinicians or researchers" (Silverstein & Bellack, 2008, p. 1111).

Personal recovery: An ecological perspective

An ecological approach can be said to provide a framework that allows for the incorporation of the individual, their environment, and the interaction between the two. This has therefore been identified as a crucial but unexploited lens for the investigation of factors supporting and hindering personal recovery. Such an approach is commonly associated with systems theory (Bateson, 1972), community psychology (Nelson & Prilleltensky, 2005) human development (Bronfenbrenner, 1977) and public health, where an ecological approach has been recommended (Kickbusch 1988), applied (Glanz, Rimer, & Viswanath, 2008) and superseded (Hanlon, Carlisle, Hannah, Reilly, & Lyon, 2011).

In an isolated example of the application of this approach within the recovery literature, Onken and colleagues (2007) suggest (after Watzlawick, Weakland, & Fish, 1974), that recovery involves elements of first order change (e.g. improvement in individual mental health) and second order change (e.g. decreased barriers to social inclusion) and an interactional relationship between the two. On this basis four dimensions of recovery were identified; Person-centred elements of recovery, Re-authoring elements of recovery, Exchange-centred elements of recovery, and Community-centred elements of recovery. Below is presented a novel expression of these dimensions as mapped onto an established ecological framework (Bronfenbrenner, 1977).

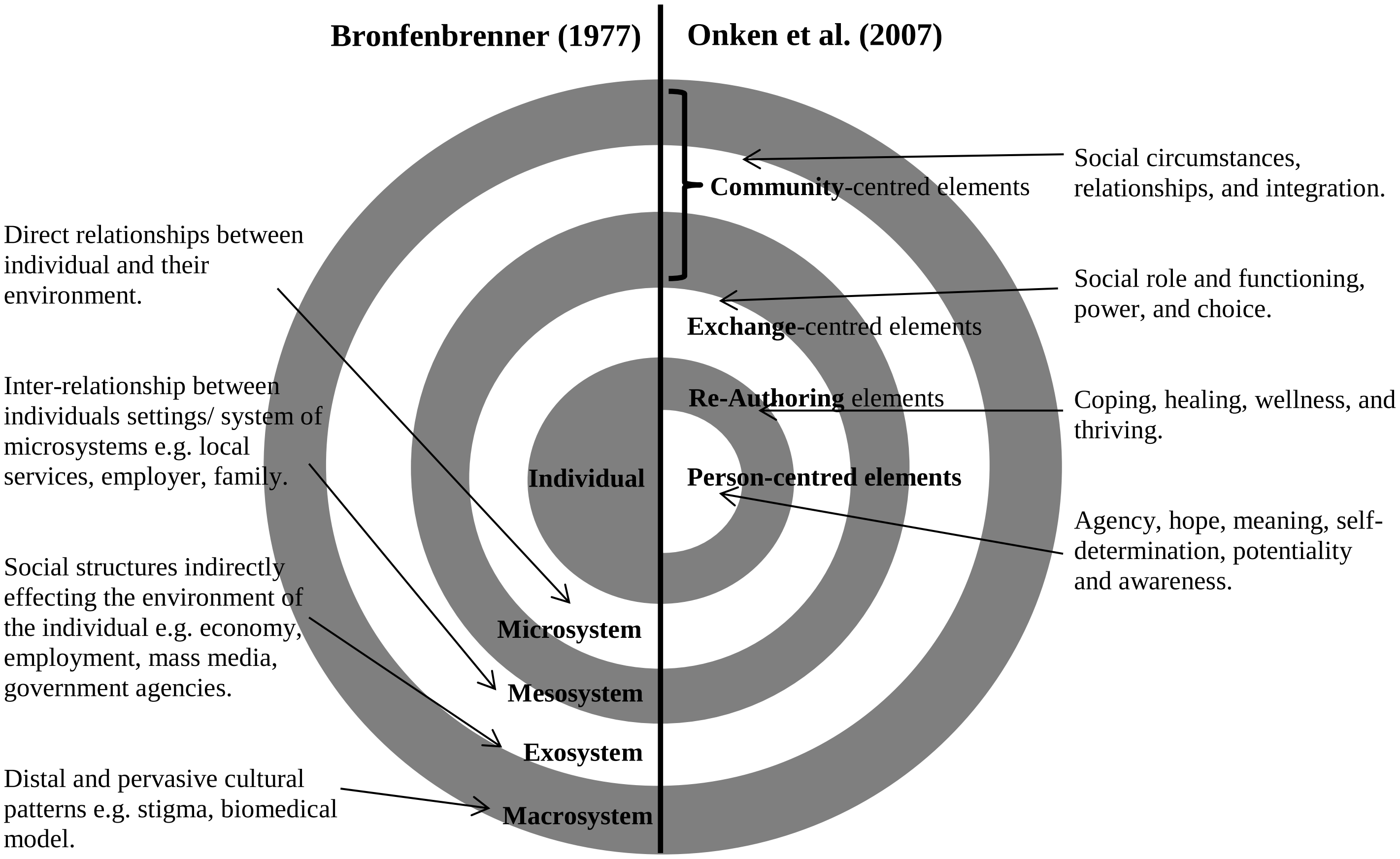

Figure 1: A novel ecological framework of recovery informed by Bronfenbrenner (1977) and Onken et al. (2007)

For Onken et al. (2007) person-centred elements of recovery include agency, hope, self-determination, meaning in life, and awareness and potentiality, all of which are heavily associated with the individual and are helped and hindered through interactions with others. Informed by the work of Foucault (1979; 1980), White (1989; 1991) and Freire (2000), re-authoring elements of recovery include increased coping, healing, wellness and thriving through the re-authoring of individual experiences leading to new meanings and personal growth. Resulting from improvements in agency, purpose, and wellness, individuals become more able to engage with issues of social role and functioning, power and choice. This process is referred to as Exchange-centred elements of recovery. Finally, as psychiatric disability is seen to reside at the interface between individual and environment, community-centred elements of recovery are seen as vital. In addition to the availability of friends and peers, recovery requires society to provide material supports for safety, wellbeing and good physical and psychological health.

Despite providing an initial ecologically-informed review, this previous study is undermined by the absence of a systematic review methodology. This increases the possibility of researcher bias through the accidental exclusion of potentially significant studies and a lack of consideration of the validity of previous studies (Grant & Booth, 2009). Such criticisms support the aim of this current study in further developing the methodological rigour of this domain of literature. This study aims to do so through providing a more rigorous and replicable systematic review of the current empirical literature. In addition, by extending the date range of this review to the present this study will include the articles that have comprised a recent surge of interest in this aspect of mental health research.

Systematic review methodology

This review aims to consider all empirical English language studies published since 2007, and the only previous ecologically-informed review. In order to provide a critical evaluation of the current state of recovery-related research this study has adopted a systematic review methodology (CRD, 2008; Grant & Booth, 2009). The completion of a review of a domain of literature that is poorly defined is seen to require a pragmatic and rigorous approach to literature searching, this issue in the context of personal recovery is discussed elsewhere (e.g. Tew et al., 2012). This review was rigorous in searching all databases (Psychinfo, Ovid Medline, Cochrane, Evidence-based medicine (EBM), Google). In doing so a broad list of search terms and wildcards (*) was applied based on themes identified within extant literature (e.g. Recov*, Agency, Meaning, Purpose, Self-determination, Hope, Optimism, Wellbeing, Social inclusion, Social exclusion, Social integration, Power, Empower*, Identity). Leading to 7205 results.

Articles were included if pertaining to personal recovery, published after 2007, and in English. Articles were excluded if reporting on clinical recovery, psychotherapy or pharmacological interventions, published outside peer-reviewed journals, derived of single-case designs, editorials, chapters, manuals, and practice guidelines. Manual searches of reference sections and discussions with research supervisors led to the inclusion of 39 studies comprising; nine reviews, six RCTs, 14 experimental, quasi-experimental or correlational studies, and 10 qualitative studies. Studies were evaluated according to guidance regarding the critiquing of reviews (Grant & Booth, 2009) and quantitative (Papworth & Milne, 2001) and qualitative studies (Elliot, Fischer, & Rennie, 1999). Studies were found to cluster into six domains including; Individual and Social elements of recovery, Peer-led and Statutory services, and Community and Societal aspects. These findings are presented in Table 1 and are discussed below.

Domain	Reference	Methodology	No. papers	Sample
Individual elements of recovery	Schrank, Stanghellini and Slade (2008)	Systematic review	151	-
	Schrank, Bird, Rudnick and Slade (2012)	Systematic review	57	-
	Hobbs and Baker (2012)	Qualitative: Grounded Theory	-	8
	Clarke, Oades and Crowe (2012)	Correlational study	-	144
	Lucksted et al. (2011)	Quasi-experimental study	-	50
	Lysaker, Roe, Ringer, Gilmore and Yanos (2012)	Quasi-experimental study	-	70
Social elements of recovery	Tew et al. (2012)	Pragmatic review	71	-
	Topor, Borg, Di Girolamo and Davidson (2011)	Literature review	Unknown	-
	Hendryx, Green and Perrin (2009)	Correlational study	-	153
	Pernice-Duca and Onaga (2009)	Quasi-experimental study	-	221
	Carolan, Onaga, Pernice-Duca and Jimenez (2011)	Qualitative: Grounded Theory	-	20

	Schon, Denhov and Topor (2009)	Qualitative: Grounded Theory	-	58
Peer-led services and recovery	Doughty and Tse (2011)	Systematic review	29	-
	Repper and Carter (2011)	Systematic review	38	-
	Walker and Bryant (2013)	Systematic review	27	-
	Cook, Steigman, et al. (2012)	RCT	-	428
	Cook, Copeland, et al. (2012)	RCT	-	519
	Greenfield, Stoneking, Humphreys, Sundby and Bond (2008)	RCT	-	393
	van Gestel-Timmermans, Brouwers, van Assen and Niewenhuizen (2012)	RCT	-	333
	Moran, Russinova and Stepas (2012)	Correlational study	-	30
	Resnick and Rosenheck (2008)	Quasi-experimental study	-	296
	Lewis, Hopper and Healion (2012)	Ethnography	-	25
	Whitley, Strickler and Drake (2012)	Qualitative: Thematic Analysis	-	Unknown
Statutory services and recovery	Le Boutillier et al. (2011)	Systematic review	30	-
	Barbic, Krupa and Armstrong (2009)	RCT	-	33
	Segal, Silverman and Temkin (2011)	RCT	-	139
	Barrett et al. (2010)	Quasi-experimental study	-	45

	Marshall, Oades and Crowe (2009)	Quasi-experimental study	-	92
	Hicks, Deane and Crowe (2012)	Correlational study	-	61
	Russinova, Rogers, Ellison and Lyass (2011)	Correlational study	-	995
	Piat and Lal (2012)	Qualitative: Unknown	-	68
	Roe, Hasson-Ohayon, Derhi, Yanos, and Lysaker (2010)	Qualitative: Grounded Theory	-	18
Community aspects of recovery	Connell, King and Crowe (2011)	Correlational study	-	234
	Kaplan, Salzer and Brusilovskiy (2012)	Correlational study	-	1827
	Dunn, Wewiorski and Rogers (2008)	Qualitative: Grounded Theory	-	23
	Svanberg, Gumley and Wilson (2010)	Qualitative: Grounded Theory	-	16
Societal aspects of recovery	Corrigan and Wassell (2008)	Literature review	Unknown	-
	Corrigan, Powell and Michaels (2013)	Experimental study	-	151
	Yates, Holmes and Priest (2012)	Qualitative: Grounded Theory	-	8

Table 1: Literature search results

Systematic review results

Individual elements of recovery

Recognising the centrality of hope in recovery, Schrank and colleagues (2008) reviewed studies of the conceptualisations and measurements of hope. The authors identified an emergent definition of hope as a "future-orientated expectation…of attaining personally-valued goals, relationships or spirituality, where attainment: i) will give meaning, ii) is subjectively considered realistic or possible and iii) depends on personal activity or characteristics or external factors" (p. 426). Also highlighted was the role of the biomedical model in diminishing hope, and the benefits of hope-promoting interventions at an individual level, and access to role models via peer-support at a socio-environmental level. A subsequent narrative synthesis of the hope in recovery literature (Schrank et al., 2012) identified three determinants of hope including; isolation, direction, and correlations (with self-efficacy, self-esteem, empowerment, spirituality, quality of life, and social support). Key recommendations for more hopeful interventions included genuine collaboration, improved relationships with staff and peers, and the pursuit of realistic goals.

Based on a UK sample, Hobbs and Baker (2012) provide a grounded theory model of 'the role of hope in recovery' identifying three categories; influence of others, personal hope, and doing recovery. The authors provide implications for clinicians including the need for belief in recovery, an awareness of their sense of hope on the client, and the provision of new narratives of recovery and understandings of their difficulties. Also highlighted is the need for services to increase access to role models through peer support.

In an Australian study, Clarke and colleagues (2012) sought to determine whether certain types of goals correlate with different stages of recovery (Moratorium, Awareness, Preparation, Rebuilding, Growth; Andresen, Oades, & Caputi, 2003). Contrary to expectations, this study found goals to be set throughout recovery, shifting from 'avoidance' goals (e.g. health management) earlier in recovery towards ‘approach’ goals (e.g. relationships, meaning-making) in latter stages. Authors recommend a focus on the identification of ‘recovery stage appropriate’ goals.

In quasi-experimental studies with US samples, both Lucksted et al. (2011) and Lysaker and colleagues (2012) sought to investigate self-stigma. Identifying that “self-stigma can lead to…poorer illness management, social avoidance, and…achievement of recovery goals” (p. 51) Lucksted and colleagues found that a nine week intervention facilitated a decrease in self-stigma and increases in recovery-orientation and social support. In contrast, Lysaker et al. (2012) sought to evaluate change in self-stigma as a result of a involvement with services. Authors concluded that decreases in self-stigma may correlate with increased self-esteem, that higher emotional distress may impair stigma reduction, and that a decrease in self-stigma may not be a naturalistic outcome from treatment.

Social elements of recovery

The following reviews identifying five recovery processes (CHIME; e.g. Leamy et al., 2011), Tew and colleagues (2012) provided a ‘pragmatic’ literature review of the factors “more social in conception” (p. 445). Tew and colleagues recommend that empowerment may be facilitated through the implementation of personal budgets by statutory services, increased social inclusion, and the development of user-run services. Empowerment may therefore be dependent on overcoming negative self-identity and stigma. Whilst clinicians can support individuals in re-storying identity, community and societal level anti-stigma campaigns are required, where targeted engagement has proven more effective than mass media campaigns. In summary Tew recommends professionals may need to shift their attention to working with communities to increase their inclusiveness and safety.

A review of qualitative literature leads Topor and colleagues (2011) to determine that relationships, home, money and employment are crucial in rebalancing an illness identity. Whilst friendships provide a normalising experience, acceptance, altruism, and the sharing of self-management skills, families support aspects of identity unrelated to illness, and provide material needs and emotional needs. Regarding relationships with clinicians, a working alliance based on reciprocity and acceptance is vital. A home is seen to provide a place for personal growth, to express choice, and a base from which to explore. Increased personal budgets are seen to have a positive impact on social activities, and on reduced distress and isolation.

Schon and colleagues (2009) provide a grounded theory study based on a Swedish sample exploring the social factors decisive in recovery. The authors identify a core category defined as recovering through a social process, which acknowledges that social relationships promote individual processes relevant to recovery. Three subordinate dimensions are found. The social self reflects the discovery of healthier parts of one's identity, social interventions relates to the importance of statutory and self-help groups in providing social interaction, whilst connection to others refers to the discovery of reciprocal relationships with peers. Hendryx et al. (2009) provide a correlational study based on a US sample. This study explored the relationships between recovery, social support, social network size, and meaningful activity. Whilst the authors identified that the nature of the activities was unrelated to recovery, activities and social support were associated with recovery, and for individuals with limited social support, an elevated level activity may facilitate recovery.

Two final US studies focussed on a specific form of recovery community referred to as clubhouses. Pernice-Duca and Onaga (2009) provide a US based longitudinal study evaluating the contribution of social networks on recovery. Whilst clubhouses are found to facilitate empowerment, supportive relationships with peers, self-esteem and self-efficacy, wider social inclusion is not guaranteed. Carolan and colleagues (2011) provide a grounded theory model of the role of a clubhouse in supporting social relationships. Authors identified two over-arching domains including; the Clubhouse environment and Opportunities for growth. Fundamentally, staff, members and the clubhouse structure provided a safe context for interaction, support and growth in senses of self-efficacy, meaning and purpose.

Peer-led services and recovery

In a review of all controlled-studies from high-income countries, Doughty and Tse (2011) found both consumer-led and statutory services to provide equally positive outcomes for employment, living conditions, and hospitalisations/cost. Peer-support work (PSW) was seen to provide meaningful employment, but also concerns regarding risk to wellbeing, role confusion and variability in the extent of consumer involvement. A systematic review of international studies on peer work in statutory services, including published and grey literature, Repper and Carter (2011) reported PSW made no difference to clinical outcomes. Grey literature was however found to highlight the additional contribution of PSW where providing peer support represents a socially-valued role that facilitates hope, belief in recovery, empowerment, increased self-management, self-efficacy and self-esteem, and social inclusion. A third review (Walker & Bryant, 2013) synthesised the qualitative findings of studies into the experiences of providers and consumers of PSW, and their non-peer co-workers. Whilst PSWs experienced healthy relationships with peers and non-peer staff, and increased wellness over and above employment, the transition from patient to PSW was found to be challenging, including discrimination by non-peer staff. PSWs led to increased empathy towards consumers amongst non-peer staff, whilst consumers reported increases in social networks and wellness, communities also experienced diminished stigma.

In the first of four randomised-controlled trials (RCTs), van Gestel-Timmermans and colleagues (2012) evaluated the effects of a 12-week peer-run recovery course. A Dutch sample with ‘major psychiatric problems’ were randomised to an experimental or control condition. Significant effects were identified on standardised subjective outcomes of empowerment, hope and self-efficacy, but not for quality of life or loneliness. Whilst indicative of the benefits of PSWs as role models, drop-out rate and discrepancy between conditions means findings should be treated cautiously. Cook, Copeland et al. (2012) examined the efficacy of Wellness Recovery Action Planning (WRAP), a US-based peer-led self-management intervention. Statistically significant differences were identified favouring the experimental group for reduction in symptomology, and improvement in hopefulness and quality of life. Although recovery-related outcomes remained significantly different at follow-up, symptom severity appeared to attenuate overtime.

A third RCT (Cook, Steigman et al., 2012) randomised a US sample with SMI to a peer-run recovery intervention (BRIDGES) and waiting-list. The experimental condition comprising eight weekly peer-led recovery classes, focussing on self-help and independent living skills, led to significant improvement on standardised measures of recovery, including confidence and hopefulness/agency. In an earlier US-based RCT, Greenfield and colleagues (2008) randomly assigned participants to a peer-run programme on an unlocked ward or a statutory locked ward. Differences favouring the PSW-run system were identified on professional-rated and self-reported measures of psychopathology and service satisfaction.

Although attrition rate was high, limiting the reliability of follow-up data, participants were relatively severe and ethnically diverse, implying a degree of generalizability.

A US-based correlational study by Moran and colleagues (2012) examined the relationships between PSW experiences of recovery, occupational history and the positive psychology concepts of post-traumatic growth and generativity (i.e. commitment to a cause larger than oneself). Acknowledging the limitation of a small sample size, authors identified significant association between generativity, past experience of work in helping professions, and access to peer-support/self-help groups. A quasi-experimental study (Resnick & Rosenheck, 2008) compared standard care with a peer-led support program. Whilst an intention-to-treat analysis identified significant differences favouring the experimental group for a measure of empowerment, an as-treated analysis of individuals completing >10 sessions identified additional improvements in confidence and clinical measures.

Of two qualitative studies, Whitley and colleagues (2012) explore the nature of 24 recovery centres sampled from across English-speaking nations, excluding the UK. Throughout this sample, rhetoric of recovery was pronounced, however differences included extent of consumer managerial involvement. Success was often predicated on the qualities of individual leaders, and centres varied in the clarity of goals, model, evaluation, governance, evidence-based practices, and extent of professional involvement, some appearing as direct replacements for traditional day centres. Successful centres were found to provide services unavailable in statutory mental health settings, including peer-support and community integration, in a hopeful, supportive, and non-stigmatizing setting. Finally, Lewis and colleagues (2012) provide an ethnographic study of a US-based fully peer-operated mental health centre. Data was collected via participant observation, interviews and a focus group.

Lewis and colleagues identified that an intimate, authentic and reciprocal culture created a sense of mutual accountability for self and peers in what amounted to “a shared project of recovery” (p. 61), further facilitated by education “democratising expert knowledge” (p. 64) and the availability of peer role models.

Statutory services and recovery

Identifying a need for clarity regarding recovery-oriented practice, Le Boutillier and colleagues (2011) synthesised 30 guidance documents from 6 countries identifying 16 themes, clustered into four practice domains including; promoting citizenship, organisational commitment, supporting personally-defined recovery and working relationships. Significantly ‘informed choice’ represents the modal theme, appearing in 80% of documents. Le Boutillier and colleagues support a need for whole systems organisational reform (Shepherd et al., 2010). Citing Slade (2010), who suggests that 21st Century clinicians need to become “social activists who challenge stigma and discrimination…promoting societal well-being” (p. 2), this review finds that clinicians will be required to make a shift in their practice into new and potentially uncomfortable socio-political domains.

Of two RCTs of recovery-oriented statutory services, Segal and colleagues (2011) randomised US clients to a ‘co-produced’ service or a statutory community mental health service control condition. No differences were found for measures of symptomology or hopelessness, however significant improvements in social integration, empowerment, and self-efficacy were found to favour the control group, leading to the conclusion that this form of co-produced service, hierarchically organised and staff-run, may be less helpful than statutory mental health services. Limitations to the structural organisation of the co-produced service limit generalisability of these findings. A second, Canadian, RCT (Barbic et al.,

2009) randomised individuals to a 12 week recovery workbook approach or a treatment as usual control group. Significant differences, favouring the experimental group, were identified for measures of hope, empowerment and recovery, leading to the conclusion that such groups may present a meaningful addition to the recovery-orientation of services, although generalization is cautioned.

Of two quasi-experimental studies, Barrett et al. (2010) sampled individuals from two US-based mental health treatment programs. In keeping with their hypotheses, authors found that the recovery-orientation of a service predicted consumers’ sense of empowerment, and their satisfaction with services. Additionally, they identified that sense of empowerment mediated the relationship between recovery-orientation and satisfaction. In a second study, Marshall and colleagues (2009) sampled consumers from a range of statutory and non-statutory services, some of whom were engaged in a form of recovery-focused support. Authors found that, when compared with those receiving more traditional services, individuals obtaining recovery-focused support valued additional encouragement to take responsibility for recovery, goal-related activities and increased collaboration with staff.

Two correlational studies sought to consider the recovery-promoting competencies of professionals. Russinova and colleagues (2011) aimed to evaluate the perceptions of US ‘consumers’, consumer-providers and providers regarding a range of hope and empowerment facilitating competencies. Russinova and colleagues identified that consumers valued providers’ availability, interest in their developing coping skills, and competence in establishing respectful, hopeful and authentic therapeutic alliances. Hicks et al. (2012) sought to explore the relationship between working alliance and recovery. Findings from an

Australian sample indicated a positive relationship between alliance and hope, that changes in alliance predicted recovery, and that changes in recovery predicted alliance.

Of two qualitative studies identified, Roe and colleagues (2010) explored the experiences of Narrative Enhancement and Cognitive Therapy, an Israel-based clinician provided group intervention for self-stigma involving the construction of new life stories. Qualitative analysis of interviews led to the identification of two change processes; The therapeutic alliance, and Participants' active role, and six domains of improvement; Experiential learning, Positive change in experience of self, Acquiring cognitive skills, Enhanced hope, Coping, and Emotional change. Participants reported that relationships based on re-narrating life stories allowed a shift from an illness identity towards an integrated sense of wellness. Piat and Lal (2012) highlighted that the challenges services encounter in becoming more recovery-oriented has gone unstudied. Qualitative analysis of focus group data from three Canadian sites led to the identification of themes including; Positive attitudes towards reform, Scepticism towards reform, and Challenges in implementing recovery-oriented practice. Recommendations include the provision of staff training and the active engagement of consumers in services.

Community aspects of recovery

Kaplan and colleagues (2012) sought to examine the relationships between community participation and recovery. Contrasting the community participation of young and mature adults receiving US consumer-led mental health services the authors identified that community participation was strongly associated with recovery and meaning, and that association of participation with recovery, quality of life and meaning of life was the same for emerging adults as it was for mature adults. Additionally, young adults were more likely to be students and to spend time with a friend, whilst mature adults had greater participation as parents, spirituality, and self-help/mutual support. In a finding hypothesised as developmentally appropriate, younger adults scored more highly on measures of recovery, quality of life and meaning.

The remaining studies focus specifically on employment. Connell and colleagues (2011) analysed data from pre-existing Australian data from varying mental health organizations to explore the relationship between recovery and employment. Contrary to their hypotheses authors found no difference in recovery scores between employed and unemployed individuals. In a qualitative analysis of pre-existing interview transcripts Dunn and colleagues (2008) sought to explore how US-based individuals perceive work and its effects on their recovery. Analysis led to the identification of two domains of the benefits of paid employment in recovery including; Work has personal meaning, and Work promotes recovery. Individuals expressed well-established vocational identities and, even in times of crisis, work facilitated recovery through providing pride, self-esteem, financial gain, and a sense of coping. ‘Giving back’ through helping occupations, as peer-workers, was prominent. Finally, Svanberg and colleagues (2010), in a UK-based study, aimed to explore experiences of recovery in the context of two social enterprise vocational rehabilitations schemes. Qualitative analysis of interviews led to a grounded theory model of recovery through participation in these emerging ‘social firms’ including three categories including; The meaning of recovery, The experience of mental illness, Working in an emerging social firm. A degree of consensus on the meaning of recovery and experience of mental illness was possible. Additionally, participants recognised that a structured but flexible environment with both therapeutic and vocational components facilitated a sense of purpose, self-confidence, hope and connectedness, allowing for improvements to be gained and generalised into other aspects of life.

Societal aspects of recovery

Identifying stigma as a significant societal barrier to recovery, Corrigan and Wassell (2008) identified three forms; public stigma, self-stigma, and label avoidance. Public stigma is summarised as what society does to people with SMI. Whilst interventions such as public protest and education have been popular, it is social contact between individuals with and without mental health problems that has been more effective. Self-stigma involves the internalisation of public stigma. Individualised interventions include psychological approaches to challenging stigma's legitimacy, highlighting the potential to make informed decisions regarding disclosure, and the fostering of group identity. Label avoidance involves the avoidance of mental health services due to a fear of social implications. Interventions are less well understood but education and social contact are recommended. Relatedly, identifying that recovery congruent attitudes among the general public are crucial for social inclusion and the role mass media has in influencing stigmatising attitudes, Corrigan and colleagues (2013) randomly assigned US adult participants to one of three journalistic articles discussing mental illness in a positive, neutral or a negative context. The authors identified that the positive, recovery-focussed, article significantly decreased measures of stigma and increased affirming attitudes, with the opposite occurring for the negative article. Corrigan et al. concluded that that not all stories regarding mental health have a negative effect on public attitudes, and that public stigma may be alleviated through increasingly responsible journalism.

Finally, in a UK-based study, Yates and colleagues (2012) offer a qualitative ecological understanding of the impact of aspects of individuals' social and environmental conditions on recovery. Interviews were triangulated with additional data from photovoice and ethnography, leading to a grounded theory model of four overlapping theoretical ecological factors. Housing, space and agency highlights the role of home in providing a sense of space and agency over the social environment. Ample surroundings provide a sense of permanence and security. However, restricted housing opportunities, attributed to wider economic circumstances, are a limitation on recovery. Representations of social identity explained that individuals' social environments were shaped by the many social groups to which they belonged. Natural environments explains the role of accessible natural features in maintaining recovery and providing recuperation from stressors. Finally, Replacement communities represents a socially bound discovery of purpose, value and identity, helping to heal feelings of loss and rejection. The authors conclude that such an ecological approach provides a rich understanding which highlights the proximal and distal resources and stressors influencing recovery and implies a focus on social change in addition to the provision of individualised evidence-based treatments.

Conclusion

Review limitations

Personal recovery presents a poorly-defined domain of literature therefore despite the broad search strategy employed relevant studies may have been missed due to the limitations of academic databases and generic search terms. Similarly, although theoretically prudent and assuaged by the inclusion of nine review studies, the exclusion of articles published prior to 2007 may have limited the information available for this study. Although the comprehensiveness of this study represents a distinct strength, the wide variety of articles and themes uncovered limited the ability of this review to individually critique the methodological status of studies.

Methodological critique

Despite these limitations a broad and meaningful review of the current status of recovery literature has been provided. An ecological presentation of sub-sections illustrates that aspects of recovery research including individual, social, peer-led and statutory services are derived from a number of well-articulated, empirically-sound methodologies, including systematic reviews, randomly controlled studies and qualitative studies. The domains of community and societal aspects of recovery were found to be less well-founded. On the basis of studies included it is apparent that investigations into personal recovery continue to explore either individualistic or environmental aspects of recovery with less consideration of their mutual interaction.

Within this body of literature a need for further investigation of the individual and environmental recovery processes (e.g. CHIME), and how they may be facilitated, persists. In keeping with this purpose further UK-based studies may be required. Quantitative studies will require increased sample sizes, randomisation, intent-to-treat analyses, inclusion of drop-outs, extended follow-up, longitudinal designs and further exploration of individual and environmental variables. Although quantitative studies will be beneficial, recovery literature continues to require an improved understanding of the “environments of recovery” (Svanberg et al., 2010, p. 494). Therefore more nuanced explorations of individual elements of recovery (e.g. hope, meaning in life), environmental factors (statutory services, peer-workers, stigma, economics) and their interaction are required. This implies the benefit of qualitative methodologies including Grounded Theory (Corbin & Strauss, 2008), allowing for the inclusion of heterogeneous samples (ethnicity, SMI) and sources of data.

Summary

Recovery research continues to meet the challenges it has been set for increased rigour (Anthony, 1993; Silverstein & Bellack, 2008) however an ecological lens is required. This approach adopted by this review has allowed for a tension regarding the role of policy makers and statutory services in supporting personal recovery to be positioned within a wider tapestry of individual and environmental factors. It is apparent that in order to thrive in the 21st Century and to maintain our professional purpose on alleviating distress and increasing wellbeing (BPS, 2010), and in-keeping with a public health shift towards wellbeing (Hanlon et al., 2011), clinical psychology will be required to applying its unique competencies in novel domains including a focus on social inclusion, social activism, challenging stigma, and promoting wellbeing at a societal level (Slade, 2010; Harper & Speed, 2012). To do so will require research that identifies where "problems (and therefore solutions) lie outside the traditional service delivery system such as disability rights, stigma, and societal responses to suffering…[involving] new types of evidence…including research on wellbeing and positive psychology" (Slade, Adams & O'Hagan, 2012, p. 1).

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Matt Spencer BA Hons Grad Dip

Major Research Project

Section B: Empirical paper

An ecological exploration of the discovery of meaning and hope in personal recovery in the context of severe mental illness: A grounded theory study.

Word count: 7952 (+358)

A thesis submitted in partial fulfilment of the requirements of Canterbury Christ Church University for the degree of Doctor of Clinical Psychology

Abstract

Objectives: (1) To develop an ecological understanding of personal recovery in the context of severe mental illness (SMI) with a UK-based sample. (2) To develop a model of the discovery of hope and meaning in recovery, and relevant helping and hindering factors.

Method: A grounded theory methodology was employed as a framework for collecting and analysing qualitative data.

Results: This study provides an emergent ecological model of growth in the context of personal recovery incorporating seven theoretical categories including; prevailing contexts, the importance of relationships, purposeful goals, values-commitment, emerging self-efficacy, wellness experience, and tangible and intangible hope.

Conclusions**:** The emergent model provides a novel understanding of the individual, ecological and interactional factors facilitating the discovery of hope and meaning in life. It is anticipated that such findings will benefit the provision of statutory and peer-run mental health services, and support further research into growth in the context of SMI.

Introduction

Recovery

Discussions of recovery in the context of severe mental illness (SMI) have traditionally focussed on clinician-oriented definitions. This biomedical approach to ‘clinical recovery’ (Slade, 2009) has been critiqued for its assumption on the basis of limited evidence of a deterioration over the life course (e.g. Bentall, 2009), an assumption that is undermined by findings of robust longitudinal studies (e.g. Harrison et al., 2001). These findings have led to the conclusion that “bad outcome is not… necessary…it is a consequence of the interaction between the individual and his or her social and economic world” (Warner, 2007, p. 1444-1445).

A second usage of the term recovery has grown from accounts of people with lived experience of SMI (e.g. Coleman, 1999; O’Hagan, 1996). Although a plethora of alternative distinctions between ‘user-based’ and ‘service-based’ definitions (Schrank & Slade, 2007) exist within the service user literature the distinction between ‘clinical’ recovery and ‘personal’ recovery (Slade, 2009) be utilised throughout this study, with ‘personal recovery’ and ‘recovery’ being used interchangeably. This breadth of conceptualisations is seen to emphasise the constructivist nature of personal recovery, however a single definition has reached wide acceptance:

> “Recovery is a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness” (Anthony, 1993, p. 527).

While attention has focussed on recovery from ‘schizophrenia’, the problematic reliability of mental health diagnoses (Boyle, 2002) makes findings applicable to people experiencing SMI in general (Silverstein & Bellack, 2008).

Personal recovery has become prominent in policy across the English-speaking world (Le Boutillier et al., 2011). This approach has remained constant in UK policy since the turn of the century (Department of Health; DH, 1999; National Institute for Clinical and Healthcare Excellence; NICE, 2009) and recent policy (HM Government, 2011) has formalised a collaboration between the National Health Service (NHS) Confederation and the Centre for Mental Health to reorganise services around tenets of personal recovery (Shepherd, Boardman, & Burns, 2010). However, highlighting a significant tension, statutory services have been criticised for the opportunistic appropriation of recovery at a time of significant public sector ‘efficiency saving’ (Perkins & Slade, 2012).

Empirical and theoretical background

The empirical basis of recovery has been questioned (Silverstein & Bellack, 2008; Slade & Hayward, 2007) leading to a focus on developing a conceptual understanding of recovery (Leamy et al., 2011; Slade et al., 2012). Contributing to this field, Leamy and colleagues synthesised existing first person conceptualisations of recovery identifying three superordinate concepts including; (1) thirteen characteristics of the unique and non-linear recovery journey (Appendix 4), (2) five stages of recovery which mapped reliably onto the trans-theoretical model of change (Prochaska & DiClemente, 1982; Appendix 5), and in keeping with the findings of previous publications (e.g. Andresen, Caputi, & Oades, 2006; Bonney & Stickley, 2008) (3) five core recovery processes including; Connectedness, Hope, Identity, Meaning in life, and Empowerment (‘CHIME’).

Whilst consensus regarding the journeys and stages of recovery may have been reached (Leamy et al., 2011; Slade et al., 2012) further research is required into the recovery processes and factors helping and hindering their discovery and maintenance. Whilst research has begun to acknowledge socio-environmental factors implicated in SMI, including maltreatment (Keyes et al., 2012; Read & Bentall, 2012), trauma and abuse (Holmes, 2012), stigma (Corrigan & Penn, 1997; Van Zelst, 2009) and the loss of power (Tew et al., 2012), further research is seen to require a focus on positive psychology concepts (Slade, 2010; Slade, Adams, & O'Hagan, 2012).

Although subjective narratives are fundamental to personal recovery they present difficulties for the identification of generalised proximal and distal socio-environmental influencing factors (Harper & Speed, 2012) leading to the call for an ecological approach (Leamy et al., 2011; Onken, Craig, Ridgway, Ralph, & Cook, 2007; Silverstein & Bellack, 2008; Yates, Holmes, & Priest, 2012). This is said to allow for the incorporation of the individual, their environment, and the interaction between the two (Onken et al., 2007; Spencer, 2013).

Whilst research from English-speaking countries is prominent (91%; Slade et al., 2012), further UK-based research is required with individuals experiencing a range of SMI and from varying backgrounds (Leamy et al., 2011). While processes “more social in conception” (Connectedness, Identity and Empowerment; Tew et al., 2012, p. 445) have been reviewed, further research in the psychological and socio-environmental mechanisms that facilitate the discovery and maintenance of the processes more psychological in nature, namely Hope and Meaning in life, is pertinent.

Hope

Schrank and colleagues (2008) define hope as a "future-orientated expectation…of attaining personally-valued goals, relationships or spirituality, where attainment: i) will give meaning, ii) is subjectively considered realistic or possible and iii) depends on personal activity or characteristics or external factors" (p. 426).

Hope is widely cited in recovery narratives as a 'catalyst' (Andresen, Oades, & Caputi, 2003) and crucial in launching the recovery journey (Anthony, 1993). Hope is seen to fluctuate (Onken et al., 2007) and maintains recovery through the belief that improvement is possible (Jacobson & Greenley, 2001). Sources of hope include from within, through spirituality, peers, role models and professionals (Deegan, 1988; Onken et al., 2007). Conversely lack of hope among professionals, informed by the false sense of inevitable deterioration, is seen to diminish hope (Schrank et al., 2008).

Within recovery literature three models of hope exist. Snyder and colleagues' (2006) theory-driven model of hope in psychiatric rehabilitation comprises three elements including (1) setting goals; (2) finding, planning and implementing pathways to the goal ('pathway thinking'); and (3) exhibiting goal-directed activity ('agency thinking'). Russinova's (1999) theory-driven cyclical relational model focusses on the role of clinicians in instilling hope. Recovery and hope are said to exist in a dialectical relationship where "hope functions as both a source and an outcome of the recovery process" (p. 53). According to Russinova, recovery involves the identification of internal and external resources which facilitate increased activity, and a contingent sense of meaning and purpose in life. This process contributes to increase interpersonal relationships, and therefore further access to external resources, and increased hope, facilitating a sense of growing internal resources.

Finally, Hobbs and Baker (2012) offer a grounded theory model of the interaction between hope and recovery that is comprised of three interacting categories; personal hope, doing recovery, and the influence of others on hope. Personal hope refers to the ability to interpret life events as catalysts for recovery through triggering hope. Hope was seen to contribute to the active process of 'doing recovery' through providing the motivation to maintain the transition to a more recovery-focussed life, involving the obtaining of understanding. Finally, relationships were significant in providing support, models of recovery, and belief in the possibility of recovery.

Meaning in life

Both Russinova (1999) and Schrank et al. (2008) offer hypothesised associations between hope and meaning in recovery. Russinova implies that meaning in life may represent both an outcome and an integral component of the cycle of hope in recovery, whereby meaning and purpose in life are seen to be triggered by increased social activity and is interrelated with the "rebuilding of a wounded self" (p. 53). Schrank and colleagues, citing Husserl (1966) and Thompson (2007), assert that the discovery of meaning in life takes place through an on-going revision of past experiences, hope and meaning therefore exist in a reciprocal relationship, whereby increased meaning in past experiences leads to increased hope for the future and vice versa.

These approaches offer subtly differing conceptualisations of meaning in life, that are commonly conflated (Steger, 2012). Steger clarifies that meaning in life represents a superordinate term encompassing two dimensions; comprehension and purpose. Comprehension represents the ability to make sense of and understand self and external world. Purpose refers to the presence of overarching, life-long aspirations that are self-congruent and motivating. It is therefore possible that hope may have a role in both facilitating purpose (e.g. Russinova, 1999) and in developing a sense of comprehension (e.g. Schrank et al., 2008). This is mirrored by a distinction between purpose and meaning and re-authoring within the recovery literature (Onken et al., 2007). Here purpose and meaning refers to the discovery of what makes life enriching, whilst re-authoring, informed by Foucault (1979; 1980), White (1989; 1991) and Freire (2000), is seen to involve growth through the re-storying of the challenges associated with the experience of SMI.

In addition, other positive psychology theorists offer alternative conceptualisations of meaning in life. Baumeister's (1991) four needs for meaning are found to include purpose, value, self-worth and efficacy. Purpose represents the interpretation of ones actions in terms of a possible future including goals and fulfilments, value relates to the interpretation of activities as good and justifiable, efficacy refers to a sense of being able to make a difference, and self-worth represents a need for the self to be regarded positively by others.

Study rationale and aims

A paradigm shift is taking place towards an acceptance of the relevance of the personal recovery approach. Previous research has alleviated previous inadequacies in the literature leading to a degree of clarity regarding the journeys and stages of personal recovery. Interest has now turned to recovery processes, including Hope and Meaning in life, and their helping and hindering factors. An ecological approach is seen to assist this line of enquiry by overcoming the limitations imposed by a previous reliance on individualised accounts.

This study's aims are twofold, (1) to develop an ecological understanding of personal recovery with a demographically heterogeneous UK-based sample. Based on this ecological understanding, this study also aims to (2) develop a preliminary grounded theory model of the discovery of hope and meaning in recovery, and relevant helping and hindering factors.

Methodology

Participants

Participants (n=23) were recruited from three London-based organisations. Ranging in age from 18-82 years, 60% of participants were male and 43% self-reported being British, English and/or White (see Table 2). All three organisations provided community-based input supporting individuals in their personal recovery in the context of mental health difficulties. Two organisations were voluntary sector and peer-run, a third was co-produced by service users and NHS staff. Participants were included in the study if they recognised their own lived experience of personal recovery in the context of mental health difficulties and an increase in hope and meaning in life. Given the problematic nature of mental health diagnoses (Boyle, 2002) no exclusions were made on the basis of diagnosis, however individuals were excluded if they lacked fluency in English or capacity to consent.

Number	Pseudonym	Gender	Focus group/ Organisation number	Preferred description of ethnicity	Preferred description of difficulty
1	Chris	M	1	-	Voice hearer
2	Nina	F	1	-	Voice hearer
3	Mark	M	1	-	Voice hearer
4	Steve	M	1	-	Voice hearer
5	David	M	1	-	Voice hearer
6	Carol	F	2	White British	Depression
7	Alan	M	2	British	Paranoid schizophrenia
8	Pete	M	2	-	Not given
9	Oliver	M	2	-	Not given
10	Lisa	F	2	White British	Personality Disorder
11	Dean	M	2	White	Psychosis
12	Malcolm	M	2	British Turkish Cypriot	Bipolar
13	Jack	M	2	British Indian	Schizophrenia
14	Anna	F	3	-	-
15	Jane	F	3	-	-
16	Belinda	F	3	White British	Depressive personality
17	Liam	M	3	White English	Mild depression
18	Miles	M	3	White British	Schizophrenia
19	Sham	M	3	British Asian	Paranoid schizophrenia
20	Vinnie	M	3	White	Loopy
21	Toni	F	3	British	Anxiety/ Depression
22	Chrissie	F	3	White British	OCD, Complex PTSD
23	Sally	-	3	White British	Life

Table 2: Participant demographic data

Design

This exploratory study required the adoption of a qualitative design. Data collection via focus groups was considered beneficial for the development of an ecological model. Such an approach is recognised for its capacity to reduce interviewer subjectivity and is “less artificial than on-to-one interviews…mean[ing] that the data generated by it are likely to have higher ecological validity” (Willig, 2001, p. 29). Focus groups commenced with open-ended questions, allowing for the researcher to “mobilize participants to…comment on one another’s contributions” (p. 29).

Procedure

Ethical approval was granted by an NHS Research Ethics Committee (Appendix 6). Approval was obtained from organisations according to management policy (Appendix 11) and/or NHS Trust R&D departments (Appendix 7). Quotations presented below are anonymised and have been allocated a number to distinguish organisational membership (e.g. Toni3).

Suitable organisations, and potential participants, were identified through visits and presentations at recovery-oriented organisations (e.g. Friends of East End Loonies), fundraising events (e.g. Humane Therapy) and research network meetings (e.g. Recovery Research Network), and via research supervisors. As a result a range of organisations were consulted. Each focus group required preliminary visits to each organisation, giving opportunity to circulate the study’s ethical information (Appendices 8-10) and to discuss inclusion and exclusion criteria, leading to the identification of suitable participants. The focus groups were then arranged for a mutually convenient date and time, lasting between 90-

120 minutes. All were semi-structured and based on an initial protocol (See Box 1 and Appendix 12). Prior to each focus group ground rules were agreed; including duration, confidentiality, respect for individual opinion, and my role as facilitator. Each group commenced with a question regarding individual definitions of recovery after which time my role as facilitator became to observe the groups' discussions, facilitating conversation, whilst managing group process and encouraging the consideration of minority perspectives.

Participants found the focus groups to have been a respectful environment in which to construct their own story, and to help others to do so. Audio-recordings were transcribed by the researcher, and participants were provided with a written summary offering an opportunity for further individualised feedback (Appendix 13). As a result of the analysis of the initial focus group, subsequent recruitment followed the theoretical sampling approach, thereby "letting the research guide… [the] data collection" (Corbin & Strauss, 2008, p. 158). Further focus groups were therefore organised with the aim of further developing or refuting concepts emergent in the data through processes of constant comparison between both focus groups and participants (Corbin & Strauss, 2008). This led to refinement of the focus group protocol overtime.

In addition, two sources of triangulation were identified. To provide further data and a comfortable start point for discussions (Romano, McKay, & Boydell, 2011), participants were asked to bring items representing their recovery. A presentation given by a leader of one included organisation on her experiences of the mental health system was also included.

Preamble

Key questions:

- How might you define recovery?
- What processes have been involved in your recovery?
    - What does hope/meaning mean to you?
    - What made it possible/difficult to discover?
- How have organisations/individuals/experiences enabled/inhibited the discovery of hope/meaning?
- What else has recovery meant for you (positive and negatives)?
- What/how do you hope to develop?
- Questions regarding recovery-oriented practice.

Debrief

Box 1: Abbreviated initial focus group protocol

Data analysis

To illuminate the mechanisms underpinning the discovery hope and meaning in recovery and to generate hypotheses from the data, Grounded Theory's (GT; Corbin & Strauss, 2008, Henwood & Pidgeon, 2003) focus on theory-building made this approach the most suitable method of analysis. GT provides (1) a framework for considering meanings in participant accounts (Corbin & Strauss, 2008), (2) takes into account researcher subjectivity through the rigorous analysis of data (Mays & Pope, 1995), and (3) allows for the identification of emergent psychological and social processes in the development of an explanatory theoretical model (Henwood & Pidgeon, 2003). In applying this approach four stages of analysis were followed including (1) open-coding; (2) constant comparison, theoretical sampling, and theoretical memos; (3) focused coding until a pragmatic degree of theoretical sufficiency was reached (Dey, 1999); leading to (4) the development of an explanatory theory (Henwood & Pigeon, 2003).

Quality assurance

Guidelines for enhancing methodological credibility were followed throughout this study (Elliot, Fischer, & Rennie, 1999; Appendix 2).

My own journey through clinical psychology has provided me with extensive encounters with psychological distress, leading me to favour an approach to clinical work that is summarised by the social constructionist (White & Epston, 1990) and humanistic (Rogers, 1961) approaches. Throughout the course of this study the keeping of a reflective diary (Appendix 15) allowed me to acknowledge my own subjectivity, whilst maintaining my sensitivity to concepts emergent within the data.

Whilst participants represent a suitably heterogeneous sample with demographic data provided (Table 2), they are unified in the commonality of their experience of coping with life in the context of the cultural, social and political pressures of early 21st century London.

To ground results quotations are used throughout the results section and additional quotes, sub-categories and categories are provided (Appendix 16). To establish further methodological credibility, research supervisors and colleagues in a grounded theory peer-support group crossed-checked a coded transcript. Additionally, respondent validation was sought through emailing preliminary findings to participants. To ensure coherence of results, findings are presented in both narrative and diagrammatic form.

Finally, this study aims to develop theoretically generalisable insight into the universal processes involved in recovery. This has however required operationalization through the recruitment of a relatively heterogeneous purposive sample, meaning that findings may be limited in their applicability to a specific group of individuals accessing recovery-oriented organisations within London. Therefore, whilst broader generalisability of findings may be limited, it is hoped that findings discussed below resonate with all readers.

Results

> Vinnie3: Recovery is where you regain control over your life, where you start to have your own aspirations, wants and agenda again.

As this quotation infers, this study identifies that the processes of recovery, and the discovery of hope and meaning, are found to be derived from participants' experience of three core processes referred to in this model as purposeful goals ('wants and agenda'), emerging self-efficacy ('control'), and values-commitment ('aspirations').

Figure 2 presents an emergent ecological model of growth in the context of personal recovery that is elucidated further in narrative form below. These three core processes, on which hope and meaning are based, are found to be embedded within broader contextual challenges to, and opportunities for, growth and change. The opportunities and challenges are summarised as ecological factors including experiences associated with illness, the availability of resources within the surrounding environment, and the prevailing societal context, and are made more or less favourable by the role of interpersonal relationships.

Reflecting previous findings that recovery is individualised and non-linear, this model is found to be dynamic rather than developmental, growing or contracting as internal and external conditions, mediated by interpersonal relationships, become more or less favourable for the individual. However, one developmental implication of this model is a tendency, via processes of integration and growth, for individuals to progress from illness experience towards wellness experience.

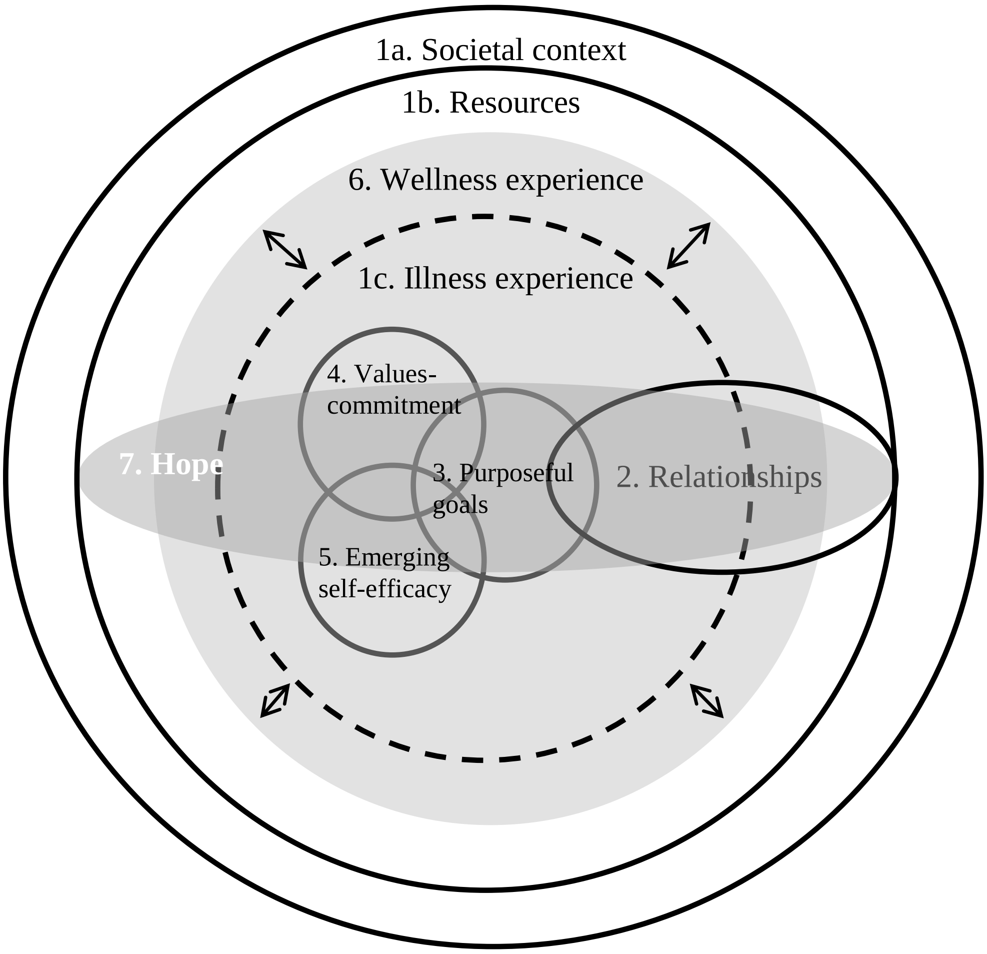

Figure 2: An emergent ecological model of growth in the context of personal recovery

Category 1. Prevailing contexts

Subcategory 1a. Societal context

This subcategory refers to external processes influencing the lives of participants. These social, economic, and political forces are seen to exacerbate pre-existing ‘vulnerabilities’.

> Chris1: We are vulnerable to a certain degree because of the way we are made up, and [further by] the way we are stunted by society.

Participants provided a strong awareness of dominant discourses as rules or ‘typical markers’ of self-worth. Abiding by these rules conveys a positive sense of meaning and inclusion by society. For many these markers have become oppressive, leading to a sense of meaninglessness, diminished value and self-worth, and exclusion.

> Carole2: It is social pressure, you feel like you have to have a job and a partner and that sort of thing to be successful.

Additionally, participants reported discrimination and stigma as a result of seeking assistance for their difficulties and the consequent diagnostic labelling, leading to an understanding of the wider social context in which they seek growth and acceptance.

> Mark1: There is a lot of stereotyping round here and we all suffer from it*…it’s* not just the way that society stigmatises people who hear voices, but the way society stigmatises groups in general.

Although support is available for the disempowered, current experiences of the labour market and benefits system were seen to further undermine.

> Alan2: I have been put on back to work schemes where it was blatant that they were using it just to get people to do a job. There was no job at the end of it…you were being treated like dirt.

Participants were particularly concerned for the accessibility of mental health services. Current structural changes were seen to undermine their needs and contribute to, rather than alleviate, suffering.

> Chrissie3: It tends to be the powers that be…the consultants or whatever, are the ones making decisions very often without ever meeting you…My fear is that with things like *Payment by Results*… it is going to become worse.

Subcategory 1b. Vitality of resources

Participants found the concept of 'growth' to be more explanatory of their experience than 'recovery', and emergent within discussions of growth was a metaphor of the cultivation of a garden. In this metaphor individual recovery is seen as taking place within a wider ecosystem derived of factors promoting or hindering growth. Access to, and quality of, social and material resources were seen as fundamental nutrients supporting growth.

> Liam3: I think people can grow through tragedy, but… *it's not a certainty, you can* use the metaphor of a garden, there are *some conditions that are better…*for growing.

Significant nutrients/resources included timing, time, medication, benefits, meaningful work and relationships. Timing and time emerge as two related but distinct concepts. **'**Timing' refers to the potential within the system surrounding the individual to respond at the point that conditions internal to the individual are at their optimum. Conversely the provision of resources in the absence of an individual's readiness can be detrimental.

Chris1: *I emphasise, it's when you are ready and not other people.*

Malcolm2: *some patients can be discharged before they don't even know that they are* recovering, and that can make it difficult for that individual to move on.

Recovery was seen as work and a life-long project, and therefore fundamentally requiring 'time'. Time was found to be dependent on the availability of other resources, including income, housing and medication.

Oliver2: I truly personally believe that this is a life-long project for me.

Dean2: Being on medication and being on benefits has given me time.

A final resource included the opportunity for meaningful activity within the environment.

Alan2: T*here's a* hell of a difference between [employment schemes] and voluntary work.

Linking the categories of prevailing context and wellness experience, participants found relationships to represent a resource helping or hindering the negotiation of resources within their surrounding environment.

> Liam3: *Then there's these gatekeepers…*paid professionals*… if they're helpful then* you are in good stead… *if…* not then you*'re* screwed.

Subcategory 1c. Illness experience

Emergent in the data was a sense of recovery from *"s*omething that is defined as mental illness*"* (Belinda3), Illness experience refers to:

> Vinnie3: a situation where y*ou…*have been overpowered…took into a current that has wrecked all your plans, played havoc with where you were and caused you not to function in the way that you have been functioning*…[and]…* put you into the hands of psycho-authorities who further interfere.

Associated experiences of loss, symptoms, hospitalisation and, in some cases, trauma and abuse, are seen to contribute to a sense of meaninglessness and hopelessness. This sense of loss is profound and encompasses relationships, identity and aspirations.

> Oliver2: *Going through… revolution…war… then becoming a refugee… I managed* all of those, but I never thought that a simple diagnosis of depression would take all that away.

Participants discussed the potency of their symptoms, their on-going struggle, and relapse.

> Malcolm2: When I am unwell and I go into hospital… I come out…*[and]…have to take*…life from the beginning, I have to create meaning and g*oals, and it doesn't* come easily.

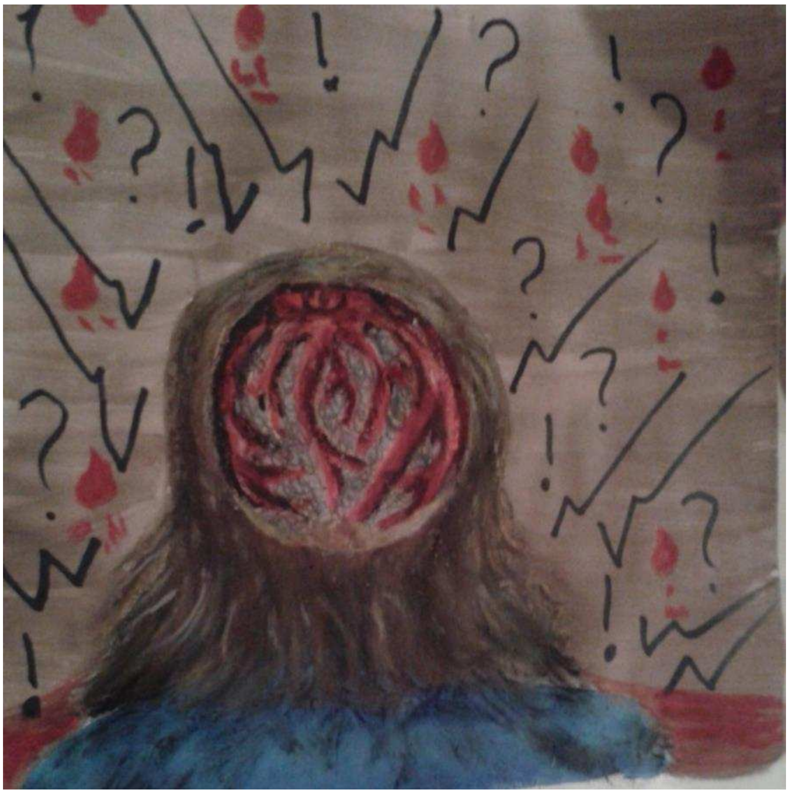

Figure 3: A painting provided by Toni representing an aspect of 'illness experience'

A significant aspect of many people's experience is that of hospitalisation where boredom and discouragement of individuality and spirituality are commonplace.

> Lisa2: E*very day in*…hospital*…there's no meaning.*

For many, a history of neglect, trauma and other forms of invalidation represented a significant aspect of individuals' life experiences.

> David1: If I *forgot about the past I wouldn't be here. I'd be outside with normal* people.

Category 2. The importance of relationships

> Nina1: I*t's better to be around people because we are all social beings*.

Relationships were seen as vital, and positive relationships presented a significant social trigger for recovery. Hope is conveyed through encounters with helpful, understanding others. Peer role-models and helpful professionals were found to help plant and nourish the seeds of meaning and hope for recovery. However, relationships were also found to be devaluing and hopelessness-inducing.

Subcategory 2a. Diminishing relationships

Unhelpful, diminishing relationships limited growth through the processes of labelling and judging, leading to a diminished sense of self-worth. Significantly these relationships were found to be common in contact with family members and professionals.

> Mark1: *Fear of being further labelled, you've already been labelled which you* consider to be a big problem, so you are obviously going to be worried about being labelled even further.

Narratives of family and acquaintances become internalised, maintaining participants' difficulties and restricting their sense of their own ability to seek assistance.

> Belinda3: My own blood kin were lethal to me, in terms of dragging me down…I carried their teaching in my head…*whatever I did wasn't good enough.*

When opportunities to access support arise individuals' hope can be diminished by the experience of flawed support.

> Chrissie3: If they then try and take it outside of that close family friends arena…if the *person they then turn to doesn't get it or they get a kind of negative response…* that makes them feel even worse… it*'s* even harder for them to try again.

When individuals are able to access professional support, the basis of 'helping' relationships on a medicalised understanding of distress was found to be insufficient. Being seen as a "bundle of neurons" (Oliver2) led individuals to feel less than a whole-being, leading to calls for an increased sense of humanity in mental health.

> Chrissie3: O*f course… things go awry, because they are not actually* dealing with the actual person…they just sort of fasten on to this diagnosis of whatever it is and think

> ‘oh that is *how you treat that diagnosis’ without actually thinking that this person* might have other issues that are far more important.

> Chris1: You cross that medical model with some humanity, makes it better.

Subcategory 2b. Enabling relationships

Genuinely helpful relationships are seen as vital enabling catalysts for recovery.

> Toni3: [When] *I fall into a hole and I’m* in very deep, which I have been ... there are *some holes that you just can’t get out of by yourself.*

Peers and peer organisations provide relationships based on a unique understanding unavailable elsewhere in society. For individuals who may feel insecure in personal relationships, such settings provide the secure base, time and understanding to develop trusting and valuing relationships.

> Mark1: These sorts of groups are a sort of [healthy] dependency.

> Alan2: I*t’s like people that understand you and can accept you for who you are, whereas the rest of society maybe don’t*.

Engaging in the varying activities offered by such organisations with accepting peers allows opportunities to develop hope, and to talk and reflect on experiences.

> Jane3: I find a new lease of hope from coming here and doing hobbies and things that I really enjoy.

> Nina1: Talking about it, even saying something about it, letting the feeling out, you can let something go.

Outcomes include the awakening of a sense of agency through engagement in activities, engagement in relationships leads to a sense of being valued and of reciprocity.

> Alan2: [This organisation has] provided me with my own way of building my self-esteem.

> Steve1: [I appreciate] being understood, and hopefully people take away something about what I say.

Participants also provided evidence that recovery-promoting interactions can take place with professionals. Being genuinely understood and empathised with was restorative. Additionally, care staff, therapists and consultant psychiatrists were influential as initial sources of efficacy supporting goal-directed activity, and in the scaffolding of a growing sense of the potential for change, and therefore hope.

> Toni3: [Care staff] started getting me out of my hole with colouring in, which is sort of primary school stuff, but actually colouring in for me has led to where I am now with the art.

> Alan2: A care plan can be great, it gives you a bit of structure, something to aim for.

> Chris1: The first time I was ever introduced to a psychiatrist... he put a tablet on the *table and said 'that's 10% towards your recovery, the other 90% is what you do with your life'. He planted a seed.*

Category 3. Purposeful goals

Scaffolded via enabling and understanding relationships, individuals were more able to determine intrinsically motivating activities. Equally, part of recovery appears to be an appraisal of what may now be possible and what may be out of reach.

> Vinnie3: *Recovery…[is]…*being able to set our own goals again, and being able to pursue our own goals.

> Liam3: Acknowledging that some other goals may not be achievable, or have passed.

The setting of intrinsically-valued goals were seen to provide purpose and meaning in life.

> Malcolm2: When I am well, I seem to be taking on a lot of projects and I have a lot of things that give my life meaning

The setting of goals fell into an hierarchy of subcategories including; problem management, hobbies and activities, volunteering, training and employment, and activism.

Participants were interested in the autonomous management of psychological difficulties, with the aim of coping independent of services.

> Toni3: When I am in a bad state I self-harm and it makes me feel better*…my* goal …is to be able to control it.

> Nina1: Coming here and talking about it and placing [voices] and letting [them] go has freed me to move on. [‘Placing’ refers to a process of comprehending the origin and meaning of voices]

In addition to overcoming problems, individuals were interested in living beyond the confines of ‘illness experience’. Purposeful goals included a focus on interests, hobbies and self-development, providing a conduit for self-expression, access to role models, and external sources of hope.

> Lisa2: The other day I played pool for the first time… it was just an activity that I *hadn’t done before…a*nd that was meaningful to me.

> Miles3: Regarding finding a hobby that you enjoy doing and using it to let out anger I *was doing it with boxing…I haven’t really found many things that I’m good at.*

Other goals sought included volunteering, support work, training and education. Whilst also providing a pathway to paid employment, unpaid activity, including peer support, was seen to provide a valuable source of self-worth, as contributions are recognised.

> Carole2: When I was sitting at home every day I felt really worthless. Now I do volunteering and do other things.

> Chrissie3: *One of the things that has kept me going…has been to form a support* group to help other people [abused by professionals].

A significant purpose for many included activism. Through creating change within a system that has had a contributory factor in their own difficulties activism presented an opportunity to find meaning in their own experiences. Activism remained motivating despite the enormity of the challenge and the potential for failure, and individuals were aware of the hopeful communication activism provides for individuals in more challenging situations.

> Carole2: *Mental health awareness… probably gives us all a sense that we are trying to contribute…to bringing something good out of some*thing bad.

> Chrissie3: *I certainly don't expect to succeed…t*hat you have actually expressed your opinion*…[and]…*tried to do some*thing about it, someone…* will have been affected by that.

Category 4. Values-commitment

Individuals found previous values to have been challenged through their experiences, leading to the need to establish new values. An element of recovery identified as a values-battle (Chris1). This process relates to the shedding of internalised and degrading dominant discourses, replacing them with more wellbeing-focussed values.

> Alan2: *It's about trying to redefine what is important in life to me*.

> Liam3: So the idea is whether we create our own kind of markers.

Emergent values included a need for compassion and love for self and others, a belief in the possibility of growth after tragedy, a focus on positive in people's lives and to make a positive contribution to society, and for increased self-knowledge and openness to the full range of emotions.

Figure 4: A material item Dean carried with him as a reminder of his value of love for self and others

> Sham3: *Initially I was so disabled…I said …'I will keep love in my heart, I can't show* that love, but I will keep that love in my heart, towards people, towards animals, towards the world.

> Toni3: I think that also bad stuff can lead to good stuff.

> Chris1: I... aspire to be a good member of society, someone that is thought of as being caring and nurturing.

Finally, values guided the selection of life-goals, provided a source of self-worth when acknowledged by others, and a source of determination and resilience against failure.

> Sham3: *Values*...shape your ability to be determined... *[and]*...make you determined against adversity.

Category 5. Emerging self-efficacy

Emergent in the data is the discovery by individuals of their increasing potentiality as actors in their own lives. Restorative and enabling relationships convey a sense of self-worth and the identification and attainment of intrinsically-valued goals. Significantly, peer-led organisations are seen to facilitate this through promoting agency and choice.

> Chris1: The group is here as a self-help group...it must give people options and choices in their life...*p*eople select things they want from the group. Once they have had that need met then they...move on.

Participants provide a generalised sense of increasing self-efficacy and empowerment, which occurs in tandem with increasing hopefulness that change is possible.

> Jane3: There are positive things out there…we have to look for them.

> Jack2: *It's about taking chances in life*... we have had less chances than other people…*t*ake your chances. We all have chances in life.

This hopeful sense of possibility is applied in various specific contexts with the aim of facilitating and maintaining a sense of wellness. Examples include identifying resources, meaning relationships and purposeful activities.

> Liam3: It is about identifying resources and using them, I guess that way you need to be a bit entrepreneurial.

> Belinda3: The issue *of nice people, somehow that…* is very much like creating the circumstances that will have a beneficial effect.

Category 6. Wellness experience

> Chris1: Once you throw illness out of the scenario people immediately feel better.

Present within participant accounts is an emergent concept of wellness. This concept indicates an increasing sense of the ability of individuals to experience change in their lives. This category is dependent on the experience of previously discussed concepts including enabling relationships, values, goals and self-efficacy. Wellness experience implies a sense of positive change and hopefulness through engagement in reflection on experience and developing insight, the generation of more hopeful narratives through the re-storying of life experiences, and an understanding of symptoms and helpful wellness strategies.

Subcategory 6a. Recovery and change

Figure 5: Toni's painting expressing her sense of the possibility of flourishing over time

'Recovery' is seen as individual and unique, involving an increasing sense of realism and optimal functioning, where the ability to experience the journey of recovery may represent an end in itself.

> Mark1: All roads lead to Rome… you can get to recovery, but there are many ways to *get there, so you have to find which way you're comfortable with.*

> Alan2: Everyone has the same kind of journey that they are on but they go about it on a different path.

However, emergent in participant accounts is the sense that recovery represents a concept applied to their experience rather than experienced directly. In place of recovery, processes of change and growth represented more acceptable and explanatory concepts, processes taking place through participants interactions and engagement with peers, others and systems.

> Toni3: That is quite difficult at times, it is a challenging process, but it is a process of change I think.

> Belinda3: With every passing moment we are having different experiences, stuff is going on, and those experiences can affect and are effecting us.

Subcategory 6b. Reflection, insight and acceptance of emotions

Through this process of change individuals reported learning to reflect and learn from experience and, as a result, develop insight into their difficulties and an increasing ability to openly experience previously suppressed emotions, leading to a fuller life. Such processes are available to all, given access to appropriate conditions and role-models.

> Chris1: Reflection is a big part of the group, I hope… *people reflect while they're out* socialising.

> Malcolm2: It appears that it is about discovery of yourself

> Nina1: Recovery is part of getting back to your feelings, because you *haven't* recovered because you have supressed your feelings.

Subcategory 6c. Narratives and re-storying past and future

Across participants a key concept of change involved the re-authoring of past experiences and life stories. For many, the revisiting of labels represents an expression of self-efficacy leading to the alleviation of stigma, and an increased sense of positive-connotation and empowerment.

> Chris1: We *call ourselves 'voice hearers'…not 'paranoid schizophrenics'… [it]… hasn't got any of the connotations of violence.*

Through reflection on past experiences individuals found themselves more able to see strengths and enduring values and aspects of personality, providing direction and meaning in the present and future.

> Dean2: I*f I didn't have the psychosis and this whole thing, then maybe I would never* have experienced this.

> Liam3: [Reflection is] *so exciting, because otherwise I think there's something that* we are missing out on. For example, *I didn't complete my degre*e and my father died when I was very young, when I was 19, and those things are more important to me know? now than when they were at the time.

Finally, developing a sense of flexibility in how the self and experiences are described led to a more hopeful sense of the present and the future.

> Mark1: If you just said that you were having a bad day, well you know, you can get over a day but can you get over an illness? So what you say becomes very important, to us.

Dean2: [I no longer see] myself as a victi*m…[instead I say]* what can I learn from this?

Subcategory 6d. Patterns of symptoms and wellness strategies

In keeping with the development of increased reflexivity and insight, and meaningful and hopeful narratives and expectations, individuals expressed an increasing capacity to identify patterns in ‘problems’ and to flexibly employ strategies, developed from varying sources, to maintain their sense of change and growth away from illness and towards wellness.

> Chrissie3: *[When I relapse]…f*or about 48 hours I am just paralysed and numb, and *then eventually I think ‘ok, I have had to go through that so I understand how that feels when that happens’.*

> Dean2: Instead of the pain be*ing ‘oh man, look at me, I shouldn’t have done that’…it’s like ‘what is the gift in the pain?’.*

> Pete2: I have learned not to listen to everything [my mind] says, just ignore some of the things.

Category 7. Tangible and intangible hope

Within participant accounts hope is defined as "a human sense of possibility*" (Sally3)* and *"t*hinking positively about the possibility of new situations*" (Mark1).* Participants provided insight into the sources of hope, its relevance, and how it may be introduced and modelled. Individuals reported finding hope within themselves, via role-models, through spirituality, activity and group membership, and in literature.

> Jane3: I have got a spiritual background*…m*y hope is within my faith.

> Lisa2: I like volunteering, and I like [this organisation], that gives me a bit of hope.

Participants found hope to have been vital in the past, present and future, as a catalyst, aim and outcome of recovery.

> Pete2: I feel that hope was a big factor in my recovery, just clinging on to the thought that one day things will hopefully be back to normal

> Toni3: Developing hope is part of my recovery.

> Jane3: Recovery for me, means, I have been ill and I am now finding the hope to try and get better.

Finally, participants were able to state how they introduce hope into their lives and that of others.

Toni3*: It's a question of building for the future, and not looking backwards.*

Pete2: A part of my recovery really was to put the past in the past and to live for today and the future

Chris1: *I work with people…*in a positive way. We talk about the positive rather than the negative in their lives.

Paradoxically, although integral to growth and pervasive within accounts, participants found explicit discussion of the factors facilitating and hindering hope to be challenging. Emergent within participant accounts is a sense that hope may represent a 'superordinate' if ill-defined category, an internal state more 'felt' than 'known'. It is possible that hope is discovered and maintained, as represented in Figure 2, though in the presence of other more easily identifiable concepts including relationships, goals, values, self-efficacy, laying the foundation for a greater sense of wellness experience, that *"bad stuff can lead to good stuff"* (Toni2).

Discussion

A significant finding of this study is the recognition that 'recovery' may represent an externally applied concept, perhaps more closely allied to oppressive dominant discourses than wellness-promoting values. As a result this study has developed an emergent ecological model of growth in the context of personal recovery, grounded in the lived experience of a heterogeneous sample.

The ecological approach adopted by this study successfully positioned a model of growth, and the discovery of hope and meaning, within a broader socio-environmental context. As a consequence a range of distal and proximal socio-environmental factors (Harper & Speed, 2012) influencing illness and wellness have been identified. Within the category prevailing contexts factors inhibiting growth were found to include oppressive discourses, invalidating relationships and trauma and abuse. These were found to mirror extant literature (e.g. Holmes, 2012; Keyes et al., 2012; Read & Bentall, 2012). Labour exploitation and inadequate mental health services were also found to be inhibitory, whilst access to favourable resources, including medication, supportive services and organisations, and reasonable benefits, housing and employment opportunities were found to be assistive.

In keeping with the expectations of an ecological model, relationships were found to represent a significant interactional factor in assisting or limiting an individuals' capacity to obtain wellness. This study identified that for hope and meaning in life to be discovered enabling relationships were required. Whilst also assisting in negotiating a challenging external world, relationships were found to impart a restorative sense of self-worth and value and to trigger initial purposeful goals. On the basis of enabling and valuing relationships and the commencement of the pursuit of purposeful goals, individuals recognised an increasing sense of control over their lives (emerging self-efficacy) and felt increasingly able to evaluate internalised oppressive dominant discourses and to re-establish more congruent and wellness-promoting values (values-commitment). Fundamentally, the discovery of both hope and meaning in life was found to be on the bases of these underpinning processes.

Participants understood hope as a “future-orientated expectation” (Schrank et al., 2008, p. 426) and, further mirroring the findings in the literature (e.g. Anthony, 1993; Deegan, 1988), found it to reside within the person, to be facilitated by role-models, spirituality and activities, and to represent a catalyst and outcome of recovery. Conversely, factors facilitating the discovery of hope and its maintenance were less easily identifiable. Instead, hope was found to represent an internal ‘felt’ state, arising through enabling relationships, a developing sense of individual ownership of purposeful goals, a consequent increase in self-efficacy, and a growing values-commitment. This approach to the discovery and maintenance of hope is complementary with extant models, confirming the role of an individuals’ awareness of their own potential to obtain valued-goals (Snyder et al., 2006), the necessity of assistive interpersonal relationships in the discovery of internal resources and the accessing of external resources (Russinova, 1999), and the vitality of a supportive social context and peer role models (Hobbs & Baker, 2012).

Like hope, meaning in life was found to be both explicit and more embedded within this model. Parallels with Baumeister’s (1991) needs for meaning are perhaps most explicit, whereby enabling relationships, purposeful goals, emerging self-efficacy and values-commitment correspond approximately with Baumeister’s needs for self-worth, purpose, self-efficacy and value, respectively. Similarly Steger’s (2012) concept of purpose may be seen to represent a composite of purposeful goals and values-commitment.

Within this model, recovery was identified as a component of a larger category of wellness, incorporating more emergent concepts of change, growth, insight and re-storying. This aspect of the model suggests that meaning in life is not limited to the identification of purposeful and meaningful activities, but also involves the integration and comprehension of past experiences, symptoms, social pressures and discourses, leading to the identification of a more coherent life-story and therefore hopeful future. This aspect of the model expresses common ground with Steger's (2012) concept of meaning as comprehension, and relates closely to Onken and colleagues' (2007) re-authoring elements of recovery.

Satisfyingly, through the consideration of both hope and meaning in life, this model has been able to identify shared underlying mechanisms for both recovery processes (Leamy et al., 2011). This has additionally elucidated pre-existing hypotheses, shedding light on both Russinova's (1999) predicted role of hope in the "rebuilding of a wounded self" (p. 53) and Schrank and colleagues' (2008) assertion of the role of the identification of positive meaning in the past experiences on increased hope for the future.

A final observation is the surprising implication of this study for two associated domains of literature including recovery-style and post-traumatic growth. Studies of recovery-styles have identified two forms, referred to as 'integration' and 'sealing-over', with differences attributed to attachment style, depression and self-esteem (Leonard, 2011). Findings from this study support the suggestion that recovery-style may represent more of a continuum, whereby 'integration' may be facilitated by processes identified by this study. Secondly, and in keeping with a developing literature on the role of trauma in SMI (e.g. Holmes, 2012), this model may be consistent with the findings of the post-traumatic growth literature (Joseph & Linley, 2006). This area of research has identified the benefits of a clinical focus on growth, in addition to the reduction of distress, and has identified associations between growth, optimism (hope), self-efficacy and interpersonal relationships.

Limitations

One of the main limitations of this study was a reliance on focus groups. This approach made it more difficult to obtain a sense of individuals’ trajectories and where hope and meaning seemed to be more prominent for a given individual. However, and as intended, focus groups provided several advantages. These included the minimising of researcher bias, the development of a shared ethos within groups and an opportunity for collaborative discussion and elaboration, bringing out the social and interactional elements contributing to hope and meaning, and increasing ecological validity of findings. Although demographically heterogeneous, more rigorous recording of demographic data and specific sampling of black and minority ethnic (BME) groups may have led to an increased understanding of similarities and differences between these more heterogeneous groups and BME groups specifically. Finally, participants were sampled from London-based organisations, meaning that findings may not be generalisable to individuals beyond this municipal area and among individuals not engaged with recovery-oriented organisations. Such an approach to recruitment may have led to selection-bias, whereby only individuals interested in or experiencing the phenomena of interest may have taken part.

Clinical implications

The clinical implications of this study fall into three broad categories including; direct, community and societal implications.

This study highlights the necessity of an empathetic and valuing relationship between individuals and mental health staff, irrespective of discipline. Such a relationship provides the fertile conditions for the identification of goals, based on renegotiated and wellness-focussed values, in turn facilitating the discovery of self-efficacy and hope. This has implication for clinical psychologists providing psychological therapies, and in their work with multidisciplinary staff in facilitating a more hopeful, formulation-based, approach to the contextual understanding of individuals' presentations.

Whilst psychological therapies provide space for the integration of experiences, so too can peer relationships. Staff may seek therefore to encourage relationships between clients and peer role models. This also implies the necessity of a shift in clinical work from individualised approaches to increased community intervention, examples being the provision of support to peer-led community organisations and the instigation of co-produced peer support fora.

Finally, this study has highlighted the significant role of societal factors on the possibility of recovery and growth. The implication of this is that clinicians, including clinical psychologists, will be required to engage in societal level interventions. This is seen to include interventions that increase a population's awareness of social forces facilitating SMI and limiting recovery, whilst providing a genuine sense of empowerment to address such processes (Harper & Speed, 2012). This has been referred to as 'conscientiousisation' (Freire, 2000). Another aspect of intervention will include a public health approach, requiring the identification and promotion of processes found to support wellbeing and growth at a societal level (Antonovsky, 1996; Hanlon et al., 2012).

Future research

This study would benefit from replication and extension to include alternative samples, for example considering the discovery of hope and meaning in life among BME groups. Additionally, sampling of individuals from outside of London and from within NHS organisations (e.g. Recovery Education Centres; Shepherd et al., 2010) may prove informative. The relevance of this study to literature regarding recovery-style and post-traumatic growth may benefit from further investigation. In keeping with this avenue of research it will be beneficial to sample individuals with experience of SMI from outside recovery or NHS settings.

Conclusions

In providing an emergent ecological model of growth in the context of personal recovery this study has contributed to this domain of literature. First of all, this sample found the concept of growth to be more explanatory than personal recovery, growth taking place from illness experience towards wellness. By focussing on factors helping and hindering the discovery of both hope and meaning in life this study has identified core individual, ecological and interactional processes underpinning their discovery and maintenance. Significantly, interpersonal relationships were found to mediate access to positive societal factors promoting growth, and to facilitate individual processes including purposeful goals, self-efficacy and values-commitment, three processes found to underpin the discovery of both hope and meaning. These findings are seen to have implications for current clinical practice and future research, including the role of social and societal factors in the onset and maintenance of distress, and an increased need for an understanding of how clinical practice can contribute to growth.

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Matt Spencer BA Hons Grad Dip

Major Research Project

Section C: Critical appraisal

Word count: 1900

A thesis submitted in partial fulfilment of the requirements of Canterbury Christ Church
University for the degree of Doctor of Clinical Psychology

Question 1: What research skills have you learned and what research abilities have you developed from undertaking this project and what do you think you need to learn further?

The completion of this study has developed my skills across the various stages of the research process. As a result of the Salomons research fair I followed-up several appealing and available studies, unfortunately these proved either unfeasible or oversubscribed. As a consequence I resorted to reflection on my own research interests, contrasting them with those of available research supervisors. This process required me to develop skills for the completion of an initial literature review and the resilience to identify, and negate, a number of options before settling on a realistic research area. As a consequence I believe I was able to identify a feasible and relevant topic that was also personally interesting, a necessity which has maintained my interest throughout what has at times proven a particularly demanding period.

Obtaining approval for my proposal from the course was a helpful process, preparing me to present and defend my research with a subsequent NHS Research Ethics Committee (REC). I am pleased to have had the opportunity to complete the paperwork necessary in order to obtain NHS ethical approval, I found this to be a demanding enterprise but I am convinced it will be of great value for future NHS ethics submissions. Despite the rigorous practice offered by the Salomons research proposal process, I found the presentation to the REC, and the obtaining of consequent NHS ethical approval, to represent a significant challenge. I was to regret my selection of REC on the basis of convenience. For future reference I will identify RECs with experience of the research topic for which I am seeking approval.

Whilst research into ‘personal recovery’ has been an established domain of interest for psychology and psychiatry for over a quarter of a century (e.g. Deegan, 1988), the absence of a mental health professional on my REC left me presenting on a novel alternative to ‘clinical recovery’ to an unfavourable and at times hostile audience of scientists, general practitioners and representatives of the pharmaceutical industry. Although supported by a favourable member of the committee, a vicar, the REC was concerned regarding the safety of this research, querying whether it may ‘jeopardise…patients' mental health status’. Although their concerns were alleviated through subsequent letters this challenging process left me with a vivid insight into the paternalistic and at times oppressive concerns of the wider community for the volatility and fragility of individuals diagnosed with mental health problems. This experience awakened my potential as a ‘social agent’, leading me to discuss the possibility of recovery with friends and acquaintances.

Despite having previously completed several critical reviews during the course, I found completing a thorough systematic review to provide a significant development in my skills. Personal recovery continues to present an ill-defined domain of literature, as a consequence, and in order to complete a rigorous review, I learned to be flexible in my application of rather rigid academic database ‘search terms’ and ‘wildcards’. Initial results were very broad leaving me with a significant burden of manual searches of abstracts and reference sections before reaching a manageable and highly relevant domain of literature to be reviewed.

Having identified a relevant and urgent area of research and obtained necessary ethical approval, participant recruitment proved a satisfying and eye-opening, if time-consuming, challenge. Over many months I have been in contact with many recovery-oriented organisations across the South East of England. Frustratingly, whilst the majority of organisations were found to be interested in this study many found it too difficult to allocate scarce resources to support the project. Over the course of several months, and a great many visits to organisations, fund-raising events and research networks across London, I developed links to organisations that were able to support the study. Whilst this process was at times lonely and frustrating, requiring perseverance and self-belief, I was very satisfied to have had the experience of coming across very capable and warm individuals most of whom were coping, albeit variably, and thriving despite significant adversity and discrimination, who also accepted me despite my label as a ‘professional’!

Having previously only presented my study to professionals, over the course of the recruitment process I learned to adapt my material to engage groups of potential participants. This involved a process of reflection on how mental health difficulties are socially constructed, and on my own contribution to dominant and individualising discourses. On several occasions I was able to take part in more enabling and empowering exchanges. In one example, I was asked to facilitate a discussion on research methodology prior to promoting my study to potential participants. This exchange led on to the successful completion of one focus group.

Early in the study I became a member of the Recovery Research Network (www.researchintorecovery.com). This allowed me contact with professional and peer-worker researchers, and allowed me to ‘tune in’ to current debate in recovery research. This also provided me with an opportunity to engage with a number of key researchers, a significant example being Professor Mike Slade, a prolific researcher cited extensively in this study. These discussions boosted my confidence in the relevance of my study and the direction it was now taking.

Having recognised that the exploratory nature of this study most suited a qualitative methodology I identified that grounded theory (Corbin & Strauss, 2008) would provide the ‘critical-realist’ required. This method of analysis, in its critical-realist form, was selected due to its potential to generate hypotheses from the data, for building a theory over time as an outcome of an ‘iterative process’, and for maintaining and acknowledging researcher subjectivity whilst permitting the inclusion of multiple sources of data and pre-existing literature.

Although I have previous experience of qualitative research, I found this study to require a significant improvement in my skills. Whilst I have experience of individual interviews and of clinical group work, the selection of focus groups as the primary source of data collection presented a challenge. I was able to pilot my focus group protocol and practice facilitation skills with a cohort of fellow trainees, and over the course of this research became more comfortable in ‘conducting’ the focus group, allowing for a more naturalistic flow in participants responses to each other. It was satisfying that, at the close of each focus group, participants reported finding the meeting to have been an enjoyable opportunity to hear about the experiences of others and to re-author their own story.

Question 2: If you were able to do this project again, what would you do differently and why?

Considering the limitations on this project as a doctoral dissertation, which involved a limited timescale and particular expectations, it would have been challenging to carry out this study in a markedly differing fashion, additionally measures to enhance credibility of findings were adhered to throughout (Elliot, Fischer & Rennie, 1999). However were repetition possible some amendments would be considered.

First of all, an alternative approach to recruitment may have provided additional data, and overcome a possible source of selection bias. All participants were recruited on the basis of their membership of recovery-oriented organisations, whilst this was a pragmatic and informative approach to recruitment it may have limited findings to this discrete group. It may have been informative to recruit participants meeting the inclusion criteria that did not attend such groups. It is an additional loss for this study that whilst research and development consent was obtained for recruitment from a Recovery Education Centre (Shepherd, Boardman & Burns, 2010) embedded within an NHS trust this focus group did not come to fruition. Data from this perspective would have made a valuable addition to that otherwise obtained from peer-led or co-produced organisations. Finally, regarding recruitment, previous research (Leamy et al., 2011) has highlighted an interest in the possibility of differing factors underpinning recovery among BME populations. Whilst this sample included BME individuals, sampling from a BME specific organisation may have been of benefit.

Ethical approval was obtained for the completion of individual interviews should individuals provide interest in participation but a preference not to take part in a focus group. In practice no such request was made, nevertheless the completion of individual interviews may have provided additional new data.

The completion of this study within the given time frame presented a significant challenge, exacerbated by the additional pressures of the doctorate course. However, if repeated it would be satisfying to allocate additional time to presenting findings in person prior to the deadline. Given time constraints respondent validation was sought by email, however face-to-face responses would have been beneficial. Visits and presentations to participating organisations are planned to take place post-submission.

Question 3: Clinically, as a consequence of doing this study, would you do anything differently, and why?

During its early stages I became aware that this study may also represent an opportunity to acknowledge and challenge my own relationship with clinical psychology, my preconceptions regarding the provision of mental health services, and my understanding of how mental health problems may be socially-constructed.

Through collaborating in the construction of an ecological model of recovery with a range of individuals with diverse backgrounds and experiences I feel I have been given an opportunity to appreciate the role of the current UK context, in its widest sense, in the onset and maintenance of, what society finds it containing to refer to as, ‘mental illnesses’. Whilst impossible to break down the barriers between clinician and client, I now appreciate more than ever the need to view the people I work with as people, and to have an awareness of the uniqueness of the context in which they live.

Two factors stand out as learnings for clinical practice. This study has consolidated my belief in the primacy of reciprocal and hopeful relationships, especially with those for whom interpersonal relationships present a source of dread. Secondly, an initial reticence towards the benefits and relevance of peer-workers in mental health services has been replaced by a determined conviction in their role as sources of hope and support unachievable by traditional clinicians.

Question 4: If you were to undertake further research in this area what would that research project seek to answer and how would you go about doing it?

I was supported in the completion of this study through a small research group with shared interests. Other members of this group were pursuing understandings of the experiences; of individuals who had dropped out from psychological therapy, of clinicians with lived experience of severe mental illness, of clinicians suffering vicarious traumatisation, and of service users' involved in the training of clinicians.

Whilst this standalone study has provided a meaningful addition to the recovery literature, its findings of relevance to an understand of hope and meaning in life in recovery and growth have been limited by sampling only from recovery-oriented organisations, and to a lesser extent by its inability to record additional detailed demographic data. Whilst participants in this study may have met the inclusion criteria of the other studies within this small research group, this remains unknown.

A more ambitious study aimed more explicitly at identifying the universal processes underpinning the onset of and recovery from mental health problems would benefit sampling from a broader population, including those implied above, within a qualitative framework.

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Matt Spencer BA Hons Grad Dip

Major Research Project

Section D: Appendices

A thesis submitted in partial fulfilment of the requirements of Canterbury Christ Church University for the degree of Doctor of Clinical Psychology

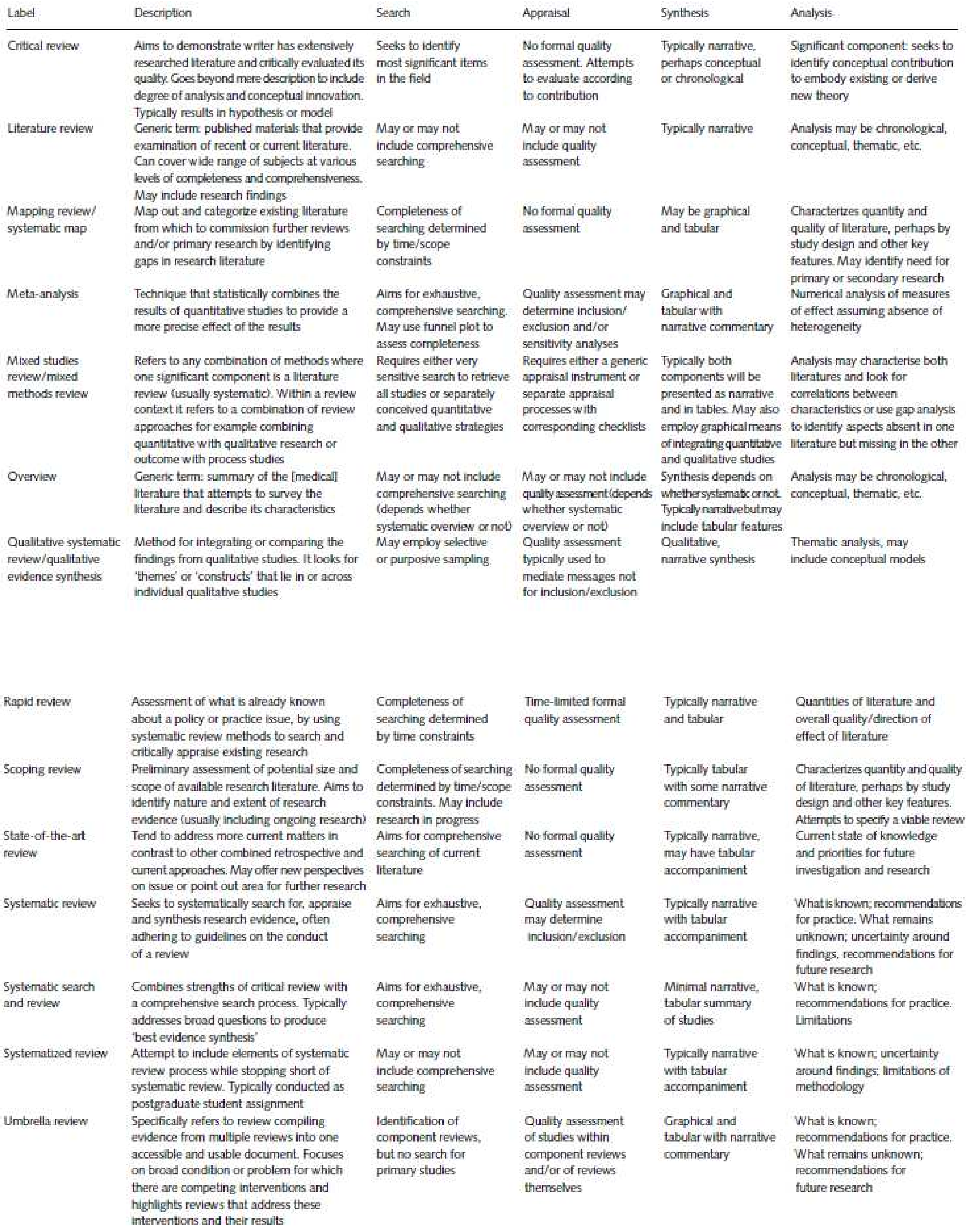
Appendix 1: Threats to validity quantitative studies (Papworth & Milne, 2001)

Study characteristics		Design Target population Sample Intervention Outcome measures
Threats to study validity	Hypothesis validity:	Ambiguous hypotheses Diffuse statistical tests
	Methodological validity:	Comparison group Pre-treatment assessment Randomisation Adequate sample size Follow-up data Reliance on self-report data Acknowledgment of limitations

Appendix 2: Evidence for qualitative methodological rigour (Elliot, Fischer & Rennie, 1999)

1. Owning one's perspective
2. Situating the sample
3. Grounding the examples
4. Providing credibility checks
5. Coherence
6. Accomplishing general versus specific research tasks
7. Resonating with readers

Appendix 3: Typology of reviews (Grant & Booth, 2009)



Label	Description	Search	Appraisal	Synthesis	Analysis
Critical review	Aims to demonstrate writer has extensively researched literature and critically evaluated its quality. Goes beyond mere description to include degree of analysis and conceptual innovation. Typically results in hypothesis or model	Seeks to identify most significant items in the field	No formal quality assessment. Attempts to evaluate according to contribution	Typically narrative, perhaps conceptual or chronological	Significant component: seeks to identify conceptual contribution to embody existing or derive new theory
Literature review	Generic term: published materials that provide examination of recent or current literature. Can cover wide range of subjects at various levels of completeness and comprehensiveness. May include research findings	May or may not include comprehensive searching	May or may not include quality assessment	Typically narrative	Analysis may be chronological, conceptual, thematic, etc.
Mapping review/ systematic map	Map out and categorize existing literature from which to commission further reviews and/or primary research by identifying gaps in research literature	Completeness of searching determined by time/scope constraints	No formal quality assessment	May be graphical and tabular	Characterizes quantity and quality of literature, perhaps by study design and other key features. May identify need for primary or secondary research
Meta-analysis	Technique that statistically combines the results of quantitative studies to provide a more precise effect of the results	Aims for exhaustive, comprehensive searching. May use funnel plot to assess completeness	Quality assessment may determine inclusion/ exclusion and/or sensitivity analyses	Graphical and tabular with narrative commentary	Numerical analysis of measures of effect assuming absence of heterogeneity
Mixed studies review/mixed methods review	Refers to any combination of methods where one significant component is a literature review (usually systematic). Within a review context it refers to a combination of review approaches for example combining quantitative with qualitative research or outcome with process studies	Requires either very sensitive search to retrieve all studies or separately conceived quantitative and qualitative strategies	Requires either a generic appraisal instrument or separate appraisal processes with corresponding checklists	Typically both components will be presented as narrative and in tables. May also employ graphical means of integrating quantitative and qualitative studies	Analysis may characterise both literatures and look for correlations between characteristics or use gap analysis to identify aspects absent in one literature but missing in the other
Overview	Generic term: summary of the [medical] literature that attempts to survey the literature and describe its characteristics	May or may not include comprehensive searching (depends whether systematic overview or not)	May or may not include quality assessment (depends whether systematic overview or not)	Synthesis depends on whether systematic or not. Typically narrative but may include tabular features	Analysis may be chronological, conceptual, thematic, etc.
Qualitative systematic review/qualitative evidence synthesis	Method for integrating or comparing the findings from qualitative studies. It looks for 'themes' or 'constructs' that lie in or across individual qualitative studies	May employ selective or purposive sampling	Quality assessment typically used to mediate messages not for inclusion/exclusion	Qualitative, narrative synthesis	Thematic analysis, may include conceptual models
Rapid review	Assessment of what is already known about a policy or practice issue, by using systematic review methods to search and critically appraise existing research	Completeness of searching determined by time constraints	Time-limited formal quality assessment	Typically narrative and tabular	Quantities of literature and overall quality/direction of effect of literature
Scoping review	Preliminary assessment of potential size and scope of available research literature. Aims to identify nature and extent of research evidence (usually including ongoing research)	Completeness of searching determined by time/scope constraints. May include research in progress	No formal quality assessment	Typically tabular with some narrative commentary	Characterizes quantity and quality of literature, perhaps by study design and other key features. Attempts to specify a viable review
State-of-the-art review	Tend to address more current matters in contrast to other combined retrospective and current approaches. May offer new perspectives on issue or point out area for further research	Aims for comprehensive searching of current literature	No formal quality assessment	Typically narrative, may have tabular accompaniment	Current state of knowledge and priorities for future investigation and research
Systematic review	Seeks to systematically search for, appraise and synthesis research evidence, often adhering to guidelines on the conduct of a review	Aims for exhaustive, comprehensive searching	Quality assessment may determine inclusion/exclusion	Typically narrative with tabular accompaniment	What is known; recommendations for practice. What remains unknown; uncertainty around findings, recommendations for future research
Systematic search and review	Combines strengths of critical review with a comprehensive search process. Typically addresses broad questions to produce 'best evidence synthesis'	Aims for exhaustive, comprehensive searching	May or may not include quality assessment	Minimal narrative, tabular summary of studies	What is known; recommendations for practice. Limitations
Systematized review	Attempt to include elements of systematic review process while stopping short of systematic review. Typically conducted as postgraduate student assignment	May or may not include comprehensive searching	May or may not include quality assessment	Typically narrative with tabular accompaniment	What is known; uncertainty around findings; limitations of methodology
Umbrella review	Specifically refers to review compiling evidence from multiple reviews into one accessible and usable document. Focuses on broad condition or problem for which there are competing interventions and highlights reviews that address these interventions and their results	Identification of component reviews, but no search for primary studies	Quality assessment of studies within component reviews and/or of reviews themselves	Graphical and tabular with narrative commentary	What is known; recommendations for practice. What remains unknown; recommendations for future research

Appendix 4: Characteristics of the recovery journey (Leamy et al., 2011)

Characteristics of recovery journey	**Number (%) of 87 studies identifying the characteristics**
Recovery is an active process	44 (50)
Individual and unique process	25 (29)
Non-linear process	21 (24)
Recovery as a journey	17 (20)
Recovery as stages or phases	15 (17)
Recovery as a struggle	14 (16)
Multidimensional process	13 (15)
Recovery is a gradual process	13 (15)
Recovery as a life-changing experience	11 (13)
Recovery without cure	9 (10)
Recovery is aided by supportive and healing environment	6 (7)
Recovery can occur without professional intervention	6 (7)
Trial and error process	6 (7)

Appendix 5: Recovery stages mapped onto trans-theoretical cycle of change (Leamy et al., 2011)*

Pre-contemplation	Contemplation	Preparation	Action	Maintenance and growth
	Novitiate recovery– struggling with disability		Semi-recovery – living with disability	Full recovery – living beyond disability
Stuck	Accepting help	Believing	Learning	Self-reliant
Descent into hell	Igniting a spark of hope	Developing insight/ activating instinct to fight back	Discovering keys to well-being	Maintaining equilibrium between internal and external forces
Demoralisation		Developing and establishing Independence		Efforts towards community integration
Occupational dependence		Supported occupational performance	Active engagement in meaningful occupations	Successful occupational performance
Dependent /unaware	Dependent /aware		Independent /aware	Interdependent /aware
Moratorium	Awareness	Preparation	Rebuilding	Growth
	Glimpses of recovery	Turning points	Road to recovery	
	Reawakening of hope after despair	No longer viewing self as primarily person with	Moving from withdrawal to engagement	Active coping rather than passive adjustment

		psychiatric disorder		
Overwhelmed by the disability		Struggling with the Disability	Living with the disability	Living beyond the disability
Initiating recovery			Regaining what was lost/moving forward	Improving quality of life
Crisis (recuperation)		Decision (rebuilding independence)		Awakening (building healthy interdependence)
	Turning point	Determination		Self-esteem

*Original studies not made accessible by Leamy et al. (2011)

Appendix 6: NHS Research Ethics Committee letters

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Appendix 7: NHS Trust Research and Development approval

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Appendix 8: Study invitation sheet

Salomons Campus at Tunbridge Wells
Department of Applied Psychology
Faculty of Social and Applied Sciences

An invitation to take part in a research study on the discovery of *meaning in life* and *hope* in personal recovery in the context of severe mental illness.

Who is doing the research? My name is Matt Spencer and I am a trainee clinical psychologist interested in how we discover hope and meaning in life in recovery from severe mental health problems.

What is the title of the study? "What psychological and social mechanisms underpin the discovery of meaning and hope in recovery from severe mental health problems?"

What is the purpose of the study? We understand that the discovery of hope and meaning in life are important processes in people's recovery, but we understand less about what might **help or hinder** these processes. The aim of this study is to attempt to find out more about what might help or hinder these processes.

Would you like to take part? I am interested in hearing from people who recognise that they have experienced the discovery of hope and meaning in their recovery, and who may have been given labels such as bipolar affective disorder, manic depression, schizophrenia, personality disorder, severe depression, or related terms.

What will happen to me if I take part? I would like to carry out a focus group with members of [redacted]. We will meet for about 1½ -2½ hours (with breaks!). When we meet for a focus group we will first agree some ground rules to help us all feel comfortable. When we are ready we can start a conversation as a group about experiences of recovery, and of hope and meaning in life, and any differences or similarities. Incidentally, if you have a picture, an object, or picture of an object that represents your sense of recovery, or discovery of hope and meaning in life, then I would like you to feel free to bring this with you.

How can I find out more?
If you are interested in taking part in this study you can find out more please ask me for an 'information sheet'. I will be visiting your organisation, and I can be contacted by email (hopeandmeaning@yahoo.co.uk) or by phone. You can leave a message for me on a confidential 24-hour voicemail phone line at my university on **01892 507673**. Please say

that the message is for me [**Matt Spencer**] and leave a contact number so that I can get back to you.

Appendix 9: Study information sheet

Canterbury
Christ Church
University

Salomons Campus at Tunbridge Wells
Department of Applied Psychology
Faculty of Social and Applied Sciences

Information for participants and organisations (Part 1)

Title of study: What psychological and social mechanisms underpin the discovery of meaning and hope in recovery from severe mental illness?

Who is the researcher and are they professionally supervised?

Hello, my name is Matt Spencer and I am a trainee clinical psychologist from Canterbury Christ Church University (CCCU). I would like to invite you to take part in this study which forms part of my doctorate in clinical psychology. Before you decide, it is important that you understand why the research is being done and what it would involve for you.

Throughout this project I am being supervised by Dr Sue Holttum, research lecturer at CCCU who has experience of receiving mental health services and who writes about social inclusion, and Dr Fabian Davis, consultant clinical psychologist and lead for social inclusion at the British Psychological Society (BPS).

You are welcome to talk to friends, family, members and others within … or health professionals about your involvement in the study if you wish. If you would like to find out more about the study I can be contacted by email (hopeandmeaning@yahoo.co.uk) or you can leave a message for me on a 24-hour voicemail phone line at 01892 507673. Please say that the message is for me [Matt Spencer] and leave a contact number so that I can get back to you.

This form contains two parts. **Part 1** of this form tells you the purpose of this study and what will happen to you if you take part. **Part 2** gives you more detailed information about the conduct of the study.

If you decide to take part in the study you will be asked to sign a consent form, a copy of which you will be given to keep along with this information sheet.

What is the purpose of the study?

Recovery from severe mental illness has been defined as:

a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even within the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness (Anthony, 1993).

Research has helped us to understand that the discovery of *hope* and *meaning in life* are important processes in people's recovery from severe mental illness. What we know less about is what might help or hinder these processes over the course of people's recovery. Only a small amount of our understanding has come from UK participants and research studies.

In this study we hope to explore how individuals recovering from severe mental illness have discovered hope and a meaning in life. In doing so we might be able to develop a better understanding of what recovery in the UK means and how it may be better supported.

Why have you been invited?

To help in this study we are interested in meeting individuals who recognise that they are experiencing recovery from severe mental illnesses, who may have been given labels such as bipolar affective disorder, manic depression, schizophrenia, personality disorder, severe depression or related terms. To help me find volunteers who would like to take part in this study I am contacting organisations in the UK that support people in their recovery.

Do I have to take part?

It is up to you to decide whether to join the study. Even if you do decide to take part, you are free to withdraw at any time, without giving a reason.

What will happen to me if I take part?

If you are experiencing personal recovery from severe mental illness and believe that you would like to make a contribution to this study I would like to hear from you.

I am looking to visit three organisations from across the UK during the summer, autumn and winter of 2012. At each organisation I hope to meet together with between 5 and 8 individuals to take part in one focus group.

Focus groups are similar to an ordinary interview or conversation but involve several people. Immediately before focus groups starts we will introduce ourselves, and then agree some rules together that will help the group to feel comfortable and safe. This will involve making an agreement on anonymity, confidentiality and the length of time that the group will meet for, which will be no more than 1½ – 2½ hours. There will be opportunity for breaks.

If you have an **object or picture that might represents your discovery of hope and meaning in life** in your personal recovery from mental health problems then I would like you to bring it along to the focus group. The focus group will start with a discussion about these items. We will continue with an open and shared discussion about how hope and meaning in life have been discovered, helped and hindered.

The focus groups will be audio-recorded. These recordings will then be written up as transcripts. All personal information will be anonymised, and these transcripts will then be used for qualitative analysis. About two weeks after the focus group I will write to you with a summary of the focus group. If you request it, I would be happy to send you a summary of the findings of this research or a copy of the research article when finished after autumn 2013.

Will I be paid for my participation?

We cannot pay you for taking part, but we are able to reimburse your travel costs up to a £7.00 limit, in return for a travel ticket or receipt.

Are there any disadvantages or risks in taking part?

Whilst focus groups are not risky, it is possible that you may experience some embarrassment or shyness at the outset. I hope that the atmosphere we create will allow participants to feel more comfortable as the focus group progresses.

We will be discussing your experiences of the discovery of hope and meaning in life. I anticipate that this could be both a positive and negative experience. People who have taken part in such research have found it beneficial to talk about the positive changes they recognise in their life, but understandably some discussions may at times lead to feeling some distress.

What if there is a problem?

If you would like to take part I would encourage you to choose someone from your usual friendship or support network that you can turn to for support should you find that you need assistance with how the focus group has left you feeling.

Should you have any concerns or complaints about the way you have been dealt with during the study these will be addressed, detailed information on this is given in Part 2.

This completes part 1.

Information for participants and organisations (Part 2)

Can I leave study?

Should you decide at any time during the study that you would like your involvement in the study to end you are free to withdraw, without giving a reason. If you do withdraw from the study I would like to continue to use the data collected from you up to your withdrawal.

What if there is a problem?

Problems will be handled in accordance with the guidelines of … and my university (Canterbury Christ Church University).

If you have a concern about any aspect of this study, you can speak to me and I will do my best to address your concerns [01892 507673]. If you remain unhappy and wish to complain formally, you can do this by raising this with … .

Will my participation be kept confidential?

It is important that throughout this study your participation will be completely confidential. The only exception to this will be if you inform me of any risk to yourself or others. This would be the case in any research study.

The focus groups will be recorded on a digital audio recorder. Written transcripts will be made from the audio data, and these will be anonymised, kept strictly confidential and stored securely. They will then be used for qualitative analysis. In keeping with University regulations the data will be kept securely for 10 years and then destroyed.

Will my General Practitioner/Family doctor (GP) be involved?

There will be no contact by the researcher with any of your health care providers as a result of this study.

What will happen to the results of the research study?

It is intended that the results of this research will be published in a peer reviewed journal. If you request it you can receive a copy of the completed article or a shorter summary. You will not be identifiable in any report or publication, however your anonymised quotes from the focus groups may be used in the final, published report.

Who is organising and funding the research?

This research study is being organised by myself (Matt Spencer) as a part of my doctorate in clinical psychology, which I am studying at Canterbury Christ Church University (CCCU). Throughout this project I am supervised by two qualified psychologists. The first is a research lecturer at CCCU who has experience of receiving mental health services and who writes about social inclusion. The second is a consultant clinical psychologist who is the lead for social inclusion at the British Psychological Society (BPS). This study is funded by Canterbury Christ Church University.

Who has reviewed the study?

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect participants' interests. This study has been reviewed and given favourable opinion by both a NHS Research Ethics Committee and Canterbury Christ Church University.

Appendix 10: Study consent form

Canterbury
Christ Church
University

Salomons Campus at Tunbridge Wells
Department of Applied Psychology
Faculty of Social and Applied Sciences

Consent form for participants

Title of study: What psychological and social mechanisms underpin the discovery of meaning and hope in recovery from severe mental illness?

Name of researcher:
Organisation name:
Study Number:
Participant Identification Number for this study:

Please initial box

1. I confirm that I have read and understand the information sheet dated.................... (version............) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected. ☐

3. I agree that anonymous quotes from my interview may be used in published reports of the study findings [if applicable] ☐

4. I agree to take part in the above study. ☐

Name of Participant____________________ Date________________

Signature ___________________

Name of Person taking consent ______________ Date________________

Signature ____________________

Additional optional background information

Preferred description of ethnicity ____________________

Preferred description/label of mental health problem ___________________

Appendix 11: Non-NHS organisation consent form

Canterbury
Christ Church
University

Salomons Campus at Tunbridge Wells
Department of Applied Psychology
Faculty of Social and Applied Sciences

Consent form for participating organisations

Title of study: What psychological and social mechanisms underpin the discovery of meaning and hope in recovery from severe mental health problems?

Name of researcher:
Organisation name:

Please initial box

1. I confirm that I have read and understand the invitation and information sheets (dated.................... version............) for the above study. I have had the opportunity to consider this information, ask questions and have had these answered satisfactorily. ☐

2. I understand that participation in this study is voluntary and that members of my organisation who volunteer to participate are free to withdraw at any time without giving any reason, without my medical care or legal rights being affected. ☐

3. I provide consent on behalf of .... (name of organisation) for the researcher to recruit participants, and to collect data at this organisation. ☐

Name of Participant___________________ Date_______________

Signature ___________________

Name of Person taking consent ______________   Date________________

Signature ____________________

Appendix 12: Full initial focus group protocol

Salomons Campus at Tunbridge Wells
Department of Applied Psychology
Faculty of Social and Applied Sciences

Focus group protocol

Title of study: What psychological and social mechanisms underpin the discovery of meaning and hope in recovery from severe mental illness?

Preamble:

- Pre-focus group discussion on confidentiality, obtaining informed consent agreeing ground rules.
- Discussion of supportive individual.
- Introductory discussion based on participants material objects (representing their discovery of hope and meaning).

Key questions:

1. Participant definitions of personal recovery
2. Processes involved in your recovery (to elicit Connectedness, Hope, Identity, Meaning, Empowerment). When Hope and Meaning are identifiable within the focus group discussion to follow this format:
    a. Hope
    - What does this [being whatever words used] mean to you?
    - What has made it possible to discover or rediscover this?
    - What has made it more difficult?

    b. Meaning
      - As above.

3. Relating to organisations/individuals/experiences enabling or inhibiting processes in personal recovery:

- Role of this organisation:
    - Facilitating factors
        - How made possible?
        - What done?
        - How spoken to?
        - How treated?
        - How made to feel?
    - Hindrances
- Role of self
- Role of other health service individuals/teams
- Role of other organisations
- Role of relations and friends
- Any other?

4. What else has recovery meant for you (positive and negatives)?
5. What do you hope to develop?
6. How do you hope to develop?
7. Questions to consider regarding recovery-oriented practice:
    - Why discuss this now?
    - What do you think about national recovery-oriented practice/strategy?
    - What do you think about 'recovery-oriented practice', how does it make you feel?
    - Thoughts on past experiences of NHS approaches to recovery.
    - Thoughts on future NHS approaches to recovery.

Debrief & thanks given for participation.

Appendix 13: Example feedback letter

Canterbury
Christ Church
University

Salomons Campus at Tunbridge Wells
Department of Applied Psychology
Faculty of Social and Applied Sciences

Focus group summary

I'm writing to provide a brief summary of our discussions during our focus group on 14th November 2012. This is only a brief summary and I cannot include everything that was mentioned. All of our discussion will be considered more deeply in the final write-up of my study that I will be completing over the next 6 months.

We agreed early in the session that all comments would be kept confidential throughout the study, that no names will be mentioned here or in the final study. We also agreed that I would get in touch in Spring/Summer 2013 to find a time to feedback the findings of my study, including other focus groups, in person.

Five members of the … group completed the focus group. The aim of the focus group was to discuss members' ideas about personal recovery, and hope and meaning in life. In our one and a half hour group we explored a number of issues that seemed important to members.

We thought about what personal recovery meant to each member, a range of opinions were given. We thought about the importance of individual 'voice hearers' in their recovery, in being motivated to change, and that change could take place through accepting voices, feelings, and the past.

We found that labelling, stigmatising, stereotyping and judging are commonplace in society, and that recovery involves a struggle through this 'minefield'. That fear is a huge barrier to recovery that can make feeling accepted and safe very difficult. We found that feeling safe, accepted and connected to others is a naturally existing need, and acceptance by others, for example through your group, provides a great deal of warmth and nourishment, but that feeling comfortable can take a particularly long time.

We found that while individuals have a responsibility to choose to change and grow, it's through meeting other people with similar experiences that helpful skills can also be learned and developed. These skills included placing it, letting go, reflection and insight, the acceptance of voices, and the understanding of feelings. You described that helping each other to feel more human and valued was vital, and that the processes of talking, listening and accepting each other made a significant contribution to this.

We discussed that whilst society and individuals create problems and hold you back, only through meeting others can we plant the seed that, given time, can lead to growth. There seemed to be general agreement that growth in recovery was about identifying values that were positive, personal and sustaining, and that being in recovery was about a life-lived in keeping with these values.

Thank you for welcoming me into you group.

Best wishes.

Appendix 14: Summary of findings for Research Ethics Committee/NHS R&D

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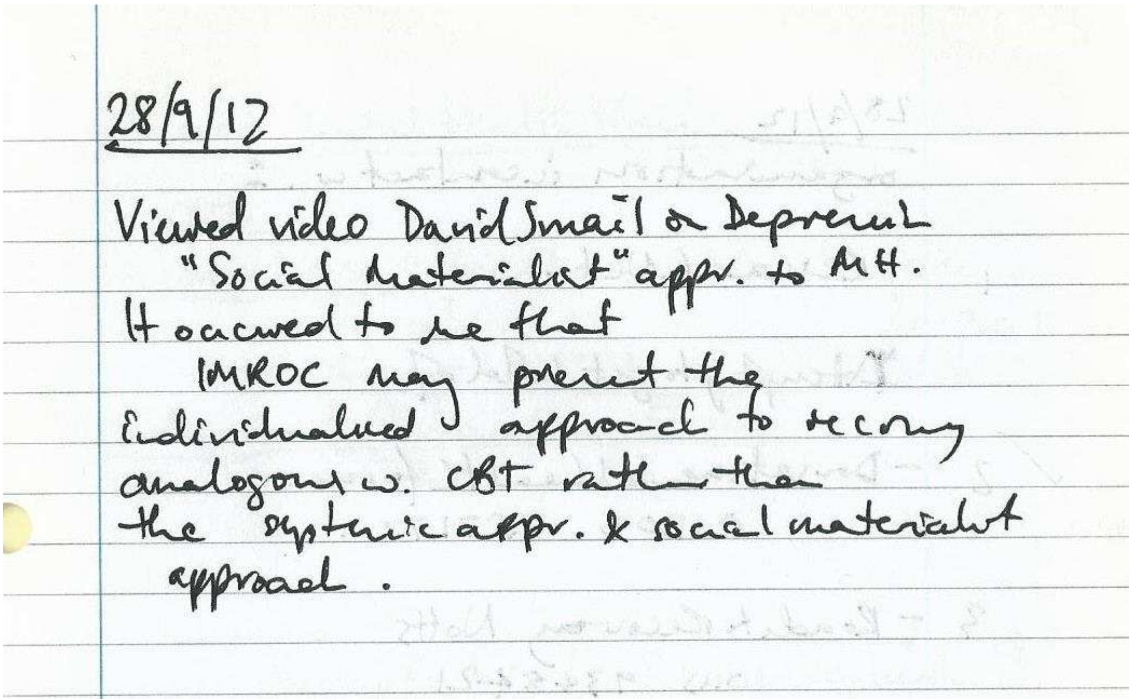
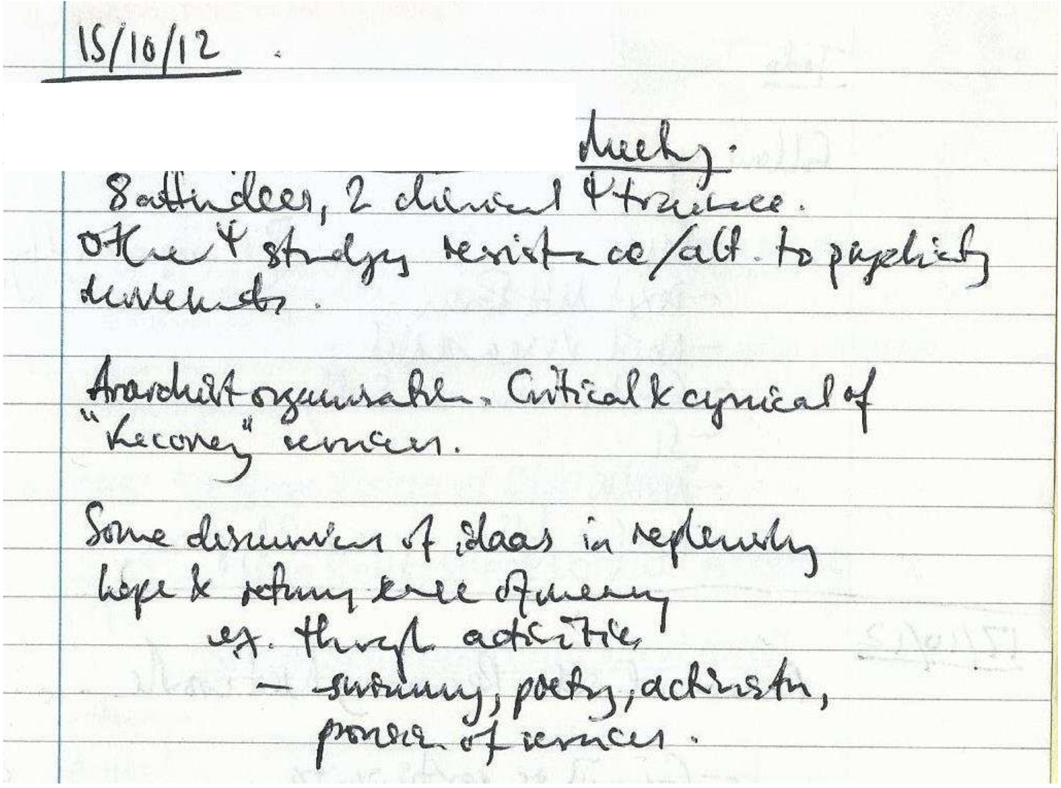
Appendix 15: Excerpts from research diary



28/9/12

Viewed video David Smail on Depression
"Social materialist" appr. to MH.
It occurred to me that
IMROC may present the
individualised approach to recovery
analogous w. CBT rather than
the systemic appr. & social materialist
approach.

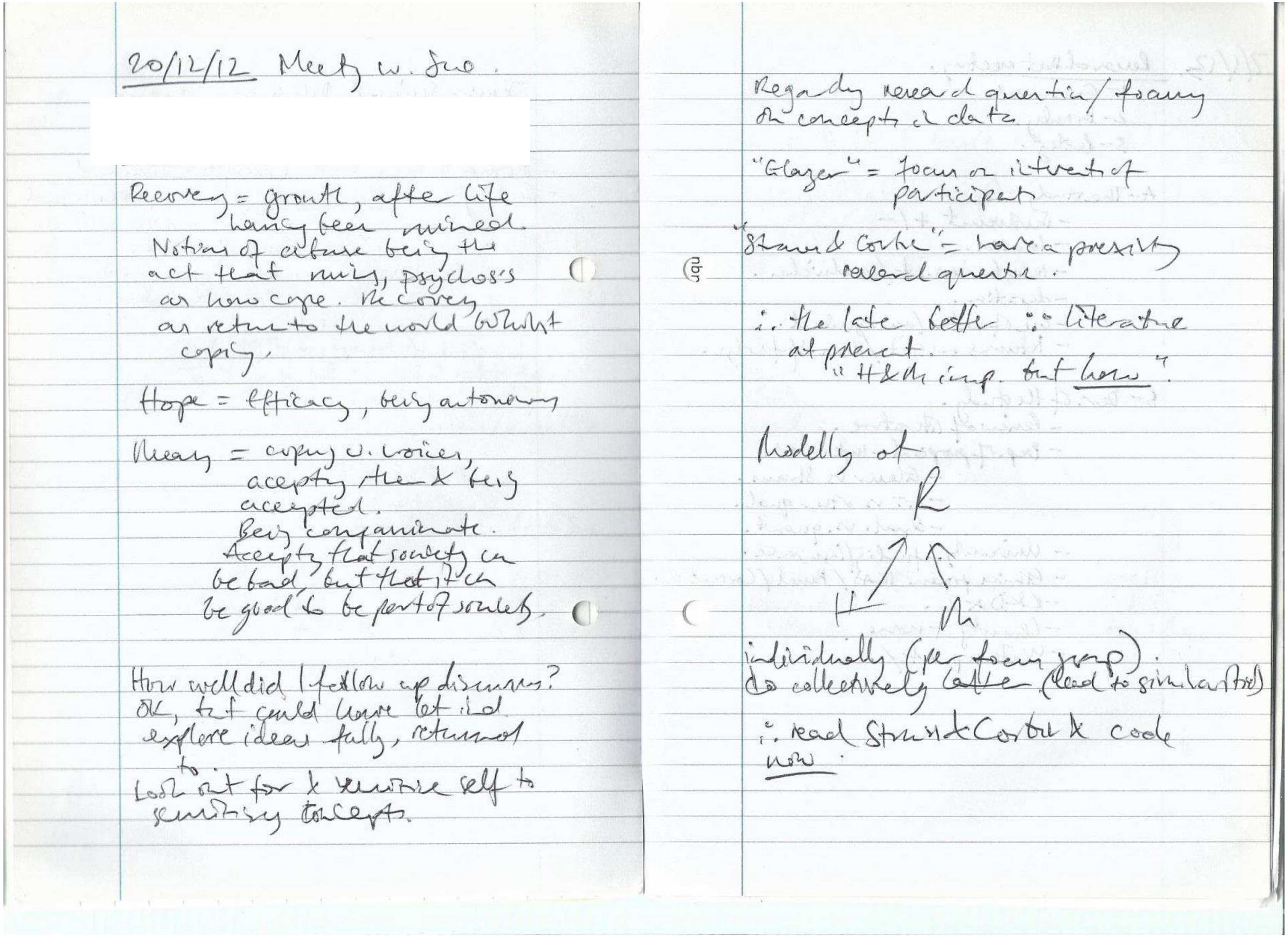


15/10/12

[redacted] meeting:
8 attendees, 2 clinical & trainee.
Others & students resistance/alt. to psychiatry
movements.

Anarchist organisation. Critical & cynical of
"Recovery" services.

Some discussion of ideas in rekindling
hope & restoring sense of meaning
eg. through activities
– swimming, poetry, activism,
provision of services.



20/12/12 Meeting w. Sue.

[redacted]

Recovery = growth, after life having been ruined.
Notions of culture being the act that ruins, psychosis as how cope. Recovery as return to the world whilst coping.

Hope = efficacy, being autonomous

Meaning = coping w. voices, accepting them & being accepted.
Being compassionate.
Accepting that society can be bad, but that it can be good to be part of society.

How well did I follow up discussions?
OK, but could have let ind. explore ideas fully, returned to.
Look out for & sensitise self to sensitising concepts.

Regarding research question/focusing on concepts in data.

"Glaser" = focus on interests of participants

"Strauss & Corbin" = have a preexisting research question.

∴ the latter better ∵ literature at present.
"H&M imp. but how".

Modelling of

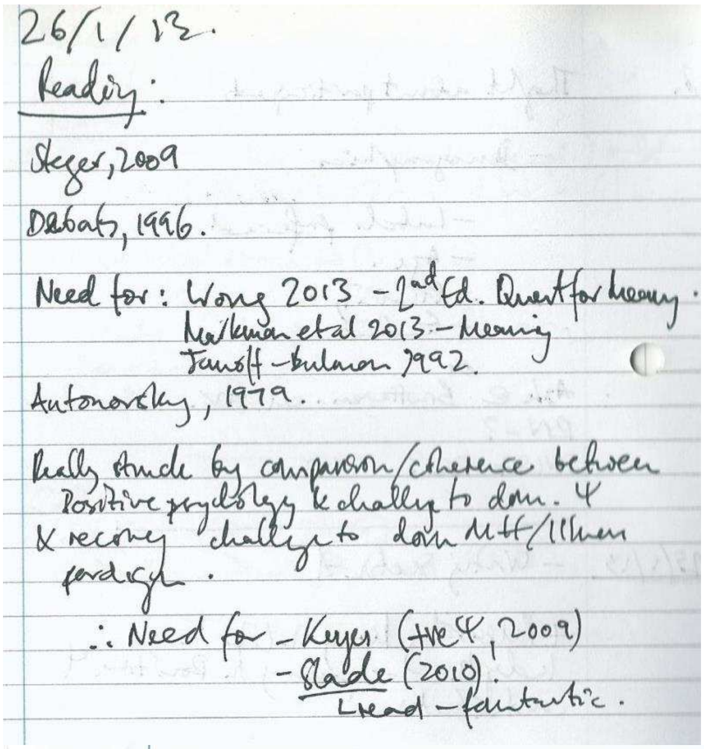
R

↗ ↖

H M

individually (per focus group).
do collectively later (lead to similarities)

∴ read Strauss & Corbin & code now.


26/1/13.

Reading:

Steger, 2009

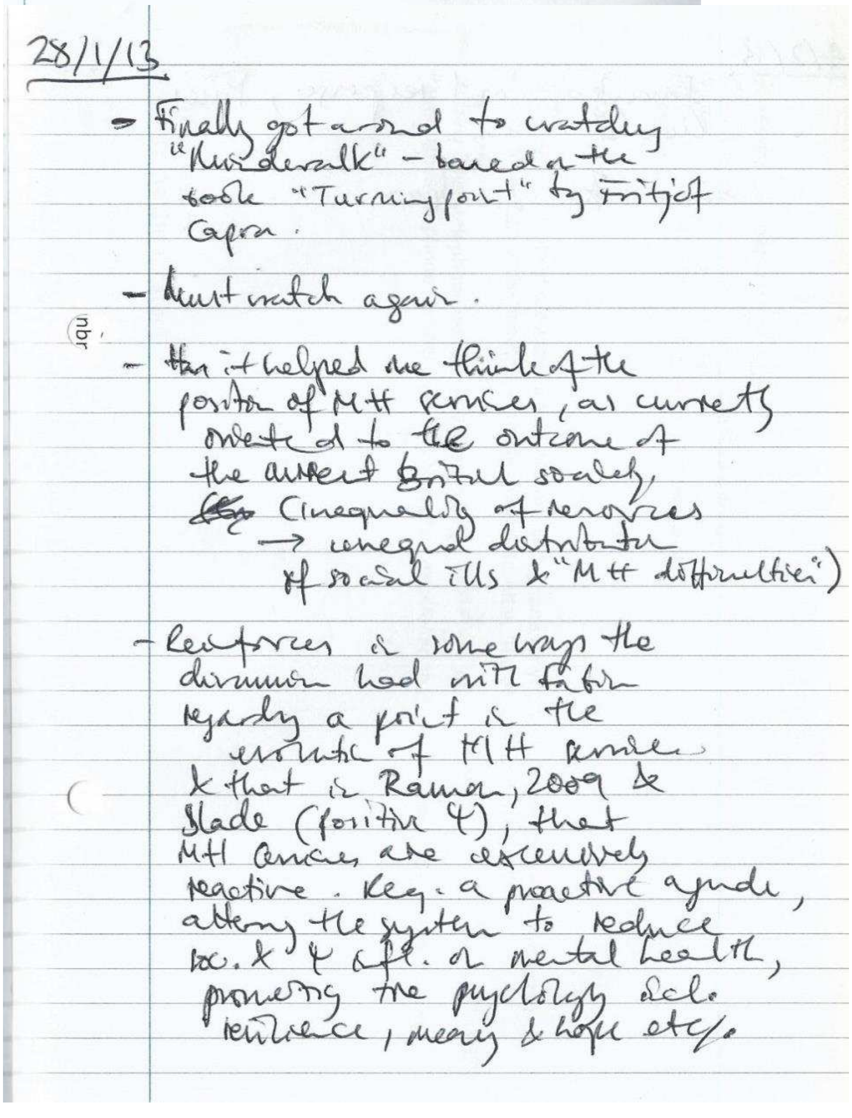
Debats, 1996.

Need for: Wong 2013 – 2nd Ed. Quest for Meaning.
Markman et al 2013 – Meaning
Janoff-Bulman 1992.

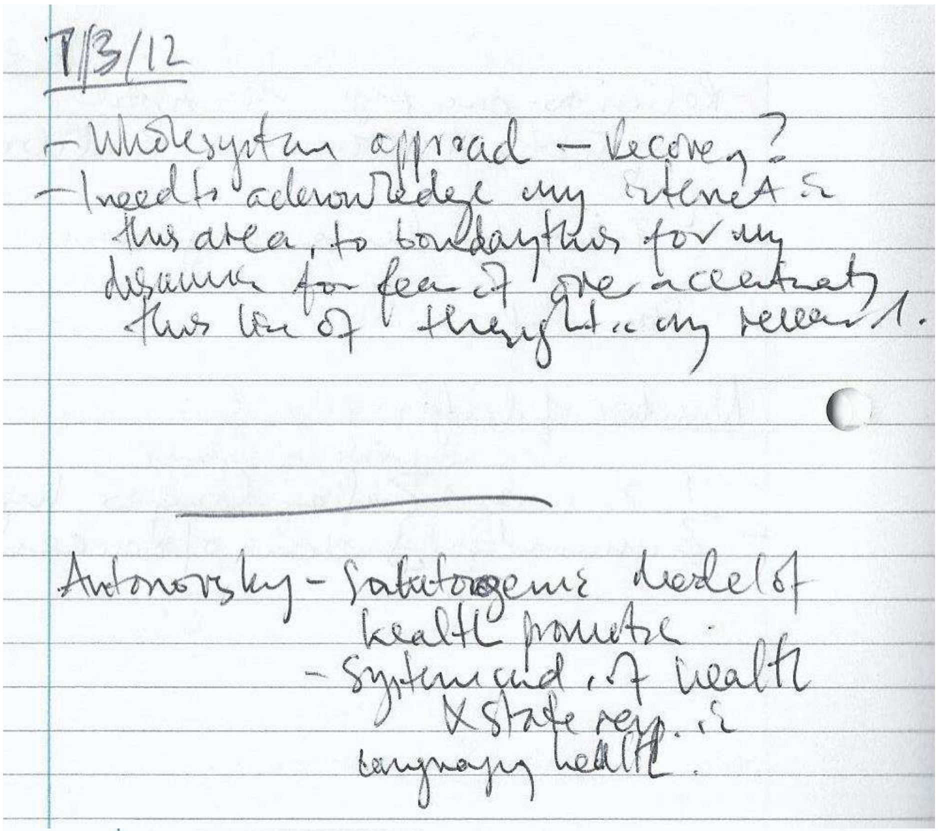
Antonovsky, 1979.

Really struck by comparison/coherence between Positive psychology & challenge to dom. Ψ & recovery challenge to dom MH/Illness paradigm.

∴ Need for – Keyes (+ve Ψ, 2009)
– Slade (2010)!
I read – fantastic.


28/1/13

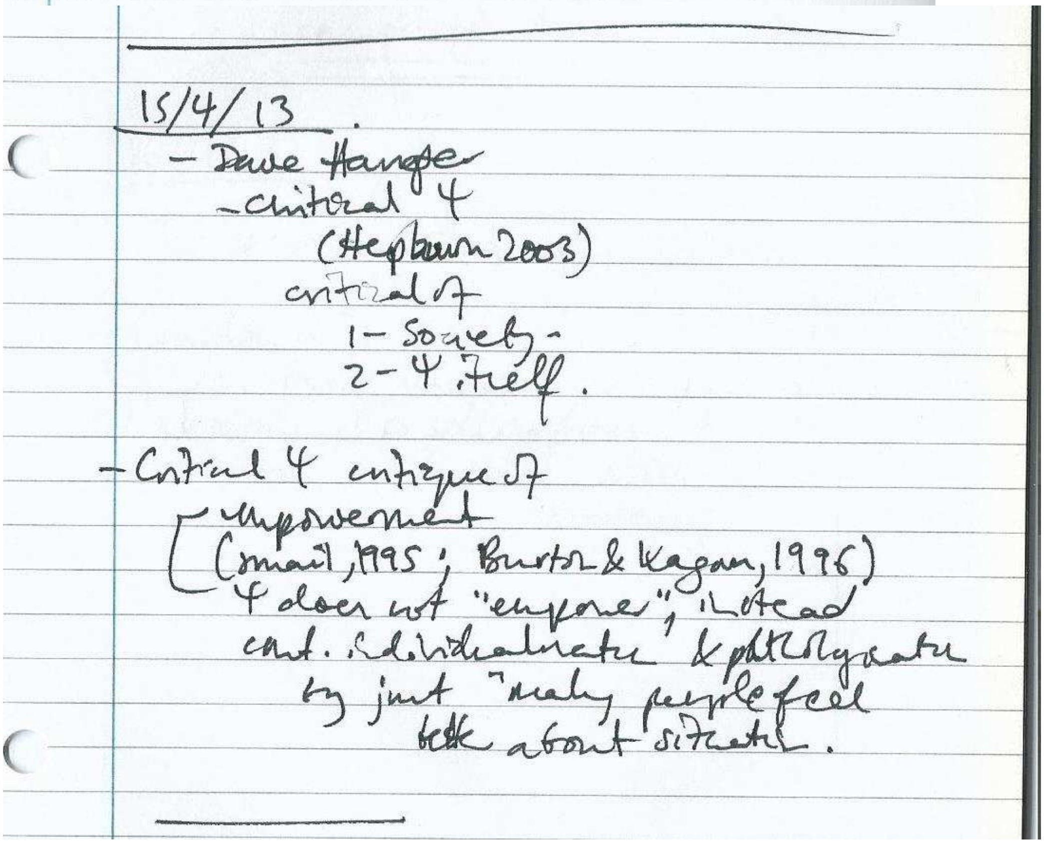
- Finally got around to watching "Mindwalk" – based on the book "Turning point" by Fritjof Capra.
- Must watch again.
- Think it helped me think of the position of MH services, as currently oriented to the outcome of the current British society, (inequality of resources → unequal distribution of social ills & "MH difficulties")
- Reinforces in some ways the discussion had with Fabian regarding a point in the evolution of MH services & that in Raman, 2009 & Slade (positive Ψ), that MH services are excessively reactive. Req. a proactive agenda, altering the system to reduce soc. & Ψ aff. on mental health, promoting the psychology of resilience, meaning & hope etc/.



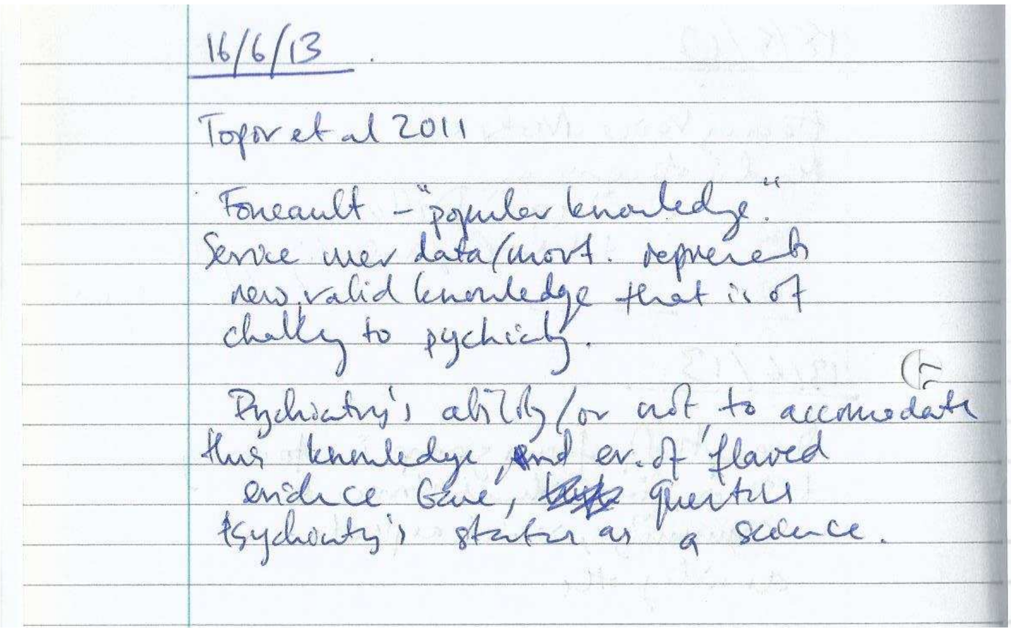
7/3/12

- Whole system approach – recovery?
- I need to acknowledge my interest in this area, to bound this for my discussion for fear of over-accentuating this line of thought in my research.

Antonovsky – Salutogenic model of health promotion.
- Systemic [illegible] of health & state resp. in [illegible] health.



15/4/13.
- Dave Harper
  - critical ψ
    (Hepburn 2003)
    critical of
    1 – society –
    2 – ψ itself.
- Critical ψ critique of empowerment
  (Smail, 1995; Burton & Kagan, 1996)
  ψ does not "empower", instead cont. individualises & pathologises by just "making people feel better about situation.



16/6/13.

Topor et al 2011

Foucault – "popular knowledge".
Service user data/movt. represents
new, valid knowledge that is of
challenge to psychiatry.

Psychiatry's ability/or not to accommodate
this knowledge, and ev. of 'flawed
evidence base', ~~[illegible]~~ questions
psychiatry's status as a science.

Appendix 16: Audit trail: Categories, subcategories and additional quotations

Categories	Sub-categories	Quotations
Prevailing contexts	Societal context	Malcolm: Today's life is more challenging, there is more people and more unemployment, everything is difficult. Tina: There's a lot of negative stuff out there Alan: it's a perception isn't it, there is a social stigma. If you hear on the news that someone is suffering from paranoid schizophrenia then it is always a negative thing, because someone has committed a terrible crime or whatever Jack: supposedly we are all a threat to society, threat to yourselves, threat to someone else, that sort of things Carole: And there's labelling about being unemployed, which can make you feel bad if you are not in a job
	Vitality of resources	Liam: let's not say money let's say resources. So you see then you got social capital, of having friends and family, cultural capital, and economic, and dare I say it the blessing of living in London, one of the greatest cities in the world. You know, things could be far, far worse. Mark: I have a suggestion about timing…noticing how long it takes someone to people to recover from a bereavement there appeared to be something like a natural 13 month cycle where people did not return to their full self, so to speak, after the incident Malcolm: Gradually with the medication I come to a balance, but to take that journey it take quite a while Jack: You need some sort of financial recompense if you are going to recover. So you aren't going to recover if there are going to be any benefits. Pete: benefits give you time and space to get yourself together, get your head together.
	Illness experience	Lisa: I went into hospital quite young, all of a sudden I couldn't go to university, I never took my driving test, I've never been to a school prom

		Lisa: When you have got no qualifications, you have been locked up in hospital for years, you’ve got scars, or even anything like that, it takes away a lot of what you can do Pete: I feel like it’s taken me 13 years to get where I am now. I have missed out on a lot of time. Lisa: I think you lose your identity when you go in to hospital, because all of a sudden you have got a diagnosis and that can take a lot out of you Lisa: I have quite a nasty diagnosis, of personality disorder, and it’s like (being told that) there is something flawed in you Belinda: And my recovery from those symptoms has taken me until now. I still regard myself as trying to drag myself up from that very disabled position Alan: the first two times I was hospitalised I refused to accept my diagnosis. It was only when it reached the stage that I was having hallucinations, hearing voices, seeing things, and hearing things all the time that I accepted that Pete: a particular gentleman that was there as well, and he had very strong religious beliefs. But actually on the ward they discouraged it. Pete: That’s why hospital, there’s not much to do there, so that can make you feel worse Steve: I was abused by a man and a woman. Like Chris said it made me think of the words sex as being something vile and not a good thing David: I got abused when I was in a children’s home
The importance of relationships	Diminishing relationships	Lisa: They used to look at me as if I was the worst person in the world. Chrissie: Often they don’t have somebody to actually do that with, as you were saying, if it is the people that are closest to them that are the cause of the problem. Nina: I learned from my own experiences that people use you, hold you back so that you don’t get better and you don’t move yourself on

		Steve: fear of being judged, which you find in these groups that doesn’t happen Oliver: And in the hands of professionals, so to speak, or the system, I shouldn’t say professionals I should say the system. The left hand doesn’t know what the right hand is doing. All these lovely people here trying to help, to bring you back to your feet. But another part of the system, a part that you are dependent on because obviously you need the roof over your head, you need a little support if you can just pull through this. Oliver: We know that in that medical model there is no place for God Oliver: the medical model so to speak doesn’t allow soul Nina: On the meds I was just like a vegetable, with no feelings. I still haven’t got no real genuine feelings but I did manage to connect to my feelings and sort them out
	Enabling relationships	Alan: relationships and things like that become more important Malcolm: To be able to get somewhere I know it is important to be supported as much as possible Carole: If you’re recovering you need maybe psychological support from a professional, maybe a support network around you, sort of friends and family. Jane: I find a new lease of hope from coming here and doing hobbies and things that I really enjoy Lisa: It’s like a therapy session. Nina: Talking about it, even saying something about it, letting the feeling out, you can let something go. Chris: Where you can share things. Chris: there is a lot of unloading that goes on here, people can get things off of their chest David: I mean, when it comes to this group, you are recovering bits of it David: As I’ve been coming to this group I have got on better, I have come out of my shell a bit. I know that.

	Chris: we actually try to downplay the labels here Nina: since coming to this support group I have noticed so many things Lisa: It makes you feel like you’ve got a bit of self-worth, and you go out and you have done what you have done, and you feel good about yourself, you feel that you’ve accomplished something. Mark: it allows you to stand outside of yourself, and to look at somebody who has been described as having the same condition as yourself. So you can stand outside and see how somebody is behaving and whatever Oliver: Now that I realise, going back, looking back at the experiences that I have had at the compassionate love that people, professionals have, trying to do their best
Purposeful goals	Malcolm: Once you start to focus on other things, like other people and the things that you like to do, it makes your mind work better and gradually you are able to feel more healthy Jane: when you are in that deep dark state, it doesn’t matter what people say, you are not enjoying it when you’re in that dark hole. But when you start to recover, then you can try to start to enjoy things in life, and aim for small goals Vinnie: I am very cautious and have very realistic aims Alan: over time I have realised that some things may be are out of my grasp Lisa: it might be beyond my grasp to get a job again Vinnie: I think one has to take a flexible approach to the reality of the situation Chris: [Employment] That it is normal for society isn’t it. It’s normal in a very much unnatural world. Nina: your mind is focussed, you’re doing something. Your skills, instincts, your brain, it all wakes up again, you’ll be able to get yourself holidays Chrissie: in my case it is visual arts, mainly painting and photography, that sort of thing

	Lisa: I come here and hear about the projects and get quite interested in them. Pete: What I’m trying to do is better myself all the time, I’m quite content at the moment. I read things, learn things, do things. That’s the way I find meaning. Liam: activism can also be a hobby, that either we enjoy for the company or the sake of doing something, or chanting is fun Vinnie: I would rather do some campaigning that is probably a very cheap way of keeping myself occupied … I find that campaigning keeps me well and sane. Jane: campaigning means you haven’t given up
Values-commitment	Chris: A lot of it is about letting go of old values Alan: You have a different set of values. When I was working, I was in a corporate environment, it was very hard-nosed, no emotion, you were only as good as the last job you did. But my entire set of values has changed since I came out of hospital. Sham: My own value was for myself that I will not compromise my values to reach my potential. Sham: then next I said I will be patient, ‘maybe my intellect and my personality will recover’, and sure enough, eight years later I went to university Toni: I think that also bad stuff can lead to good stuff (tragedy and growth) Liam: tragedy doesn’t produce growth, but it is one of many things that can Liam: So the idea is whether we create our own kind of markers. Dean: initially thought that, it was all these external things like you were saying a job or a partner and children all of that, these external things. Now for me meaning is actually going inward and getting to know my true self Chris: Remember the value that if you don’t love yourself then no one will love you. That’s a value we work by, that sort of thing. It can be called self-nurturing as well. It’s coming to terms with her past and

	not letting it interfere too much with the future. Chris: We talk about the positive rather than the negative in their lives. They're the values that we need to look at and think to ourselves, 'Yeah, I've had a shit life, but I can change'. Nina: You can look in the mirror and can say 'I love myself'. I love me and I want to put me first, and I care not about other people, because I need to care for myself. Chris: Remember the value that if you don't love yourself then no one will love you. That's a value we work by Chris: working with people that haven't made many choices or options in life, who have had things forced upon them Nina: You can look in the mirror and can say 'I love myself'. I love me and I want to put me first, and I care not about other people, because I need to care for myself. Sham: Every time I caught a knock back, and something tried to erode my values, I was more determined to plod ahead and to go as far as I could go. So to have values sometimes can be a great way of giving you determination. Chrissie: It just makes me even more determined to fight the system, to try and campaign for better resources and for better rights
Emerging self-efficacy	Chris: [A psychiatrist] planted a seed then that didn't come to fruition for another 15 years when I decided I really had to do something for my mental health. Chris: You have to cut your shackles a little bit at a time Nina: You get it [determination] from yourself don't you. If you want to achieve something, when I did my degree there was nobody there, so I was like 'come on' Nina: you have to keep on trying, to keep moving forward, to feel yourself out of your bloody head instead of staying in there and feeling like I did for most of my life any way Sham: I read this great man… he suffered a great deal

from illness, and he said that it is throughout tragedies that we grow…[however]…we have to grasp the situation

Jane: there are positive things out there, I think we have to look for them

Sham: when you're back is to the wall you have to fight back, there is no other way. I think it was George Bernard Shaw who said 'if you don't find the circumstances that you want, you create the circumstances'

Alan: all I can do are things for my own self-esteem, essentially, yes? So I go to college, I do voluntary work, I go to [organisation], and it is all part of finding my own sense of identity

Pete: I also know that I want to do things, I'm not going to put things off. I want to do things today not tomorrow. I don't think 'I want to do that in a couple of years', I want to do it next week.

Jack: You have to be resilient to make progress. You have got to believe in yourself.

Liam: I do see a bit of it as being a game, kind of like a puzzle, or developing strategies and using tactics, that to me makes sense

Liam: So it is about identifying resources and using them, I guess that way you need to be a bit entrepreneurial.

Carole: you just make the best of it given your limitations

Carole: Make the most of what you've got now.

Liam: I do see a bit of it as being a game, kind of like a puzzle, or developing strategies and using tactics, that to me makes sense

Jack: it's about networking, looking at what you can do and can't do in perhaps a more positive way than more of a self-centred way.

Sham: if our family is a tragedy then use them as an opportunity to grow

		Lisa: I started to take more responsibility… sometimes I would think ‘I wouldn’t be doing this if that person hadn’t done that’. I don’t think like that anymore. Jack: strive to improve your life, but you have to realise what is an improvement Dean: I wake up in the morning and it’s like ‘OK, what opportunity will there be to share what I have learned? Oliver: to not become needing of the system again, under no circumstances do I want to be touched by them again
Wellness experience	Recovery and change	Vinnie: it can mean different things to different people. Chrissie: it really is down to the individual Jane: I think that for everyone recovery has got a different stage Liam: I think recovery means being in as good a position as you can be now. Toni: I am in recovery at the moment, I have been in a very bad place, I have been in hospital a couple of times. Toni: As I move through the recovery process it’s very scary Jane: just to feel good within yourself is your recovery Alan: life is a journey isn’t it, recovery is a journey Carole: I think recovery to me is probably feeling OK Pete: recovery for me was being symptoms free Pete: trying to forget that I am diagnosed with schizophrenia and just to get on with my life without thinking about it and just taking the tablets David: You have to recover yourself, that to recover yourself you won’t get it done properly Nina: I think it’s different for everybody Nina: Isn’t recovery a movement forward? Mark: because you have to come to terms with in your

		everyday life it has to be your choice from the beginning. Nina: You have to find your own way out because each person’s experiences have been individual Toni: it feels like through the whole process I am changing as a person Toni: that is quite difficult at times, it is a challenging process, but it is a process of change I think Toni: I see it as change taking place, so you might end up as someone different at the end of it. Sham: I came out of hospital in 1979 I had been given a very primitive drug which completely disabled me in terms of personality and intellect. I could not count, I could not read I could not write, whereas before I had been quite literate and numerate. The thing is I wanted to get back to what I was, a thinking thoughtful person, who could count, and read, and write. Also I was changing, I could never get back to what I was as I recovered. Chris: [medication] It kills the florid and unpleasant feelings, but to live a life that is full and growing you have to come to terms with lots of things
	Reflection, insight and acceptance of emotions	Toni: with my personality, I am trying to pull apart, to tease apart what is me, what is the illness. Dean: I question those thoughts that for me caused the psychosis. When I question it and find the truth in me then it is like coming to myself Jane: So I go back to why am I like this, and there are certain problems I can pin point Dean: in terms of meaning, I’m getting to know my true self Dean: In a way, maybe a little bit of integration and moving forward Dean: after nearly six years I am very able to discern the difference between what my ego is saying and what my true self is saying, and that true self, which is love, is connected with source [god] Chris: Insight, is the key. The more insight you have

got, the better you will be.

Chris: What Nina has done is she has grown a lot of insight. She sees where they're coming from now, and it's her adjusting her relationship because balance is very important.

Mark: if you just said that you were having a bad day, well you know, you can get over a day but can you get over an illness? So what you say becomes very important, to us

Belinda: Much of this is to do with how we think about it all, how we actually think about it

Dean: in the last 5 years 8 months I have actually learned more about myself, learned how my mind works

Lisa: My recovery is a little bit different. It's not so much internal but external. It's like realising what other people think, rather than just what I think, seeing things from another person's point of view. I used to do a lot of actions, like I used to kick off a lot in the hospital, you know, self-harm, kicking doors all those kind of things that weren't very helpful. But I could never see it from another person's point of view, so I could never see how frightening it was or how scary it was for them. But now I stop, and I think, and that's my recovery. I can see from another person's point of view

Dean: is my perception it's my interpretation that determines how I feel, and how I behave and how I live.

Jane: I think it's about thinking about yourself

Dean: For me, building on what you just said is moving from thought into the body and getting to know how I feel.

Dean: for me has been to move from belief to actually knowing through felt experience. That has been a big shift for me. Like, knowing what love feels like. It is not a belief.

Dean: before, I wasn't even aware, or I was denying, repressing, or blocking,

Nina: Recovery is part of getting back to your feelings, because you haven't recovered because you have supressed your feelings.

		Nina: Old feelings that haven’t been allowed out Nina: So it was like, just let it out, feel it out. To me that’s the progression Steve: Oh yes, I see that and I feel it as well. It’s really helpful having these kind of groups to go to.
	Narratives and re-storying past and future	Toni: life experiences aren’t always due to mistakes. Dean: This business about the chatterbox of mind, I’ve noticed its not only people who have had mental illness, it’s everybody. Nina: Your feelings are important because if you can’t deal with the mess of the past, or some feelings, and you can’t even connect to it then it will forever suppress you Dean: not seeing myself as a victim of this, this and this. Saying what can I learn from this? Lisa: I started to take more responsibility… sometimes I would think ‘I wouldn’t be doing this if that person hadn’t done that’. I don’t think like that anymore. Nina: I went to this thing, it was an emotional therapist guy, because I just didn’t know the way or how to let my mum go. He was like, ‘there’s your Mum, she’s sitting on that chair’, so I almost burst into tears, but that was ages ago, and I’m over it. And then he says, ‘there’s your dad sitting there…’ and I said ‘you fat paki, I’m glad you’re dead’, he was intrigued at that. But it’s actively letting it go, letting your head go Chris: I have got a disease of the soul that they call mental illness, so it is understanding what has gone on, and what makes things happen in the future for you
	Patterns of symptoms and wellness strategies	Jane: I have found that I have started to get anxious, I don’t know if people get anxious, I get stressed and I get an awful feeling Belinda: I have been able to with an enormous amount of help, to gradually recognise that these hopelessness-inducing voices inside my head, that induce a sense of hopelessness Dean: Before, I actually believed that chatter box, the chatterbox was telling me to do things, don’t eat, don’t drink, don’t talk, don’t sleep, and that made me really unwell. So now, since the medication and the benefits

	and time, I have actually looked at that chatterbox, I have learned ways to question, to find out the truth, that’s a deeper part of myself. Toni: At the moment I employ I suppose you can call it tunnel vision. Jane: I can get so passionate about unfairness and injustice that it makes me ill Belinda: Very often what gets called the illness is often the symptoms Carole: I was always thinking, ‘you’re not good enough, you messed that up’, that gets you down, because it’s not a helpful way to think
Tangible and intangible hope	Jane: I am hoping to move on and to encourage others, and to understand. Jane: It’s not easy for anyone, but there is hope, but you have to find your hope for yourself, within yourself. Jane: I went on a walk with 16 ladies that thought they were getting old but had found a new lease of life. So there is hope Jane: I have got a spiritual background, everyone may have their religion or how they cope with things, I am a Christian and I respect all peoples’ religions. My hope is within my faith Jane: I find a new lease of hope from coming here and doing hobbies and things that I really enjoy Lisa: I like volunteering, and I like [organisation], that gives me a bit of hope. Jane: When I was ill I lost interest in hobbies, and that is why today [organisation] is really good. That is part of recovery, to join groups, to find interest in life, and to have hope that you can move on in life by setting goals Chris: if you put something positive that people can go forward from then recovery is rapid Chris: So the seed had been planted, it was just awaiting fruition Chris: when I work with people I work in a positive way. We talk about the positive rather than the negative

in their lives.

Appendix 17: Example memos

Services

Attendance of peer-led and co-produced organisations presents unique opportunities for the development of relationships on the basis of a unique understanding that is unavailable elsewhere in society, and provides significant boost to individuals' recovery. For less secure individuals this provides time and space to trust and to develop safe relationships. This being understood by like-minded individuals allows opportunities to feel safe enough to reflect on experiences

In addition to peer organisations individuals have found organisations and social structures away from mental health that foster a sense of connectedness and community including attendance of churches and religious festivals primarily motivated by the opportunity to socialise and reconnect with others

Although there is a common sense that services can be disempowering and professionals can diminish a sense of wholeness and self-worth through the basis of their relationships with individuals on a limited view of the person as a cluster of symptoms, there are examples of meaningful, productive and recovery promoting relationships with professionals. These relationships were triggers for goal directed behaviour and a growing sense of efficacy. They also indicated, like peer relationships, that change is possible, and that problems can be understood in a more complete sense.

Activism

A significantly purposeful goal for many included the engagement in mental health awareness and activism. In addition to presenting an opportunity for purposeful activity, activism presents an example of values in action, and a sense of increasing self-efficacy in choosing to make a difference to the system that has had a contributory factor in their own difficulties. Finally, it presents an example of values protecting the individual from despair, whilst activities can lead to change in the system this can be limited. Although this may be seen as failure, for many it is sustaining, determination motivated by the knowledge that campaigning for fairer more humane care indirectly models hope and understanding to as yet unknown others in more challenging situations.

Values

Growing out of positive relationships and illness experience individuals reported identifying aspects of their approach to the world that had been challenged, eroded or had become redundant. An element of their progress was the establishment of new values. This process appears to relate to the recognition of unhelpful, demoralising dominant discourses that have been internalised. Individuals then seemed able to evaluate these discourses or values, addressing them and identifying new, more wellbeing focussed values as appropriate.

Values are related to but distinct from goal-directed behaviours. Values are seen to both guide the development and selection of goals, and to buffer the individual from failure. Having identified a valued direction in which life could bow be lived, failure to obtain the goal is subordinate to living in a values congruent manner. A significant example of this is activism. Individuals have lived experience of the dominance and power of the current paradigm that they seek to influence, aware that failure is likely, however failure in these goals in in fact sustaining, bringing hope.

Meaning

Meaning therefore in this model exists at varying levels and within varying processes. Through the processes described, individuals identify meaning in the significance of relationships, in their need to be valued by others, in developing a sense of symmetry or dissonance between their own values and discourses available within their social context that inhibit or sustain them, an significantly there is a sense of meaning in action, that deeds and their basis in individual values are inherently meaningful, imbuing life with meaning.

Secondly, there is a more amorphous sense of meaning, as in understanding. This understanding is in terms of symptoms, life experiences, and to the social world. This is similar to insight, where individuals develop a sense of understanding of self, world and their interaction, choosing to relate in ways meaningful to the self, in a hope maintaining direction.

Appendix 18: Example coded transcript

This has been removed from the electronic copy

Appendix 19: Example respondent validation

This looks good.

One small point perhaps, but reading through this you make the assertion that the welfare state were seen as helpful resources, providing assistance, care and time to do the work that needs to be done to begin to feel that life can be coped with. I wish this was true. As I recall from the session we did spend some time berating the hurdles being on benefits introduce and the additional pressures this places on those in reduced circumstances and still in recovery. Otherwise your notes appear to be a fair reflection.

I look forward to seeing you again. In the meantime good luck with your studies!

Best regards.

Appendix 20: Psychiatric Rehabilitation Journal submission guidelines

http://www.apa.org/pubs/journals/prj/index.aspx

Instructions to Authors

Psychiatric Rehabilitation Journal (**PRJ**) publishes original contributions related to the rehabilitation, psychosocial treatment, and recovery of people with serious mental illnesses. **PRJ's** target audience includes psychiatric rehabilitation practitioners and researchers, as well as recipients of mental health and rehabilitation services.

PRJ encourages submissions regarding mechanisms of change in rehabilitation and psychosocial treatment programs, as well as evaluation studies of model programs, and investigations of effectiveness and cost-effectiveness of programs conducted in "real world" settings. Descriptive studies of "cutting edge" programs, especially those informed by the lived experience of mental illness, are also welcome.

Topics within the purview of **PRJ** include:

- studies of the development, refinement, or evaluation of psychiatric rehabilitation or psychosocial treatment programs, including rigorous case studies, open pilot studies, quasi-experimental designs, and randomized controlled trials
- research on the implementation of rehabilitation or psychosocial treatment programs, including studies of organizations and organizational change
- studies of peer support or other peer provided interventions for persons living with serious mental illness
- qualitative or quantitative research addressing important domains of functioning for psychiatric rehabilitation, such as employment, education, parenting, housing, social relationships, community inclusion, health, and well-being
- studies of evidence-based interventions, recovery-based care, and their integration
- research on special populations of people with serious mental illnesses, such as persons with co-occurring substance use disorders, older individuals, people with intellectual disability or other developmental disabilities, persons with a recent onset of mental illness, or people with co-morbid medical disorders
- studies focusing on special needs or disparities in access to, or outcomes from rehabilitation or psychosocial treatments for minority populations based on characteristics such as ethnicity, race, religion, culture, or sexual orientation
- research on the development or psychometric evaluation of instruments designed to measure outcomes relevant to rehabilitation or psychosocial treatment
- studies aimed at better understanding the nature of recovery from serious mental illness, including research focusing on hope, empowerment, self-determination, and resiliency
- studies utilizing participatory action approaches to research design, implementation, and evaluation

Submission

Submit manuscripts electronically (.rtf or .doc) through the Manuscript Submission Portal.

We strive to ensure that articles and brief reports published in the journal include implications for practice to promote the translation of research findings into practical applications for the field. **Psychiatric Rehabilitation Journal** (**PRJ**) also promotes the U.S. Psychiatric Rehabilitation Association goal of improving the quality of services designed to support positive community adjustment and integration.

PRJ gives priority to submissions that are clearly applicable to the development, administration, and delivery of services. Articles that include descriptive or exploratory studies; qualitative studies; pre-post evaluations of services; measurement development or testing; survey research; and quasi-experimental or randomized studies will be accepted for review. Literature reviews, policy studies, and brief reports are also accepted for review.

PRJ welcomes submissions from mental health and psychiatric rehabilitation researchers, service providers, administrators or policy makers; persons with a psychiatric disability; and family members. We also welcome perspectives and personal accounts for the "Coping With" and "Speaking Out" sections.

Masked Review

This journal has a policy of masked review for all submissions. A title page should include all authors' names and institutional affiliations. The manuscript should omit this information but should include the title of the manuscript. Make every effort to see that the manuscript itself contains no clues to the authors' identity.

Manuscript Preparation

Prepare manuscripts according to the **Publication Manual of the American Psychological Association** (6th edition). Manuscripts may be copyedited for bias-free language (see Chapter 3 of the **Publication Manual**).

Follow US Psychiatric Rehabilitation Association (USPRA) Language Guidelines. These guidelines are based on the fundamental values of the psychiatric rehabilitation field: respecting the worth and dignity of all persons and groups, as well as honoring and advocating for individual rights and interests, and opposing discrimination in services and in society.

Review APA's Checklist for Manuscript Submission before submitting your article.

Use 12-point Times New Roman font with consistent headings and subheadings and omit underlining. **Please do not use Endnotes in submissions. All references should be included in the reference list in APA format.**

All research manuscripts should include a structured abstract containing a maximum of 250 words with the following sections:

- **Objective:** the primary purpose of the article
- **Methods:** data sources, subjects, design, measurement, data analysis
- **Results:** key findings
- **Conclusions and Implications for Practice:** implications, future directions

All theoretical manuscripts should include a structured abstract with the following sections:

- **Topic:** in one sentence
- **Purpose:** thesis or organizing construct and the scope of the article
- **Sources Used:** personal observation, published literature, etc.
- **Conclusions and Implications for Practice:** implications, future directions

Abstracts for brief reports should not exceed 150 words.

Please supply up to five keywords or brief phrases after the abstract.

Length

Articles should not exceed 5,000 words; manuscripts submitted for the "Coping With" and "Speaking Out" sections, as well as Brief Reports should not exceed 1,500 words. Letters to the Editor should be under 300 words. Word count excludes references, tables, and figures.

Formatting

Double-space all copy. Other formatting instructions, as well as instructions on preparing tables, figures, references, metrics, and abstracts, appear in the **Manual**.

Below are additional instructions regarding the preparation of display equations and tables.

Display Equations

We strongly encourage you to use MathType (third-party software) or Equation Editor 3.0 (built into pre-2007 versions of Word) to construct your equations, rather than the equation support that is built into Word 2007 and Word 2010. Equations composed with the built-in Word 2007/Word 2010 equation support are converted to low resolution graphics when they enter the production process and must be rekeyed by the typesetter, which may introduce errors.

To construct your equations with MathType or Equation Editor 3.0:

- Go to the Text section of the Insert tab and select Object.
- Select MathType or Equation Editor 3.0 in the drop-down menu.

If you have an equation that has already been produced using Microsoft Word 2007 or 2010 and you have access to the full version of MathType 6.5 or later, you can convert this equation to MathType by clicking on MathType Insert Equation. Copy the equation from Microsoft Word and paste it into the MathType box. Verify that your equation is correct, click File, and then click Update. Your equation has now been inserted into your Word file as a MathType Equation.

Use Equation Editor 3.0 or MathType only for equations or for formulas that cannot be produced as Word text using the Times or Symbol font.

Tables

Use Word's Insert Table function when you create tables. Using spaces or tabs in your table will create problems when the table is typeset and may result in errors.

Submitting Supplemental Materials

APA can now place supplementary materials online, available via the published article in the PsycARTICLES® database. Please see Supplementing Your Article With Online Material for more details.

References

List references in alphabetical order. Each listed reference should be cited in text, and each text citation should be listed in the References section. **Please do not use Endnotes in submissions. All references should be included in the reference list in APA format.**

Examples of basic reference formats:

Journal Article:
Herbst-Damm, K. L., & Kulik, J. A. (2005). Volunteer support, marital status, and the survival times of terminally ill patients. **Health Psychology**, **24**, 225–229. doi: 10.1037/0278-6133.24.2.225

Authored Book:
Mitchell, T. R., & Larson, J. R., Jr. (1987). **People in organizations: An introduction to organizational behavior** (3rd ed.). New York, NY: McGraw-Hill.

Chapter in an Edited Book:
Bjork, R. A. (1989). Retrieval inhibition as an adaptive mechanism in human memory. In H. L. Roediger III & F. I. M. Craik (Eds.), **Varieties of memory & consciousness** (pp. 309–330). Hillsdale, NJ: Erlbaum.

Figures

Graphics files are welcome if supplied as Tiff, EPS, or PowerPoint files. The minimum line weight for line art is 0.5 point for optimal printing.

When possible, please place symbol legends below the figure instead of to the side.

Original color figures can be printed in color at the editor's and publisher's discretion provided the author agrees to pay

- $255 for one figure
- $425 for two figures
- $575 for three figures
- $675 for four figures
- $55 for each additional figure

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See also APA Journals® Internet Posting Guidelines.

APA requires authors to reveal any possible conflict of interest in the conduct and reporting of research (e.g., financial interests in a test or procedure, funding by pharmaceutical companies for drug research).

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Authors of accepted manuscripts are required to transfer the copyright to APA.

Download Publication Rights (Copyright Transfer) Form (PDF, 83KB)

Ethical Principles

It is a violation of APA Ethical Principles to publish "as original data, data that have been previously published" (Standard 8.13).

In addition, APA Ethical Principles specify that "after research results are published, psychologists do not withhold the data on which their conclusions are based from other competent professionals who seek to verify the substantive claims through reanalysis and who intend to use such data only for that purpose, provided that the confidentiality of the participants can be protected and unless legal rights concerning proprietary data preclude their release" (Standard 8.14).

APA expects authors to adhere to these standards. Specifically, APA expects authors to have their data available throughout the editorial review process and for at least 5 years after the date of publication.

Authors are required to state in writing that they have complied with APA ethical standards in the treatment of their sample, human or animal, or to describe the details of treatment.

Download Certification of Compliance With APA Ethical Principles Form (PDF, 26KB)

The APA Ethics Office provides the full Ethical Principles of Psychologists and Code of Conduct electronically on their website in HTML, PDF, and Word format. You may also request a copy by emailing or calling the APA Ethics Office (202-336-5930). You may also read "Ethical Principles," December 1992, **American Psychologist**, Vol. 47, pp. 1597–1611.