Recovery in a mental health setting: an Interpretative Phenomenological Analysis of how an individual experiences a Peer-Supported Self-Management Intervention.

Thesis submitted in partial fulfillment for the degree of Doctorate in Clinical Psychology at the University of Leicester

By

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Declaration

I, Hannah Istead, can confirm that this thesis and its contents is my own original work. It has been written and submitted as part fulfilment of the Doctoral degree in Clinical Psychology. I also confirm that this thesis and its contents have not been submitted for any other degree or academic qualification.

Thesis Abstract.

Recovery in a mental health setting: an Interpretative Phenomenological Analysis of how an individual experiences a Peer-Supported Self-Management Intervention

Peer support workers are people with lived experience of mental health distress who provide mental health interventions or services to people with mental health problems who are at an earlier stage in their recovery journey (Davidson *et al.,* 2006). Disclosing personal strategies with a recipient is seen as one beneficial aspect of the peer support model. However minimal research has been conducted to explore how the individual experiences this relationship. This remains an important question due to the increase in recovery-orientated services operating peer support models in UK mental health settings.

Literature Review

The act of self-disclosure (SD) within the peer model may be seen as a critical ingredient to the models success. Qualitative studies examining client's perception of therapist SD were reviewed using the meta-ethnographic process. Seven studies were found to meet inclusion criteria. Themes identified were that SD could simultaneously strengthen and also impede the alliance formed between therapist and client. Findings overlap with the salient components of effective therapeutic alliance, but also that SD can trigger early unhelpful attachment experiences leading to alliance ruptures.

Research Report

Little is known about the circumstances in which the peer support model works (Repper & Carter, 2011). Semi-structured interviews were conducted with seven individuals who had been in receipt of peer support self-management intervention as part of a Randomised Controlled Trial. Interviews were analysed using interpretative phenomenological analysis. Findings indicated that internal and external stigmatising attitudes and concealment of mental health identity contributed to ambivalent identification with the peer. Contrary to this, individuals also used the relationship to challenge stigmatising attitudes. Results are also considered in light of criticisms of the recovery model.

Critical Appraisal

Critique of the research methodology and limitations are discussed. The trainee reflects on a psychology of humanistic values, counter to the experimental/positivist psychological tradition.

Acknowledgements

Word counts

Abstract	298

<u>Section A: Literature Review</u>

Abstract	295
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<u>Section B: Research Report</u>

Abstract	265
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<u>Section C: Critical Appraisal</u>

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<u>Section A Literature Review</u>

How does the client perceive the act of therapist self-disclosure: a meta-ethnography of qualitative research

Submitted: May 2015

By: Hannah Istead

To: The University of Leicester, School of Psychology, Clinical Section, In partial fulfillment of the degree of, Doctorate in Clinical Psychology

1. Literature Review Abstract

Purpose:

Research into Therapist self-disclosure (TSD) has generated a robust empirical evidence-base examining the effects upon the client, however an imprecise definition and empirical evidence base mostly using analogous designs with non-clients may have lead to trite conclusions. In an effort to fill the gap and re-contextualise the phenomenon, qualitative studies using clinical evidence were used to explore the clients' perception of TSD within the context of the therapeutic dyad.

Method: Seven qualitative studies using clients in naturalistic settings, most of which examined the view of clients' perception of TSD, were reviewed using the meta-ethnographic research process.

Results: Seven themes were identified in how TSD was interpreted to effect the connection made in therapy, how the therapist is received within the dyad and how clients engage in therapy following the use of TSD. Themes identified were: minimising the power imbalance, modeling – reciprocal sharing, humanness, increased connection, negotiating cultural identity impeding involvement, blurring of boundaries and uncertainty of roles, re-experiencing of familiar interpersonal dynamics.

Conclusions: While broadly consistent with existing TSD theoretical frameworks, findings highlight important implications for the use of therapy relevant disclosure and how this may simultaneously strengthen and also impede the alliance formed between therapist and client. The themes arising indicate that clients are not passive recipients of TSD, the resultant effects of TSD were dynamic and individuals had engaged to a great extent with what it might mean to them. Discussion focuses on how findings overlap with the salient components of effective therapeutic alliance and how TSD can contribute towards a more collaborative alliance, but also evidence to indicate that TSD can trigger early unhelpful attachment experiences, leading to alliance ruptures. The preliminary results of the meta-ethnographic are presented, together with the assessment of utility, possibilities, and shortcomings of the explored method.

Keywords: therapist self-discloure; therapeutic alliance; client perspective;meta-ethnographic:

2. Introduction

2.1 Background

The topic of therapist self-disclosure (TSD) has long been considered in counseling and psychotherapy literature, remaining a controversial topic (Chesner & Baumeister, 1985; Watkins, 1990; Ziv-Beiman, 2013). A recent review indicates over 90% of therapists disclose to clients (Henretty & Levitt's, 2010). Relational changes in psychotherapy have led to increasing acceptance of judicious use of TSD such as therapists conveying immediate feelings about the interaction taking place (Safran & Muran, 2000). However it does remain an uncommon therapeutic strategy comprising less than 3.5% of therapist interventions (Knox & Hill, 2002). Evolution of this construct can be traced back to Classical psychoanalysis paradigm, whereby Freud emphasised "anonymity, equanimity and abstinence" (Freud, 1915; Goldstein, 1997). Therapists who might transgress could be seen to be burdening the client with their own unconscious or conscious feelings towards the client and crossing the professional boundaries (Greenspan, 1986). In contrast a pro-disclosure argument emerged in the 1950's within humanists' framework. Sharing of therapy-relevant self-disclosure about immediate therapy experience was felt to model honesty and would be reciprocal in nature and encourage the client to self-disclose (Henretty *et al.,* 2014; Wells, 1994; Watkins, 1990). Since this time, contemporary debate has evolved and feminist therapists have advocated for skillful use of disclosure as a way to empower their clients and reduce the power imbalance present in the therapeutic relationship (Greenspan, 1986; Mahalik, Van Ormer, & Simi 2000). Similarly, multicultural therapists assert self-disclosure can cultivate trust where mistrust might exist between culturally specific identities and that norms shared with others may differ widely by culture (Constantine & kwan, 2003).

To establish an appropriate perspective regarding this question, the following section begins by reviewing the term TSD, the relationship between the technique and its effect upon the therapeutic dyad; finally reviewing current methodological limitations in the current practice-based evidence. It concludes with a case for a synthesis of qualitative studies upon the topic of TSD.

TSD inconsistency in definition

TSD is conceptualised in a range of ways, however the concept remains somewhat broad and elusive (Ziv-Beiman, 2013; Hill & Knox, 2002; Watkins, 1990; Barrett & Berman 2001; Yalom 2001). Knox and Hill, (2003) define TSD as "verbal statements revealing something personal about the therapist". The definition has been operationalised over time by the need to examine its outcome upon the therapeutic dyad. Some researchers have provided broad definitions whereby TSD is categorized by the content of the disclosure into self-involving statements such as sharing of personal information about a similar situation and non-intimate disclosures such as demographic details (Dowd & Boroto, 1982; McCarthy & Betz, 1978). Henretty *et al.,* (2014) state that three distinctive types of SD have received most attention and have been used to guide research into examining the effect of SD on the therapeutic relationship. Those types have been defined as a) disclosures that pertain to intra-therapy experience, that represent therapy relevant comments, such as thoughts or feelings about the client or therapy, (also known as countertransference disclosures (Myers & Hayes 2006), b) extra-therapy disclosure represents comments made by the therapist that represent past, present and personal life of the therapist, c) whether the disclosure reveals similarity to the client or dissimilarity, and d) whether the disclosure holds positive or negative emotional content valence. For further clarification positive and negative emotional valence is defined as positive or negative feelings and thoughts expressed about the client (e.g., "I really respect your decision or in the case of negative valence, "I feel sad when I hear you say that") (Henretty *et al*., 2014) .

Results of a meta-analytic review examined how grouped types of disclosures (i.e., inter/extratherapy, similarity/dissimarlity, and negative/positive) differentially effect the therapeutic relationship.   Henretty *et al.,* (2014) express a strong disclaimer regarding findings and conclusions as they indicate that the evidence base remains to be very inconsistent (due to variation in assessment means) and there is much heterogeneity among studies.   53 studies were found to meet their inclusion criteria. Over half were published in peer-reviewed journals, the average sample size was 118 participants; mean ages ranged from 19 to 40 years old. 58% of the participant sample was female and 42% of the counselors were female. Six percent of the 53 studies used real therapeutic sessions, where as the vast majority used analogue design sessions. Henretty *et al.,* (2014) conducted multivariate statistics on the

experimental trial results to calculate effect sizes for the different variables. Overall they found that TSD had a small but favorable effect on participants. Specifically they discovered that therapists that use TSD that reveal, a) similarity between client and therapist, b) is of negative content valence and, c) is related to either intra-therapy or extra-therapy experience, but specifically extra-therapy experiences has favorable (on measures of professional attractiveness) impact on clients when compared with non-disclosure. Therefore therapists who disclose personal information that is similar to the client, but may have a negative contents, may actually be beneficial to the relationship. In contrast though an earlier qualitative review discovered that therapists that use positive inter-therapy (disclosure pertaining to therapy experience) disclosures had more favorably effect on clients than negative inter-therapy disclosures (Watkins, 1990). What remains evident from the reviews is that the results are mixed and the variation in studies are possibly leading to difficulties in drawing any conclusions about the impact of TSD on the client and therapeutic alliance.

Attempting to operationalise a term like TSD into an independent variable means the interactional and relational aspect of this interaction have become lost. Antaki, Barnes and Leudar, (2005) emphasise "self-disclosure must reveal something significant about human relations" at present the current empirical base is "robust but misleading" and it remains misleading because in the act of operationalising the interaction the meaning and context has become lost. Part of the difficulty in establishing a claim about this relationship is methodological. Antaki, Barnes and Leuder (2005) conclude that "psychology of the causes and effects, factors and outcomes kind has said nothing about how someone would go about making themselves understood to actually be disclosing something" (Potter & Edwards, 2001 cited in Antaki, Barnes & Leuder 2005, p182). "Moreover, the endeavor to identify specific, active ingredients often implies decontextualization of parts of therapy, removing them from the essential interpersonal context of the therapy" (Samstag, 2002 cited by Jorgensen, 2004). It could be argued the largely positivist approach to this phenomenon has left its audience with just "objectively defined facts" (Henwood & Pigeon, 1994).

TSD and Therapeutic Alliance

A systematic review of 85 studies examining the effects of TSD on clients' perceptions of therapists trustworthiness, level of regard, empathy, congruence and unconditionality using standardized questionnaires found a non significant effect for the five variables (Henretty & Levitt's, 2010). It was however found TSD did have a positive effect on the perceived warmth of the therapist. Research exploring the impact of TSD on therapeutic alliance has shown TSD was not significantly related to scores on the working alliance inventory (Kelly & Roderguex, 2007). In contrast, clients in an analogue study rated their relationship alliance higher with disclosing therapists than non - disclosing therapists (VandeCreek & Angstadt, 1985). A naturalistic study by Barrett and Berman (2001) found an increase in TSD resulted in a decrease in client symptomology. Henretty and Levitt's, (2010) synthesized 30 studies examining the act of TSD versus non-TSD and discovered the majority of studies (20) favored the use of TSD and that TSD elicited more positive responses and perceptions from clients than non-disclosing therapist. However evidence from 4 studies revealed TSD did more harm than good. In summary research into effects of TSD on the therapeutic relationship indicate disclosing therapists may be perceived as having more warmth, however it has been shown this does not improve the working alliance. Disclosure may lead to a more positive complaint reduction and therapists who disclose are favored more than non-disclosing therapists.

Methodological limitations of the evidence base

Despite a robust evidence base a number of limitations have arisen from researchers' attempts to conceptualise and evidence the impact of TSD (Watkins, 1990; Anderson & Mandell, 1989; Ziv-Beiman, 2013). Attempting to define and aggregate the effects of TSD has proved almost impossible (Heritty & Levitt, 2010; Knox & Hill 2002; Watkins, 1990). Methodological approaches employing analogue, mock therapy situations and students for course credits are not "experience-near" limiting what can be said about real long term therapy interaction (Henritty & levitt 2010; Sloan, 2007; Vandermoot, 2007; Watkins, 1990). Using this methodology precludes a view of the real relationship and internal experience of the dynamics of TD.

2.2 Aim of the review

The present literature review aims to systematically examine findings of published qualitative research that addressed clients' perceptions of therapist's self-disclosure within individual therapy. This is salient due to current gaps acknowledged in practice-based evidence and an attempt to re-contextualize the phenomenon can go some way in using an existing evidence base to provide a novel understanding of "what works, in which situation and for whom" (Weed, 2008).

3. Method

A meta-ethnographic approach was adopted to synthesize studies in an attempt to maintain an interpretative epistemology, congruent with primary papers used as the source (Britten, *et al.,* 2002). Meta-ethnographic approach translates concepts found within qualitative research across studies: a dialogue among texts (Zimmer 2006). Unlike more generically applicable methods for synthesizing qualitative data such as a narrative synthesis it goes beyond the standard accumulation of knowledge by attempting to carry out a re-interpretation using the secondary data (Strike & Prosner 1983). Meta-interpretation is underpinned by an interpretivist epistemology locating the researcher in the analysis process. Therefore the author's reflexive stance is integral to this discussion and can be found in appendix A. Noblit and Hare (1998) outlined seven over-lapping phases for conducting a meta-ethnographic process, beginning with identifying a focal area of interest. Namely how a client interprets the act of TSD within the therapeutic dyad. The next stages involved reading the studies, determining how they related to each other, translating the studies into one another, synthesizing the translations and finally expressing the synthesis.

3. 1 Search Strategy

Phase two involved identifying studies relevant to the area of interest. The aim was not to produce an exhaustive search or comprehensive sample (Noblit & Hare, 1988), systematic search procedures were used to ensure a final sample of items were conceptually rich. A list of search terms was generated by hand, comprising five general areas; disclosure; therapy; counseling; and use of self and real relationship (key search terms in appendix B). Literature searches were conducted in July 2014. One additional article was retrieved using the reference list of an included article for synthesis. Authors of the articles (7) included in the synthesis were contacted to obtain any additional studies the current search may have missed. No additional studies were generated.

The searches identified a large number (>1000) of papers (figure 1 illustrates search process). Results were filtered down to a final list of articles to be reviewed. This process involved the inclusion of: papers (a) be published in English; (b) published in a peer reviewed journal; (c) use qualitative methods, including single case studies; (d) focused on issues relating to clients' perceptions of therapists self-disclosure within the therapeutic dyad.

Figure 1: Search Process to Select Relevant Studies

>1000 of papers were found using search terms from searching the following databases:

Psychoinfo

Pubmed

CINAHL

Medline

This number included replications and was reviewed in light of the inclusion criteria

⬇

752 duplicates removed

⬇

N: 2947 reviewed using title

60% Clients disclosure of medical condition (ie. diagnosis of HIV)

10% Quantitive study

6% Book Review

20% Therapist Perceptions of SD

4% Professional Commentary/Theoretical/Ethical

⬇

n: 64 abstracts reviewed

1 Book review

9 Professional Opinion/Theoretical

3 Self-disclosure of client

8 Dissertations

7 Therapists Perception of SD

26 Quantitative papers

10 Clients perception of TSD

⬇

10 full papers were retrieved for full review

⬇

2 papers removed due to CASP quality score 10 or less

1 paper removed due to insufficent data on clients perception

Final number included in review: 7 papers

Inclusion and Exclusion criteria for articles

Criteria for TSD

For the purpose of this study, self-disclosure was defined as "an interaction in which therapist reveals verbal personal information about him/herself and /or reveals reactions and responses to the client as they arise in the session (Knox *et al.,* 1997). Articles were only included if they offered resultant themes generated from the client's perspective.

Criteria for qualitative literature

Only studies conducted in naturalistic settings with real time clients employing a qualitative methodology were included. Qualitative studies were included if they reported textbased and interpretative analysis based on methods such as interviews, focus groups, observations, or qualitative aspects of a survey.

Selection and Critical Appraisal

10 articles met the inclusion criteria. The Critical Appraisal Skills Program (CASP)(Public Health Research Unit, 2006) appraised the quality of each selected paper (see appendix C). This was combined with a scoring method created by Duggleby (2010) (see appendix C). Three articles were excluded (see appendix D for further explanation).

3. 2 Synthesis of the selected studies

A data extraction form was used to extract the findings (found in appendix E); this was an inclusive approach whereby all data in results sections of the papers were extracted including the author's interpretations. Phase three consisted of comparing findings to identify underlying patterns. This was achieved through repeated reading of the accounts, noting the key interpretative themes. This is an iterative process meaning extraction of qualitative information occurred through a movement between primary papers, data extraction and synthesis. Details of the studies were tabulated in order to provide context for the interpretation of each study (Appendix F). Phase four of the meta-ethnographic process determined how the study findings related to one another, (table 1). Phases five and six concluded with synthesizing the tableted themes, resulting in a narrative account. The contribution each study made was summarized to map its relationship to the emergent themes (Appendix G). As it stands the papers

become a "reciprocal translation". Seven common themes were identified across the seven studies. They offered a perspective on clients' perception of how TSD was interpreted to effect the connection made in therapy, how the therapist is received within the dyad and how they engage in therapy following the use of TSD.

Table 1: Determining how studies themes relate

Methods and Concepts	1. Audet (2010)	2. Bitar (2014)	3. Lee (1990)	4. Hanson (2005)	5. Knox (1997)	6. Tsai (2010)	7. Wells (1994)
Sample	9 clients presenting with mood disorders and addiction	10 clients, presenting difficulties not reported	2 clients, presenting difficulties stress and conflict	number not stated, but reports majority were women	13 clients, presenting difficulties depression, anxiety, drug addiction and eating disorder	35 clients, presenting difficulties adjustment disorders, mood disorders	8 clients, presenting difficulties not stated
Data Collection	Semi-structured Interview	Semi-structured interview	Conversation analysis of therapeutic dyad	Semi-structured interviews	Semi-structured interviews	Survey with qualitative questions	Semi-structured interviews
Setting	Community sample and university training facility	Community mental health agency, court mandated clients	Community mental health agency	Counseling clinics, medical practitioners, graduate level psy courses.	Community sample recruited through practicing private therapists	Community sample, therapists clients	Community sample
Type of TSD	Personal, self-disclosing, self-involving and non-immediate.	Personal self-disclosing, self-involving, and non-immediate.	Inadvertent self-involving and self-disclosing disclosures about non-immediate information	Personal, self-involving and non - immediate to the therapy situation	Personal, self-disclosing, self-involving and non-immediate information	Personal disclosure that was self-disclosing, non self-involving and non-immediate information	Self-disclosing and self-involving, personal, similar and non- immediate and immediate
Explanation/theory (brief summary)	SD facilitates comfort, egalitarianism, taking risks, but impacted closeness/feeling over whelmed, impeding involvement.	SD lessens the therapist-client hierarchy. Normalising client struggles	SD used inadvertently to over compensate for racial differences, challenge positive effects of TSD	SD inhibited disclosure of client, but also increased sense of intimacy – egalitarian relationship.	SD affects real relationship clients sense of universality, ability to use therapist as a model, and clients acquisition of insight	SD, helped to model disclosure, increased emotional intimacy. Enhanced trust and equality of relationship.	SD helped normalize, validate and empower the client, but equally made client feel that therapeutic space was unsafe and crossed boundaries, increased client inhibition

3. 3 Characteristics of selected studies

Taking place across North America, selected study sample sizes ranged from 2 to 35 clients. It was only possible to report mean age ranges and gender for five of the studies. Mean age range was 35.7 – 40 years and combined total sample was 42.85% male. Four of the studies reported ethnicity. Clients were mostly from a Caucasian background (Hanson, 2007; Audet & Everall, 2010). Bitar *et al.,* (2014) and Lee, (1990) recruited from a Hispanic background. Difficulties clients sought therapy for were; depression, anxiety, addiction, personality and eating difficulties. Therapy duration was reported for only four of the studies and ranged from 2mths – 10 years. The therapeutic orientation and professional background of the therapist were reported for all of the studies, summarised in Appendix H.

Foci and research questions of the studies varied, but all reported client's perceptions of TSD and how this affected the therapeutic relationship. Three studies exclusively focused on the client's feelings and effects of TSD (Knox, 1997; Hanson, 2007; Audet & Everall 2010). Two papers addressed TSD, incorporating questions on its cross-cultural implications (Lee, 1990, Bitar *et al.,* 2014). The remaining paper specifically looked at the use of TSD within the framework of Functional Analytic Psychotherapy (FAP) (Tsai *et al.,* 2010). Five of the studies used semi-structured interviews, one used a qualitative survey and another analysed a therapeutic dialogue. Six studies specified their data analysis method. Two employed a phemenological approach, two employed grounded theory, one used critical discourse analysis and the remaining used consensual qualitative research (CQR). Hill *et al.,* (2007) the authors of CQR, define CQR as a method that draws on the use of open-ended questions normally used in a semi-structured data collection method. The process of consensus is used through multiple researcher perspectives to arrive at judgments about the data. At least one auditor is used to check the work of the primary data team carrying out the analysis. This audit is then incorporated into the final analysis-using consensus among the group members to draw together interpretations of the data.

Types of disclosures

Across the seven studies disclosures were personal, self-disclosing, self-involving and non-immediate, such as therapists sharing information about a myriad of life events (Wells, 1994; Hanson, 2007, Bitar *et al.,* 2014, Audet & Everall, 2010). See appendix I.

4. Findings

4. 1 Minimising the power imbalance

The first theme concerns how TSD was perceived by clients to contribute to reducing the potential for a power imbalance within the therapeutic relationship. This was reported by clients in four of the studies and was the second most reported effect for disclosures (Hanson, 2007). The term "egalitarianism" was used in four papers to sum up the clients' perceived effects upon the relationship when a therapist disclosed (Audet & Everall 2010; Bitar *et al.,* 2014; Hanson, 2007; Tsai *et al.,*2010). A client (Andrea) described how "there's a natural kind of power imbalance there, its not that personal disclosure eliminates that, but I feel like it reduces it" (Audet & Everall, 2010, p.334).

Similarly, minimizing of power differentials was felt by the court-mandated clients receiving therapy, described how "he's having problems and issues. It made me feel at that level with him, because before I'd be like down here and I used to see other people up here" (Bitar *et al* ., 2014, p.421). Bitar *et al.,* (2014) reflect on how TSD may have more significance within the relationship of court-mandated clients, as the therapist is attempting to combine two roles; their accountability to the client, but also the criminal justice system, resulting in a greater power disparity. TSD could minimise the power imbalance building a more equal relationship. Sharing of therapists' personal information was perceived by clients to soften the "power differential" which might have greater need when contexts where power differences are accentuated (Bitar *et al.*, 2014). Similarly, participants reported to appreciate disclosures that made them feel the relationship was more equal, June described in response to her therapist disclosure "he is a psychologist himself and he had this issue" (Hanson, 2007 p.99). Hanson, (2007) reflects on how this might enable the client to interpret the relationship as more 'egalitarian'. This form of minimising the power differentials using TSD could be contributing to a more collaborative alliance.

4.2 Modeling – Reciprocal Sharing

A consistent theme arose across the articles concerning how clients interpret TSD as a form of modeling; in modeling how to disclose personal information the client learnt new skills by imitating the process. The majority of studies reported clients interpreting TSD in this way, featuring predominately in Audet and Everall (2010), Knox, (2007) and Tsai *et al*., (2010). Clients felt "disclosing therapists were perceived to be accessible and hearing about therapists experiences or past issues made them more willing or amenable to discussing their own problems". Mitch discussed how:

*"The sessions to that point had been more externally focused…..I wasn't pulling family into the sessions that much…. And so after my therapist disclosed about his own family, it made it easier for me to talk….broke down some barriers. Opened doors"(*Audet & Everall, 2010, p.337)

Mitch highlights how hearing about the therapists' family may have enabled him to divulge information about his family information that he may have otherwise been hesitant to discuss. Bitar *et al*., (2014) and Knox, (1997) specifically label this behavior as modeling and Knox, (1997) describes how some clients reported using therapists as models to make positive changes in themselves or to increase client self-disclosures. One client states 'disclosure facilitated her own openness and honesty in therapy'(Knox 1997). Similarly a male court-mandated participant describes:

"He shares his life experiences with me too. He talks about his family. He talks about his kids, about how he's got one on the way, stuff like that. He showed me pictures of the sonogram or whatever, where they take pictures of the baby, that's personal. That's personal stuff, and so that in exchange just loosened me up, and I started talking about my personal life. So that makes it easy. (Bitar *et al*., p.421*)*

TSD is seen to increase therapists' authenticity, making it easier for the client to share their own personal struggles. It also suggests that sharing can be risky, intimidating and TSD helped to lessen the risk and intimidating nature of the therapeutic encounter.

4.3 Humanness, increased connection.

All papers except for Lee, (1990) reported the most consistent effect arising from the use of TSD, was that TSD was deemed to contribute to a "real relationship" allowing clients to view their therapists as more human, thereby enhancing intimacy within the therapeutic encounter. Audet and Everall (2010), describe how clients labeled therapy interactions prior to disclosure as "rigid" or doctor-patient" which the authors interpret as capturing the interaction as cold and clinical. In contrast post TSD clients "interpreted the therapists as "more human and imperfect," (Audet & Everall, 2010 p.334). Similarly a client interpreted his therapist as "more real and more human and showed that his therapist had flaws like all others and did not have all the answers" (Knox, 1997, p.278). This suggests TSD could contribute in part to establishing a more authentic relationship.

Disclosure of a shared experience was also seen to increase the therapists' perceived humanness. A client asked if her therapist had used street drugs, feeling otherwise he wouldn't be able to understand her struggle with them. The therapists' disclosure was described as "stopping the argument cold" and made her think about her assumptions and stereotypes, recalling:

"It snapped me right out of that self-righteous thing, you know that "How would you know?"... like I was different than him. At that moment it made him a lot more human than I was feeling at that time.... And changed the whole perspective immediately.. it made him sort of a kindred spirit in a way" (Knox, 1997 p.280)

This suggests the individual perceives the therapist to be too dissimilar, however the disclosure appears to alter their preconceived idea, which enhances the connection between client and therapist. In contrast not sharing could be seen to decrease connection, when a therapist chose to not share this was perceived by the client to have a detrimental effect upon the therapeutic alliance. Rose recalled how she would have liked to know information about her therapist in order to establish a link, but was refused. Rose expressed feeling like she had committed a "social blunder" and this contributed to her terminating therapy (Hanson, 2007 p.100). Josephine also described how non-disclosure contributed towards feeling "inhibited"(Hanson, 2007, p.100) and she made a conscious decision to "control herself" and be "constantly on

guard". These descriptions would suggest some individuals would find therapist non-disclosure as inhibiting and actually decreased the connection made.

4.4 Impeding involvement

Although many studies reported TSD's contribution to increased connection, conversely, clients recalled how TSD could have a detrimental effect; creating impasses, blurring boundaries and minimizing the perceived professionalism of the therapist. Clients from Wells', (1994) study discussed being "pissed off" and "humiliated", expressing how disclosure had contributed to them feeling ambivalent about the relationship. Similarly the following quote from Doug recalls how:

" *Sometimes my therapist's disclosure was a problem because he'd go too far...Sometimes I just wanted to talk about myself and what was going on in my life for a bit. And he wouldn't shut up about his life...And sometimes I just wanted to talk, get things off my chest because once I'd hear myself talk I'd feel better and know the answer related to my problem. But he'd always interrupt.....And I'd be like now I got try and relate this to my experience – which I can do, but its just not as helpful as just being able to talk it out* (Audet & Everall 2010, p.338)

Doug expresses a strong opinion that disclosure was unwanted and impinged on his ability to process his own experience. TSD was also reported to be superfluous and Stan described how he perceived it as competitive and monopolizing (Audet & Everall, 2010). Possible competiveness arising from TSD was shared, one client describing how "my problems seemed trivial in comparison and I felt ashamed to be taking the time to talk about my self" (Tsai *et al*., 2010, p.6).

4.5 Blurring of boundaries and uncertainty of roles

TSD was also seen to contribute towards client's confusion about boundaries and roles within the therapeutic dyad. One client was wary about therapy boundaries and questioned what she was supposed to know as a result of the disclosure (Knox, 1997). Another recalled "Her boundaries were just gone....and it was so total a boundary violation that I...never had any control of it, it just happened" (Wells, 1994 p.30). Negative reactions evoked by the disclosure contributed to feelings the therapist had over-stepped the line, devaluing the role of the therapist. TSD also contributed to confusion about the client's role in therapy. Persistent disclosures evoked a

perception of the therapist as being in a subordinate positive akin to role reversal (Audet & Everall, 2010). Stan described how he perceived his therapist as 'crazier' than he was. He reported as struggling with whether he should help his therapist (Audet & Everall, 2010). Stan reported:

"Not that I didn't respect her, but I guess I didn't have reverence for her as therapist. She was more, oh, I'm going to see my buddy". (Audet & Everall 2010. p.335)

Stan's quote suggests TSD could diminish respect for the therapeutic encounter. The purpose of the therapeutic connection changed into a meeting of friends, as if the relationship takes on friendship norms. Equally, confusion about the role and function of the therapeutic encounter may have arisen from the use of TSD.

4. 6 Negotiating cultural identity

The negotiation of cultural identity arose from two papers. Though not a consistent theme it had importance to how cultural identity was expressed either unrecognised or recognised within the use of TSD. Lee (1990) draws attention to how cultural bias becomes evident through the therapists' use of SD and clients unconscious attempts to reclaim their identity using various discursive strategies.

Lee, (1990) illustrates how Eduardo a 40yr old immigrant from Argentina was experiencing depressive states due to conflict with his wife following separation from her and his children. In the therapeutic encounter, the client and therapist discuss his current loneliness and depressed feelings, and the client identifies that he "coaches soccer", the therapist takes this opportunity to suggest that "all of you in South America play soccer or are crazy for soccer?" (p18, Lee 1990). Lee (1990) suggests that the therapist is explicit in disclosing her view of South American men enjoying soccer and uses this in order to link it with an intervention focus of self-care. The authors suggest that the therapist may unknowingly in an attempt to be real to the client attempt to reduce their anxieties "by neutralizing racial and cultural content by overcompensating for racial differences" through self-disclosing statements. This may inadvertently represent an episode in which the therapist minimized the importance of Eduardo, the separated immigrant father, instead basing the suggestion of self-care upon her cultural view of the client's gender and ethnicity, missing the opportunity to explore his culturally embedded subjective view. Lee, (1990) concludes this results with the client disengaging. Lee, (1990) describes this as "racial countertransference",

suggesting the therapist draws on gendered stereotype of a male of Latino culture, missing the opportunity to explore how Eduardo may be experiencing immense loss from not being a caregiver anymore.

In contrast Bitar *et al.*, (2014) report how therapists careful use of disclosure may help by addressing cultural mistrust that may exist. A quote from one court-mandated Mexican-American client alludes to possible cultural stigma associated with being Mexican:

"To me, I mean, people – I don't know, its just people that got good jobs and stuff like that, they seem to be a little better than a Mexican working his butt off, but to me it was just like he was just normal. I mean he was good, he was good people. He told me about his life. He's got struggles, too, like all of us. That made me feel good. That I could open up to him and to let him know about my life". (Bitar et al., p.9)

Thus, the client felt the disclosure helped him to view the therapist as normal rather than superior, self-stigmatizing as the "Mexican working his butt off", evoking an oppressed group, working tirelessly compared with Americans with a good job. However this comparison and TSD somehow reduced the difference and enabled him to talk about his life. Although the therapist does not address racial biases, as Lee, (1990) does in the resultant discourse analysis, the act of personal disclosure was seen to help the client feel there was less of a hierarchy, but more collaborative relationship. Lee, (1990) points to how unrecognised and unprocessed cultural beliefs and values become expressed through disclosure can interrupt the engagement process.

Re-experiencing of familiar interpersonal dynamics, taking on the role of caregiver.

Clients from only two of the studies recalled how disclosure from a therapist mirrored similar interpersonal dynamics. Isabelle described how her therapist would recount a long story of her own, every time she told her something. "Isabelle felt like it was her job to listen to the therapist as the therapist's caretaker" (Hanson, 2007, p.101). Similarly Wells, (1994) describes how three clients from their study explicitly talked about how using TSD had triggered clients to feel as if they were re-experiencing a familiar interpersonal dynamic. One client described how her therapist had repeatedly revealed personal information despite the subject's requests for nondisclosure, recalling:

" it just made me feel like she was expecting me to be her equal but at the same time not seeing me as her equal… I was really struggling with that.. And I also compared that to how that was in my family, because my mom treated me like I was a buddy but never like her daughter"(Wells, 1994, p.32)

These shared recollections point to how disclosure and its repeated use were seen to evoke strong feelings of earlier unhelpful attachment patterns with caregivers. These recreated familiar interpersonal dynamics caused significant disruption to the therapeutic encounter (Wells, 1994). The use of TSD, violated boundaries clients had requested to be put in place.

4.7 Synthesizing the findings

In meta-ethnography, the final level of synthesis develops a line-of-argument; a narrative integrating findings (Noblit & Hare, 1988). The inference from these studies is that TSD is inappropriately conceived as just a 'tool' in the therapeutic bag. While each study focused on the relational effects from the therapeutic dyad, it was apparent that the resultant effects of TSD were dynamic and individuals had engaged to a great extent with what it might mean to them. Conception of TSD may be better assessed by its ability to effect power dynamics, cultural embedded concepts of identity, re-enactment of powerful earlier relational attachments and the therapeutic alliance. In light of these studies, it seems inappropriate to conceive of TSD as just an intervention or technique, but as a powerful exchange that can have far reaching systemic effects.

Table 2: Synthesis, Including Themes and Line of Arguments

Concepts	Line of Argument
Minimizing the power imbalance, modeling – reciprocal sharing, humanness, increased connection	(a) disclosure can be advantageous by reducing pre-existing power differentials, modeling how to disclose and, assist in emotional catharsis. Therapists perceived as more authentic when disclosing, this may contribute to an increased therapeutic alliance.
Blurring of boundaries, uncertainty of roles and impeding involvement	(b) disclosure can be disadvantageous and be perceived as abandoning the rules and boundaries of the therapeutic encounter and minimizing the professional nature of therapist.
Negotiating cultural identity	(c) disclosure is part of a more complex picture, cultural identity can become expressed through this, unprocessed and unrecognized it can contribute to significant impasses, however clients may also use it to help address cultural mistrust or address the therapists value system.
Re-experiencing of familiar interpersonal dynamics	(d) disclosure can have a detrimental impact on client, by tapping into previous harmful and unhelpful attachment patterns previously experienced, such as caretaker for a primary caregiver.

5. Discussion

The aim of this meta-ethnographic was to contribute to the debate about TSD, by synthesising qualitative naturalistic studies findings on individual perception of TSD within the therapeutic encounter. The synthesis identified seven themes, this is two opposing patterns of responses to TSD, one that TSD brings all the benefits of a perception of therapists as more authentic, equal and modeling how to manage emotions. Simultaneously, clients perceive TSD has blurring boundaries, reversing roles and minimising the professional nature of the therapist - evoking previous familiar unhelpful interpersonal dynamics. The remaining theme encompasses how cultural identity may be negotiated through the use of TSD and unprocessed cultural bias can be transmitted through TSD, creating an impasse. In contrast cultural mistrust can be minimised when TSD is used, however direct discussion about implicit racial differences may not be made explicit.

This meta - ethnographic approach offers a unique contribution to the current evidence base as it is the first synthesis to review only naturalistic qualitative studies as an attempt to re-contextualize the relational aspect of the therapeutic encounter. Something, which may have become obscured through the plethora of quantitative studies, leading to overly simplistic assumptions about cause and effect relationships (Knox & Hill 2002). The diversity in findings, such that TSD could be interpreted as simultaneously detrimental and providing insight, may suggest the distinct diversity found within the expressed opinions are dependent on the recipient of TSD and how the person can integrate the disclosure into therapy and what meaning they attach to the disclosed information. The themes arising from TSD appear to demonstrate that the therapist, client, and relationship variables are intimately related as previously found by others (Jorgensen 2004).

Therapeutic alliance (TA) has been argued has among one of the most important predictors of improvement in therapy (Lambert &Barley 2001, Norcross 2002, Wamplod 2001) Research into psychotherepy have repeatedly demonstrated that one of the most important determinants of therapeutic alliance are the basic personal qualities and interpersonal skills of therapists. Previous qualitative accounts consistently underscore the importance of kindness, warmth, interest and engagement as important factors contributing to the TA (Sweeney *et al.*, 2014). This is a commonly repeated finding in the mental health literature (Stenhouse 2011, Cleary *et al.*, 2012; Gilburt, *et al.* (2010). As was found here, clients felt that the TSD contributed to perceiving the therapist as more human and minimising the power imbalance and this contributed to a more collaborative relationship allowing the client to feel safe to disclose feelings. Thus, disclosing may enhance some of the salient beneficial therapeutic ingredients identified above that are seen to contribute to a stronger therapeutic alliance.

Simultaneously, disclosures were also perceived as detrimental to the therapeutic encounter, theoretically mirroring Freud's early comments on how disclosure may depart from what is expected. As it was found disclosing elicited feelings of vulnerability and distrust, which would strain the relationship (Audet & Everall, 2010). Theoretically these findings could be explained by suggestions that therapist's attunement to clients' parallels caregivers attunement to their children (Greenberg *et al.*, 1993). TSD may evoke feelings of prior developmental attachments, that haven't

been helpful. Further evidence to confirm this assumption would be the finding that clients recalled how they felt angry and prohibited by the therapist's disclosure and felt responsible for the therapist. This may also bear significance when considering the working alliance of the relationship; others have implicated attachment style as a causal factor in the alliance formation (Eagle & Wolitzky 2009, Mikulincer, Shaver, Cassidy & Berant 2009). Given that working alliance has great importance to client change (Horvath & Symonds 1991), illuminating the role of TSD and its perceived contribution to the role of client attachment in the alliance has potential clinical utility, especially when the key is in developing and maintaining the alliance. TSD may contribute to reducing the working alliance and in turn the effectiveness of the therapy.

The negotiation of cultural identity indicated cultural identity might be silently unprocessed within the dialogue existing between the client and therapist. The literature from this field advocates that disclosure may reduce possible cultural mistrust (Constantine & kwan, 2003). However participants of Bitar *et al*., (2014) study did not directly discuss how or if this occurred. In contrast and quite alarmingly Lees,(1990) paper explored how therapists may unknowingly impose a 'set of cultural' values and beliefs. This has important implications for the practice of a culturally competent therapist.

5. 1 Implications for practice and research

Further research should expand on the different contexts in which TSD is studied and continue to base their findings within more naturalistic settings and across different cultures, as this meta-synthesis highlights these gaps. Studies may also benefit from attempting to refine the definition of TSD in order to be able to bring more coherence to how certain aspects of TSD may operate. Studies here suggest that TSD can be culturally bound and when left unprocessed have a negative impact on the relationship; therefore discussion of this concept should be integral to practitioners within professional training.

Practice-based implications are that the use of TSD should be carefully considered, although it can be seen as an expression of authenticity (Bitar *et al.*, 2014) and has potential for softening power differentials. The evidence here would suggest that the use of TSD can have far-reaching, interpersonal effects leading to alliance ruptures. Practitioners might benefit from careful consideration and reflect on how such a technique may be received within the therapeutic dyad. Supervision would also be a suitable space for this dialogue to occur.

5. 2 Limitations

The minimal number of studies available brings into question the potential representativeness of the findings and limits the transferability of the findings. Equally it is difficult to discern through interviews the extent to which the quality or effectiveness of the relationship was attributable to disclosures received. It is possible themes emerging could also be attributable to other aspects of the therapeutic encounter such as the therapists level of experience. Previous researchers have indicated a problem inherent to the nature of psychotherapy is that it is almost impossible to isolate specific factors and relate these directly to changes in the client (Jorgensen, 2004). The findings are also understood through the lens of the researchers and the triple hermeneutic is to be open to potential bias, from the researchers own interpretations. One way to address this potential bias was to carry out a quality assessment. Most studies employed methods to prevent bias from arising such as using independent teams to complete analysis, acknowledging bias and attempting to bracket them. An attempt to make analysis transparent and referenced using the data to example the context and the sensitivity to the subject was used as a way to quality check the procedure of the ethnographic review and trainees attempt to be aware of any bias arising during analysis and write-up. Supervision with a senior clinical tutor and researcher was also drawn upon in order to carry out a quality check of the analysis during the procedure and also after completion.

The definition of TSD used here was broad, and previous research illustrates dissimilar/similar, intratherapy disclosures and extratherapy disclosures can have significantly different effects (Henretty & Levitt's, 2010). Future synthesizing may benefit from focusing on specific types of TSD to help clarify certain aspects of its effects. Retrospective recollection of information may also be open to bias and more subtle forms of SD such as more intimate use of SD about the intratherapy process

may have been recalled less and therefore accounts may have privileged the information therapists shared more explicitly about their own background.

The convenience samples and clients who took part may have been different to the individuals who declined, ie self-selecting and some therapists directly asked certain clients to take part. Furthermore only the most compliant may have chosen to take part, which may not be representative. The therapist orientation varied across the studies and it has been demonstrated that orientation can be a mediating factor (Edwards & Murdock, 1994) this may have significantly impacted on how the therapist would choose to use TSD if at all.

Although meta-ethnographic approach celebrates variation in studies and attempts to use these to inform the findings, determining topical similarity may be a problem inherent to qualitative synthesis and may obscure some of the commonality and differences (Sandelowski, 1997). As was found here, discourse analysis approach used by Lee, (1990) did contribute more heterogeneity to the sample, as it was possible to discern more of a micro-level understanding and offered multi-perspectives due to the analysis of the dialogue, However other approaches such as thematic and phenomenological analysis sometimes made it difficult to discern the meaning of the participants, in turn making it difficult to make comparisons across the studies.

<p style="text-align:center;">**References** (* denotes review articles)</p>

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Section B Research Study

Recovery in a mental health setting: an Interpretative Phenomenological Analysis of how an individual experiences a Peer-Supported Self-Management Intervention

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6. Research Study Abstract

Purpose: Peer support workers (PSW) are people with lived experience of mental health distress who provide mental health interventions or services to people with mental health problems who are at an earlier stage in their recovery journey. Recovery-orientated services and models such as peer-support have started to be co-opted into mental health services in the UK. Owing to limited research in this area, little is known of how the individual experiences this relationship.

Method: Semi-structured interviews were conducted with seven individuals (five females, two males, mean age 31 years) who had recently finished receiving support from a crisis resolution team. All had been in receipt of a peer-support intervention as part of a randomized controlled trial in the UK that evaluated the effects of the intervention. Interviews were analyzed using interpretative phenomenological analysis (IPA).

Results: Internal and external stigmatizatising attitudes and concealment of mental health identity contributed to ambivalent identification with the peer. Contrary to this, individuals were also seen to use the relationship to challenge stigmatising attitudes and significant identity shifts were seen to occur. Dominant narratives also drew attention to wider systematic focus of peer support intervention and how the dyad was used to discuss the repetition of unhelpful early attachment patterns, and how this mirrored relationships with mental health services.

Conclusions: Results are considered in light of criticisms of the recovery model and the essential need to better understand how stigma may operate at individual and societal levels, thereby influencing the success of an individual intervention such as peer support. Future research and shortcomings are also discussed in light of the findings.

Keywords: Peer-Support; Recovery; Stigma; Mental Health Services; Interpretative Phenomenological Analysis (IPA).

<center>**7. Introduction**</center>

7. 1 Background

Peer support workers (PSW) are people with lived experience of mental health distress who provide mental health interventions or services to people with mental health problems who are at an earlier stage in their recovery journey (Davidson *et al.,* 2006). Provision of peer support is identified as a fidelity requirement for recovery-orientated services (Armstrong & Steffen, 2009), and is commonly promoted in recovery literature (Slade 2009; Scottish Recovery Network, 2005). Recently, the NHS Confederation (2010) promoted the employment of PSW workers in delivering mental health interventions in their Implementing Recovery through Organisational Change project (ImROC).

The ImROC project (2011) was formally announced within the context of the Mental Health Strategy: No Health without Mental Health (2012). Since the inception of the proposed project, a number of key pilot sites have been set up around the UK. Peer support is being integrated into the care pathway for service users to access. To date, several NHS organizations across the UK and Scotland have incorporated this role in mental health services: Devon Partnership NHS Trust, 2007; South London & Maudsley NHS Foundation Trust, 2007; South West London and St George's Mental Health NHS Trust, 2007; and Nottingham Mental Health Trust (2007).

Provision of Peer Support in Recovery-Orientated Services

Recovery-orientated approach has its roots in a somewhat radical anti-psychiatry and civil-rights movement dating back to the 1950s (Laysha & Adams, 2012). The involvement of PSWs in mental health services originated in Australia and the USA in the 1950s with programs such as GROW: a world community mental health movement (Corrigan, 2002). The provision of PS varies considerably. Some support is solely consumer-run. In other cases, peers are employed by healthcare providers, and work alongside other healthcare professionals. The current proposal is concerned with planned peer support, whereby the peer is employed by the Mental Health Service Provider.

More recently, access to peer-provided support for people with severe mental health problems has been widely advocated in the UK and internationally by service user researchers (Clay *et al.,* 2005; Deegan, 1996; Faulkner & Basset, 2012). It has also been recommended by professional organizations (Bradstreet & Pratt, 2010; Royal College of Psychiatrists, 2009). Recent developments in peer support, based on models developed in the US and aided by the promotion of a 'recovery-focused' approach, have raised the profile of peer support in mental health, and introduced the employment of PSWs into mental health services (Faulkner & Kalathil, 2012). However, the notion of recovery has also been critiqued by psychiatric survivor movement and critical research clinicians (Dillon, 2011; Speed & Harper, 2015; Pilgrim & McCranie, 2013; Rose, 2014). Many are concerned it has been a case of 'old wine in a new bottle' (Speed & Harper, 2015, p.1). Critics are concerned that mental health services continue to use the same methods, but with different terminology. Similarly, many professionals' concepts of recovery have too often become distorted into a clinical model of service provision. (Perkins, 2015).

Quantitative Evidence for Peer Support Workers Supporting Recovery

To date, several narrative reviews, and three meta-analyses evaluating peer-provided interventions in mental health settings have been conducted (Davidson *et al.,* 1999, 2006; Solomon & Draine, 2001; Simpson & House, 2002; Repper & Carter, 2011; Chinman, *et al.,* 2014; Fuhr, *et al.,* 2014; Lloyd-Evans *et al.,* 2014). Fuhr *et al.,* (2014) carried out a meta-synthesis examining 14 randomized controlled trials (RTCs) of peer-delivered interventions compared to support as usual for individuals experiencing severe mental health distress. They discovered a small positive effect of peer-delivered interventions for quality of life and hope. Similarly, Lloyd-Evans *et al.,* (2014), performed a meta-synthesis of 18 RCTs of peer-delivered interventions, mutual support programs, and peer-delivered services for individuals experiencing mental health distress. They concluded that peer support was associated with positive effects on measures of hope, recovery and empowerment, although not consistently across different types of peer support. The authors indicated there was high risk of bias in the trials, and little or no evidence that peer support was associated with positive effects on hospitalization, overall "symptoms" or satisfaction with services.

In contrast, Solomon and Draine, (2001) highlighted the benefits of peer-interventions: reductions in hospitalisation and length of stay. Repper & Carter, (2011) concluded that peer-provided services are as efficient as non peer-provided services, with few differences between peer and professional support. In summary, the evidence illustrates a mixed presentation of the benefits of peer support. Outcome measures of personal recovery that emphasize individual values and relationships appear to indicate some positive effects from this intervention. It has been argued that personal recovery rather than clinical recovery alone should be the remit of mental health services (Dorkis & Adshead, 2011).

Inter-subjective properties of a Peer Support Relationship central to recovery

Current literature focused on the subjective nature of the relationship emphasizes that peer support can bring five key components: (a) empowerment, (b) increased social functioning, (c) increased empathy and acceptance, (d) hope, (e) a decrease in stigmatizing views about mental health. The process of mutual development of solutions and shared exploration of feelings facilitates a recipient's own support mechanism and subsequent feelings of empowerment (Ochocka, Nelson, Janzen, and Trainor, 2006). This process of normalisation moves away from the traditional definition of "mental health patient", and enables the individual to assume a more empowering identity (Mead & Macneil, 2004). The process of modelling recovery, and use of the peer's existing knowledge of local services in the community facilitate the recipient's access to local community links, thereby increasing social functioning (Maton, 1990; Yanos, Primavera, and Knight, 2001). Helping the individual to forge new links with the community can reduce their sense of isolation and aid rebuilding of their life.

In the peer support relationship, it is assumed that people who have had similar experiences relate better to each other, and can therefore offer more authentic empathy and validation (Mead & Macneil, 2004). Sells *et al.,* (2006) reported that recipients of peer support perceived higher positive regard, understanding and acceptance from peer providers than from regular providers. The authors concluded that peers might provide or possess distinctive skills in communicating the above salient therapeutic attributes, enabling them to quickly forge successful therapeutic connections with an individual. The recipients of peer support have also

demonstrated an increase in hope (Davidson *et al.,* 2006). The process of role-modeling recovery is seen as an inspiration to many receiving the support; this could provide hope to an individual in their particular stage of recovery.

The process of peer support can also be seen to have large implications for decreasing stigma associated with mental health. At the individual level, the peer can provide a role model for the possibility of success and acceptance, and the challenging of barriers presented as self-stigma (Repper & Carter, 2011). At an organizational level, peers working alongside mental health professionals can challenge and break down existing stigmatizing attitudes about mental health distress held by individuals working in mental health services. Furthermore, PSW can actively inform service development, and advocate new ways of social inclusion.

Summary

Although the findings indicate that peers can offer some form of support to others, and be as effective as professional-provided services, peer support has not been researched extensively. Little is known about the circumstances in which it works, how it works, or whom it benefits the most (Repper & Carter, 2011). In view of the increase in recovery-orientated services and models in use, the current study could inform further development and implementation of the peer-support self-management intervention in NHS trusts. The investigation could provide a framework and understanding of how the peer and recipient construct their understanding of mental health.

7. 2 Proposed Study

The proposed study formed part of a wider project called CORE (Crisis team Optimisation and RElapse prevention), which is a five-year research programme funded by the National Institute for Health Research (NIHR). A part of the project is implementation and evaluation of RCT of a peer-led intervention (see appendix J for further details) for people leaving Crisis Resolution Team (CRT) care. To date, developmental work for the intervention, involving consultation with service users' and carers' groups, and focus groups with stakeholders such as staff and previous users of crisis teams has taken place. At present, the intervention is taking place in several NHS trusts throughout the UK, due to complete in 2016.

7. 3 Aims and Objectives

The proposed research aimed to address the following questions:

1.1 How do individuals who have experienced severe mental health distress make sense of their experience of receiving support from another person who identifies as also experiencing mental health distress?

1.2 How does the individual receiving the peer support perceive the nature of this relationship, and how does it impact their wellbeing?

The objective was to establish how the recipient makes sense of, and constructs their recovery with the peer's help, and how this contributes towards the recipient's understanding of their own mental health crisis and recovery.

8. Methodology

8. 1 Study Design

The primary concern of the research was to explore and interpret the recipient's experience of peer support intervention. A qualitative methodology using Interpretative Phenomenological Analysis (Smith *et al.,* (2009) (IPA) was employed, as it captures and reflects the "principal claims and concerns" (Larkin & Thompson, 2012 p.100) of the individuals receiving the intervention. Smith and Osborn, (2003) described IPA as 'especially useful when one is concerned with complexity, process, or novelty' (p.53). Taking those three elements, Smith and Osborn, (2003) highlighted the possibility of demonstrating how IPA was a suitable method of inquiry for the proposed study. Quantitative research into peer support interventions reports improvements in an individual's personal recovery, but the subjective critical ingredients remain unknown and novel. The idiographic nature of IPA will go some way in "giving voice" (Larkin & Thompson, 2012), and reflecting the principal concerns of the individual's rather than grouped level data outcomes. IPA can assist in making sense of what it means for the individual receiving this intervention, and how this can in turn can offer an insight into the individual's recovery, which encompasses a complex process.

A first-person account of their experience generated through semi-structured interviews was felt to be the most appropriate method to understand and 'offer insight into the subjective lived experience of the individuals' (Reeves *et al.,* 2008, p.631). A qualitative method employed by Hollway and Jefferson, (2000) was also used to inform data collection and analysis. This method draws on psychoanalytic informed ideas. As Hollway and Jefferson, (2000) emphasized, the participant's account is largely invested in a particular position to protect vulnerable aspects of the self, and are motivated, largely unconsciously, to disguise the meaning of at least some of their feelings and actions. It is pertinent as a method for two reasons. Firstly, inconsistencies in accounts, changes in tone, and inconsistencies arising out of one detail (the part) and the generalized claim on the whole (the gestalt) become important to the understanding of the analysis and the hidden meaning. If the analysis is read merely at surface level, these aspects become lost. The second reason illustrates the importance of examining the researcher's own disturbance, and

studying this in relation to the production of the data and analysis. This is essential because researchers cannot be detached from the process and this examination of our subjective involvement shapes the way in which the researcher interprets the interview data. The data produced are largely co-produced out of subtle and largely unconscious dynamics (Hollway & Jefferson, 2000). This approach complements Heidegger's (1962/1927) notion of 'appearing', where one element of the account may appear superficially not be what the participant is actually discussing, but its latent meaning appears during the "whole" analysis. 'The individual will be invested in particular position in the discourse to protect vulnerable aspects of self' (Hollway & Jefferson 2000, p.26). It remained important to be open to those aspects of the discourse that seemed inconsistent or evoked certain shifts in emotion.

The premise was that a discourse approach to analysis of the person's accounts would prevent the researcher from attempting to get close to the person's positionality in relation to the phenomenon of the peer support process, and how this experience shapes their recovery. Similarly, the action and processes orientation of grounded theory (Glasser & Strauss, 1965) might have implications for the freedom of allowing the participant to be heard, and to tell their story. Therefore IPA was chosen over other qualitative methods.

8.2 Participants

Participants were selected to provide a 'perspective rather than a population' (Smith *et al.,* 2009, p.49). A key aspect of the IPA approach is to use a homogenous sample. The concept of peer support is so recent that there is no literature to guide the selection of a homogenous sample. The topic under investigation is itself novel, and thus defines the boundaries of the sample selection.

The following inclusion and exclusion criteria were applied. The current study interviewed men and women of working age (18-60+), who had engaged with the intervention of 10-week contact for the first time. They lived in an inner London location, identified themselves as having experienced mental health distress in the last 12 months, and had the capacity to give informed consent. Individuals who could not understand and communicate in English were excluded, as translators could not be funded.

There is no consensus about a suitable sample size number in qualitative research. Creswell, (1998) suggested 5-25; Morse, (1994) suggested ≥6 for phenomenological studies. Smith *et al.,* (2009) recommended "four to ten interviews" (p.52) as a suitable sample size for professional doctorates. They warned that too large a sample could expose the researcher to being overwhelmed by the amount of data generated. Analysis of individual transcripts operated alongside interviewing; an iterative process took place to help inform recruitment. Analysis of data from four to ten interviewees provided insight about the phenomenon, not empirical generalisation from a sample to populations (Patton, 2002). The details of seven participants who were included in the study are summarized in the Table XX.

Table 3: Summary of Participant Demographics

*Pseudonym	Age	Ethnic Background	Occupational Status	Presenting Issue
1. Susie (female)	42	White British	Unemployed	Complex trauma
2. Bethany (female)	37	Black/African British	Unemployed	Hearing voices
3. Emily (female)	37	White/Irish	Paid Employment	Substance misuse
4. Alice (female)	25	White/British	Unemployed	Mood swings
5. Carlos (male)	21	South American	Student	Fear/low mood
6. Lucy (female)	19	White/Polish	Student	Hearing voices
7. William (male)	42	Black/African/ British	Unemployed	Hearing voices

* Note: All interviews were transcribed verbatim and anonymised in the process of transcription. The names of the individuals, family members and PSW involved in the intervention have been changed to maintain confidentiality and anonymity.

8.3 Procedure

Research Proposal and Ethics

As the research involved interviews with service users of the NHS, ethical approval and individuals' trusts R&D was sought before the research commenced (copies of approval found appendix K). The Researcher followed the procedures regarding confidentiality and safety of the NHS Trust in which the interviews took place. A participant information sheet and consent form was provided before the interview (a copy of this is in Appendix L), and the potential participant was encouraged to ask questions. The Researcher was sensitive to the needs of the participants, who were encouraged to contact the Researcher if they experienced excessive distress after the interview.

Participant Recruitment

Participants had finished an episode of support with a Crisis Resolution Team and had consented to take part in the intervention arm of the randomised control trial. Participants were recruited from two London boroughs – the locations of the RCT. Individuals were asked at the beginning of RCT if they would be willing to take part in a qualitative interview after completion of the intervention. This option was included in the consent sheet of the main RCT. Individuals consenting to the interview were contacted following completion of the intervention. Recruitment took place between July – December 2014. The researcher provided the participant with the information sheet by post. The individual was given 48 hours to decide if they wished to participate.

A total of nine participants were contacted following their consent at baseline. Two were invited to take part, but did not participate. One was excluded due to non-completion of the 10-week intervention. The nature of the experience that had led to non-completion might have introduced too many differences to the data. It would therefore not have been possible to maintain homogeneity of the group. The second participant did not attend the arranged interview. Attempts at further contact were unsuccessful.

Interview Procedure and Materials

The Researcher used an interview schedule to guide discussion. A final version of the topic guide is in Appendix M. A preliminary topic guide was developed from a review of the existing literature. The service user and carer group currently informing the main study were consulted and the topic guide was piloted with a service user from the service user reference group from Leicester University. Adjustments to the topic guide were made: words deemed overly professional, or to be leading questions, were adapted. The questions acted as a guide. They allowed the Researcher to incorporate the interviewer's own terms and concepts into the questions, making them more appropriate or relevant to the interviewee (Willig, 2001, p.23). A regional IPA group was also used to present the research proposal, and to gather feedback on the topic guide, which was incorporated into the changes of the guide.

Individuals were given the choice of having the interview conducted at home, or in a neutral and relaxed space, assuring the privacy of the individual. All participants chose to be interviewed at home. Participants were asked to re-read the information sheet, then complete the consent sheet. Confidentiality and Anonymity was explained. The interviews lasted for 45-60 minutes. Audio-recording equipment was used to collect participants' responses after giving informed consent. Audio-recordings of qualitative interviews were downloaded to an encrypted data stick, which remained in a locked cabinet. Recordings were then deleted from the audio-recorder.

Transcription & Analysis Procedure

The audio recordings were transcribed verbatim by external transcribers who followed instructions by Smith *et al.,* (2009, p.73). The external transcribers signed a confidentiality form (see appendix N). The act of transcription itself is a form of interpretative activity. Using a transcription service may alter that, but it was balanced with the practical reality of the research being time-limited. Situating details, such as gestures, were added after verbatim transcription by the investigator. These included non-verbal communication such as laughter, significant pauses, and hesitations. Close detailed reading of the transcripts was carried out whilst listening to the audio, to allow the investigator to familiarize with the world of the participant. This also enabled the investigator to carry out any additional quality checks of the transcription. Post–interview, the investigator captured the thoughts, and inter-subjective dynamics

that the interview evoked, and the ways in which the investigator influenced the data, within a format known as a pen portrait (Hollway & Jefferson, 2000). Pen portraits are part of the psychoanalytically informed method proposed by Hollway and Jefferson (2000). Pen portraits acted as useful memory device post interview. The investigator recorded additional demographic details, taken from the environment of the interview and subjective shifts in emotions and feelings that may have arisen during the interview (i.e. transference and countertransference, possible unconscious communication). This approach aided the reflexive activity and extended the exploration of the relationship between the participant and interviewer. This became the basis for integration into the analysis, and served as a tool to situate the person in the context of their narrative. In addition to this it was also seen as a way to further inform the interpretation of the data and not as an additional method. Thereby helping to aid the movement from a descriptive analysis to a more interpretative account. The IPA of the data closely followed the four-stage process described in detail in Smith *et al.,* (2009). For detailed discussion, and diagrammatic representation, see appendix O).

8.4 Reflexivity and Quality Checks

The idiographic nature of this research highlights the importance of the ongoing reflexive process throughout the life of the research process. To engage with the participant experience, the Researcher identified and reflected on her experiences and assumptions (Larkin &Thompson, 2012). Smith *et al.,* (2009) emphasise the importance of reflective activity as being 'prereflective reflectivity to deliberatively controlled reflection' (p.188). Therefore, in carrying out an interpretation of the recipient's account, the Researcher attempted to understand what the individuals might be thinking, and what they are doing about it, whilst also being aware of their own interpretation of those events. The Researcher's epistemological position in relation to the research is in appendix P. A contextual constructivist epistemological position was drawn upon to inform data gathering and interpretation, this position would largely argue that phenomenon may be socially constructed between individuals and influenced by cultural, social and historical factors. The use of a psychoanalytically informed method may be at odds with such a position and a common criticism has been that psychoanalysis brings too many theoretical concepts to its selection and interpretation of data (Midgley, 2006). In addition to this a socially constructionist approach may also reject the idea that there is a psychological realm

beyond or below peoples speech (Edwards & Potters 1992). This discussion and how the chosen methodology is reconciled with the epistemological position are further elaborated on in appendix P. A reflexive journal was kept to detail this process, and was used to note assumptions throughout the research. This was later used to inform the movement throughout the hermeneutic circle and the various layers of understanding.

The coding process and personal reflections were discussed in supervision, to ensure vigilance of these fore-standings, and how these are implicated in the interpretive process (process documented in critical paper). The process of supervision enabled a credibility check to ensure interpretations remained grounded in the participant's views. A regional IPA group was also drawn upon to enable the investigator to explore these interpretations and further evaluate the reflexive process. Before starting the project, the investigator also completed a training course of IPA. This allowed a greater understanding of theoretical underpinning of phenomenology.

9. Results

Seven participants (5 females) were interviewed. Analysis of their interview transcripts generated 19 subthemes (Appendix Q). These were organized into three superordinate themes by linking similar meaning and content: 1)'Ambivalent identification with the peer'; 2) 'Constructing a new sense of self'; 3) 'Organisational structures mimic the power and emotional dynamics of family relations'. In concordance with the previously-stated aims of this study, this report focuses on themes pertinent to the personal experience of a peer–support intervention as stated in Table 4. Table 5 illustrates the recurrence of the identified themes, whether the subordinate theme is present for each participant, and whether it is prevalent in over half the cases.

Table 4: Table of Themes for the Group

Subordinate Themes	Sub-Themes	
A. Ambivalent identification with the peer	i.	The impact of stigma on the peer relationship
	ii	Interpersonal devices used to avoid discomfort relating to mental health identity within the relationship.
B. Constructing a new sense of self	i.	Collaborating and finding hope.
	ii.	Shift in identity and increased empathy for others distress.
C. Organizational structures mimic the power and emotional dynamics of family relations	i.	Repetition of unhelpful familiar patterns

Table 5: Identifying Recurrent Themes in the Participant's Accounts

Super-ordinate Themes	William	Lucy	Alice	Emily	Bethany	Carlos	Susie	Present in over half sample?
Ambivalent identification with the peer	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes
Constructing a new sense of self	Yes	No	Yes	Yes	Yes	Yes	No	Yes
Organizational structures mimic the power and emotional dynamics of family relations	No	No	Yes	No	No	No	Yes	No

A. Ambivalent identification with the peer

i. *The impact of stigma on the peer relationship.*

Stigmatizing attitudes (internal and external), and discrimination, seems to have largely shaped many of the accounts. In turn this has affected how the individual chooses to disclose his or her own difficulties within the dyad. Accounts understandably contain highly emotive feelings of shame, rage, alienation and fear of madness in the peer. In addition, external processes such as receiving a diagnosis and contact with mental health services have possibly reinforced feelings of oppression for participants. In this way, in the following extract, Alice discusses her initial hesitation early on in the interview about discussing her own mental health difficulties with the peer:

Maybe if she [the peer] had asked like have you got, what have you actually got, I may have said okay what have you had? But she, like after I'd been in hospital and stuff like that, but she never said what for? (p.8).

Central to Alice's account is the description of a game-like exchange. This gives the impression that Alice is hesitant, and will disclose only if the peer also discloses her identity. There is a suggestion they may be trading in secrets. The jumbled language possibly mirrors this tension and hesitation to disclose a personal piece of information about her mental health experience. Alice then returns to discussing her initial feelings about the peer's mental health and discloses she 'thought she had schizophrenia'*(p.17), which leads Alice to recall:

Without even seeing her, I was just thinking I might be sitting there, she may think I've said something what I haven't have said. Cos obviously I've researched a few like other illnesses and stuff. And she may just kind of switch on me (p.17).

This passage provides a possible explanation for Alice's earlier reservation to disclose her diagnosis. Alice speaks of a fear of unpredictability of the peer, with a suggestion Alice is fearful of madness in the peer. Alice's belief that the peer may "switch" could stem from a negative stereotype that people who have experienced mental distress are perceived as dangerous or unpredictable. This, she claims may have been shaped by

her "research", and also by external societal representations of mental "illness". Alice's principal concern lies in her identification with these labels, as the following extract suggests:

(…) I didn't want to be like labelled as they call it, it's kind of a labelling thing but it's nice to just know that. If someone's got cancer, they know they've got cancer so if I've got this, I want to know I have this and like obviously understand it a bit more. But really just even like knowing it does kind of like don't make a difference (p.34).

Alice makes two contradictory claims: one that she does not wish to be labelled, but yet it's "nice to know", and two using a medical disease analogy to make clear that knowing provides certainty, but this does not "make a difference" in her eyes. The contradictory content may suggest Alice experiences clear uncertainty and confusion about the diagnostic label. Therefore suppressing her mental health identity within the dyad becomes important to her. Suppressing her mental health identity may ease any potential for uncertainty in her identity formation.

Bethany recalls a similar discomfort in discussing her own mental health label. However she has concerns about how the peer interprets her. Bethany's account begins with concerns regarding other physical health professionals' prejudiced view of her mental health diagnosis, and she discusses her perceived reaction to learning about her diagnosis:

(…) then as soon as they find out I have bipolar, my gosh. It's like, wow (laughter). The depression is bad enough but then with the bipolar, my gosh even worse. You know (p.5).

Bethany may perceive other health professionals to be shocked at her diagnosis which she perceives as a double defect, "depression" as well as "bipolar". This insight into Bethany's perception of her own mental health may suggest she experiences discomfort understandably when communicating with others, but she too also may feel fundamentally different and flawed. This insight illuminates Bethany's concern later when she expresses further doubt as to how this person will perceive her:

Are they going to think I'm crazy? I sometimes think I'm a little bit crazy, you know, it's that kind of. So I kind of went into this, um, and then when she came it was like, after a few sessions I was thinking what does she think of me? It was that kind of thing. But then when she started speaking to me it was like yeah I've been through this, I've been through that. She didn't say she doesn't think I'm crazy but I kind of got that feeling, you know, you know, it's okay, it's. (p .11).

This passage indicates a possible sense of danger for Bethany, and may suggest a sense of being exposed for being "crazy". There is a clear level of discomfort in the passage that mirrors Bethany's discomfort in trying to make sense of her difficulties. The passage, fluctuates quickly between past and present tense, which suggests that Bethany remains undecided about this aspect of herself, but she has to reassure herself "it's okay". The intentionality of the statement and the change in past and present tense suggests an ongoing struggle and a difficulty in knowing where to position herself in relationship to this thing labelled 'madness'. The premature ending of the sentence possibly communicates how undecided she is about whether she is indeed 'crazy' or not.

Like Bethany, Emily makes direct reference to stigmatisation, which has made it difficult to identify with the mental health label, and has undermined her urgency in accessing mental health services. Emily recalls how it felt when she approached the mental health services for help and draws on her Irish background to explain her anguish when accessing help:

(...)because when I went up through the crisis system, and I saw this place I'd fended off this sort of thing, I'd fended off stress and I'd reached a point in my life where I just couldn't take any more. I walked up to the, um, hospital clinic or whatever it was called and I sort of went, oh, I felt like I was out in the sixties or something and it was these Magdalene institutes and I just thought I don't belong here, I shouldn't be here, what's going on, what's going on. There was a lot of stigma, whether that's from my generation or the background I've come from. I just felt, oh my god, what am I doing here? And it was like a dirty secret and knowing that someone else had that dirty secret, I didn't feel. (p.14).

This powerful account may indicate Emily's clear early resistance to seeking help, and how in seeking help she had been transported to a distressing image holding cultural significance. She draws on the cultural representation of the "Magdalene institute" to compare mental health services to homes for women with babies born out of wedlock in the 60s in Ireland. These homes became a destination for pregnant women labelled as fallen by their families or society. This analogy for Emily is striking and powerful, and neatly summaries the potential fear of entering the mental health system. This may represent her fear of becoming disempowered at the hands of the mental health system, much like the women who entered the Institutes.

At the heart of this lies the "dirty secret": something Emily perceives as shameful and needing to remain hidden, in order to deal with the potential for shame. The Magdalene institute analogy communicates a great deal about Emily's experience of mental health distress and its personal meaning. It suggests Emily feels disempowered and alerts us to the shameful experience of accessing services. This tells us a great deal about her internal struggle to understand her own mental health crisis and the secrecy to that. It also illustrates how she used cultural factors to shape and make sense of this frightening experience. The analogy thus functions as a direct sense-making response to a threat that is experientially real.

ii. Interpersonal devices used to avoid discomfort relating to mental health identity within the relationship.

The majority of participants throughout the interviews used a number of interpersonal devices. These possibly helped avoid the discomfort arising from engaging in a relationship with another person who has also identified themselves as having experienced mental health problems. The way in which these were employed in the dialogue may indicate individuals have used them to deal with the discomfort arising from discussing their own mental health distress and recent crisis. Interpersonal devices used were: competition with the peer, distraction used as a strategy to prevent connection in a relationship and distancing oneself from the relationship.

Central to Susie's account is a form of comparison where she discloses she is much further along in her own recovery. In the following extract Susie illustrates, perhaps unknowingly, how competition for recovery has become set up within the relational context. Susie claims 'Yes, I told her about myself first and she [the peer] told me about herself and really she's more messed up than me' (p.6). This quote early in the discussion highlights Susie's' initial concerns about the peer's own mental health, and possibly alludes to her initial desire to make direct comparison with the peer's own stage of recovery. Susie moves on to make a more direct and bold reference to her stage of recovery in relationship to the peer and recalls how 'she, oh she, she, she [the peer] obviously got further than I did because they've made her stable. Whereas I'm stable' (p.17). Susie's initial experiential claims and comparisons illustrate a sense of early discomfort when confronted with another individual who also has experienced mental health difficulties. The apparent contradiction in the two extracts, one in which she at once describes the peer as more "messed up" before describing her as "stable" is juxtaposed with Susie's blunt statement of personal stability. Susie may be engaging in a practice of "one-upmanship" to successively outdo a competitor (the peer) to make them feel subordinate and ease her discomfort.

The form of comparison acts to help Susie distance herself from the peer's own personal story of recovery as it suggests perhaps Susie feels endangered by this. This narrative accumulates into further bold statements about comparisons. The following extract illustrates this:

But when I talked it was negative because, right and she, she felt that straight away. And I said well I'm telling you the truth. I'm not here to play a game with you, I'm not just going to tell you what you want to hear (p.17).

We are confronted with a strong sense of anger and a retaliatory tone, in keeping with Susie's current emotional state of competition. The sentence appears pressured and becomes confused in places. This may represent Susie's current emotional state of flux and difficulties in trying to create a coherent narrative of her own mental health distress. However the contents of this extract are not consistent with the tone of Susie's account. Here Susie is suggesting she doesn't want to play the game and wants to be honest and move beyond the game. However, the tone possibly indicates she is

still in competitive mode. This contradictory narrative suggests two things. First, that Susie has used one-upmanship to possibly deal with feeling threatened by the peer's own mental health stability, possibly to act to make her feel more superior. Secondly, that this has prompted questions about Susie's own stage of recovery and the coherence of her own personal narrative, which presents in a mismatch between the tone and content.

Individuals, specifically Emily and William, may have used interpersonal devices in the form of distancing and distraction within the relationship to deal with the discomfort of talking about their distress. Emily's words act to symbolize her attempts to distance herself from the peer. She describes herself as being positioned by 'teetering around the edges (p.7) and 'kind of bord, at the borders' (p.10). Both instances refer to Emily's perception of her position in the relationship and also the discussion of her own mental health. The extracts indicate a possible ambivalence for Emily in engaging in this relationship. The use of borders and edges perhaps allude to Emily's position as being held back to help her possibly deal with the potential anxiety arising from attempting to engage in this intimate relationship with the peer. The following quote illuminates how this relationship has impacted on Emily's ability to try and make sense of her own mental health identity:

Just, just, just, just on the outskirts of things, to say that my particular problem, um, was drinking or drug taking. Um, or that, I wouldn't go into great depth about what I actually did or anything like that but it's just the branch. The type of problem that I had. That's really as far as I went, I didn't go massively in depth but just knowing that it was about that. Cos it's, I know other people with different problems or conditions and it's a different thing. (p.17).

The repetition of the word "just" possibly indicates Emily's hesitant approach to her relationship with the peer and this becomes evident in her speech. The repetition of her position as remaining on the "outskirts" mirrors previous words, which again encapsulate Emily's fear of entering this relationship. The use of the word "branch" appears formal when using this to describe something personal about the disclosure of her own identified difficulties.

In contrast, William struggled to recall details of the relationship. Throughout the interview there was a distinct absence of discussion about the relationship with the peer. William discussed the use of distraction to help with his mental health distress and how relaxation techniques were used jointly with the peer to offer this form of distraction. He described finding it difficult to 'find the words' (p.13) to describe how the experience has helped him to make sense of his own current situation. William indicated that talking about his own mental health difficulties wasn't possible:

Interviewer:
Were you able to talk about that with the person?

Respondent:
I tried to, yeah. Never quite cracked it though. (p.13).

This critical disclosure appears to allude to William's potential difficulty in disclosing and discussing the difficulties he has been having. Distraction used in the form of relaxation techniques has had a dual purpose, the first being clearly to help William relax, which he values. However, it also seems it may have prevented him engaging with the peer since he finds it difficult to remember anything about the relationship. This reveals the second purpose: to prevent discomfort arising for William, as he has not quite "cracked" talking about himself with the peer. This use of distraction may have helped William to avoid intimacy in the relationship, as a way to manage fear or discomfort arising from understanding his own situation and the difficulties in attempting to do this.

B. Constructing a new sense of self

i. Collaborating and finding hope.

The following theme illustrates how participants may have perceived the relationship to be collaborative, which offered hope in their recovery journeys. Some used the metaphor of a book to represent the similarity in the two journeys taking place. Carlos exclaimed 'wow, that sounds like my story' (p.6) and Alice recalls 'I was like wow, she's on the same page as me sort of thing'. (p8.). The extracts suggest that a form of identification occurred. The peers' stories may reflect essential elements of their identities. Carlos describes this further by stating, 'and it's like wow, there is a lot of

similarity, you know, between me and Adam [The peer] and that was an amazing start of the relationship that we developed throughout the period that we were seeing each other'(p.6). Carlos highlights how similarities discovered through the discussion were perceived to contribute to a good early alliance.

Some participants allude to feeling alone in their experience of mental health distress. In that way, Carlos describes 'like he has been walking in a dark room' and after some time he feels now that 'it's like walking in a dark room but now with Michael [The peer] alongside' (p.5). The room and darkness may symbolize a sense of feeling trapped and possible isolation. The following quote supports his expressed feelings when he describes that 'You know like nothing's going to change, I will be like that for ever, for the rest of my life' (p.12). Carlos expresses a strong sense of despair, as nothing will 'change'. However, it could be interpreted that a shift occurs when Carlos perceives himself to still be in this isolated position, but the peer is with him. The suggestion that he is now not alone, and the presence of the peer, offers Carlos a form of hope and relief. This is realized when he claims 'I'm able to participate in society rather than like being alone' (p.9).

Bethany speaks of a similar feeling of relief which is perhaps derived from the peer possibly providing a different perspective from that of 'expert-patient' model. Within Bethany's account, she speaks of a 'weight being lifted' (p.7) by working with the peer, and recalls how the peer is at 'the same level sort of thing' (p.11) and 'on the same path' (p.8). The word 'weight' symbolizes a form of power being exerted on her, suggesting Bethany feels burdened by the weight of her distress. The word level may indicate that Bethany perceives a form of hierarchy present in her mental health experience, the peer being at the same level. This becomes meaningful when we place Bethany's extract within the context of her narrative, which is mainly focused on her resentment of the mental health system, and feeling oppressed by its actions. The following account suggests the peer represents something helpful to her because of the multiple perspectives:

Because she [the peer] could relate on a level in the sense that she had had a diagnosis, of mental health too and she could see it from both sides. So even working with people with mental health but also experiencing certain things that I had experienced as well, you know, and working alongside people, professionals as well as seeing it from the other side. So she's seen it from, both sides and I think that was so helpful for me and it was almost when I say a weight had been lifted. (p.8).

The peer may hold multiple perspectives which means she can possibly empathize with all the levels of power and powerlessness Bethany has experienced through her mental health distress, whether that is the power and 'weight' of the mental health system, or the internal struggle of her own mental health distress. This leads to a sense of relief for Bethany.

Like the other participants, hearing of another's mental health distress may have offered hope. Alice speaks of an admiration for the peer and reflects on what she learnt about her:

Just seeing her, you wouldn't have thought she'd been through something like that because she's just like, she still says she gets her days like she's very honest, she says she still gets her days when she feels really low but she's given me like things that, what help her cope. And stuff like that, um, and I just wish I'd asked her more about what's given her the strength. I wish I'd asked her that now, cos I did have my chance and I didn't.(p.21).

Alice reflects on how the peer had given her an honest account of her own mental health difficulties, suggesting that she admired the peer. But she concludes by wishing she had pursued this aspect more. She goes onto to explain how it gave her hope:

Um, I think, um, just knowing if she can do it, I could do it. Because she's probably had her own battles and stuff and she probably thought she could never get better and she has. So I could possibly and hopefully do the same.(p.22).

Alice reasons that if the peer has managed to get through her 'battle' then she too may be capable of doing so.   Within Alice's account there is a suggestion the peer has modelled a form of recovery, thus offering hope to Alice.

ii. Shift in identity and increased empathy for others distress.

Participants refer to potential attitude changes in their lives indicating that a form of identity shift may have taken place, facilitated by discussion with the peer. Carlos speaks of learning to integrate his mental health experience and putting his new understanding to use in helping another. William describes how he senses a new found empathy for others from his own distress.   Emily emphasises the need to actively make changes to her external identity through dressmaking and engagement in a social scene.   The following accounts allude to possible shifts in identities, resulting for some in an increased empathy for others.

The integration of a possible emerging identity can be seen in the following extract. Carlos seems to hold an internal stigmatized attitude to people with mental health problems. He states: 'like you're a mentally ill person, I'm sorry but I can't talk to you cos I'm scared' (p20). A form of psychological projection could be occurring. Carlos could be defending himself from his own unpleasant impulses such as feeling scared about his own mental health difficulties.   This means he is denying they exist and placing them in the other. However Carlos's retelling of his following actions suggest a change in attitude when recalls how:

(...) I was like really scared to talk to somebody who has a mental health issue but nowadays I feel more comfortable, like oh, I can understand what you're going through [ ] last weekend. My flatmate tried to kill himself by taking an overdoses. You know, like and uh, knowing, being, almost being in the same position as he is right now, you know like, for me I was with him all the time, I was very supportive, I was very understanding. You know like I was, there's nothing to be sorry, there's nothing to be ashamed of. You know like, at least you are still alive and you're well and like, uh, the relationship with my flatmate bring out is stronger.[ ]. But you know like, um, I feel that I'm more, way more understanding of the situation that he's going through. And I feel, not pitiness but I don't know how word, as like, um, I mean, understand, yeah I think it's understanding (p.20).

This powerful but sad event may indicate how Carlos could identify with his flatmate's suicide attempt. However the significant shift appears in Carlos's struggle to identify the word to sum up the change in emotion towards this event. To pity his housemate would suggest Carlos is expressing a negative evaluation of his flatmate's difficult situation. To pity his flatmate also suggests he considers him to be in an inferior position, thereby removing himself to keep a safe emotional distance. The shift from "pity" to "understanding" suggest Carlos's attitude to mental health has shifted. His words of compassion instead of pity suggest a willingness to become personally involved. In summary, Carlos's narrative possibly paints a strong picture of internal conflict and shift in attitude. This experience has led to increased empathy and acceptance and a decrease in prejudiced views of mental health.

William, like Carlos, also describes how his personal experience may have led to finding more empathy for others. However, unlike Carlos's, William's account does not suggest possible acceptance or attitudinal change about himself and his own distress. William predominately speaks of fear within his account: fear of the outside world, fear of returning to work, and difficulty in trusting himself. The following extract may suggest this when he claims: 'um, but it's the darndest thing when you don't trust your own mind' *(p.9)*. Returning to work is also seen as contributing to a shortening of his life when he states*:* 'I think I will take years off my life by going back to work' *(p.14).* This fear and reference to a return to work as bringing him closer to death sheds further light on his comment made about greater appreciation of others distress when he claims:

Um, I've got a greater appreciation of people that have got mental health problems. And I feel a little bit more empathy with people who are, who've got nothing. Who suffer from natural disasters, and they have nothing. (p.18).

William's fears of returning to work, and of the outside world, become meaningful when he describes experiencing empathy for people who suffer 'natural disasters'. The reference to death in relationship to his job, and fear, allude to the reason why William experiences more understanding for people who have nothing as a result of a natural disaster. As this may also represent for him something closer to his own personal mental health distress, something close to a 'natural disaster'. This he

perceives as an experience where he too has lost his own resources (his mind) to be able to make sense of his own life. Therefore this possibly suggests that he find more empathy for people in this position as it may have some similarity to his own.

Emily does not make direct reference to attitudinal changes, but she speaks principally of a desire to make changes through social functioning (engaging in a music scene) and external identity (dress making). These aspects of dress and music communicate powerful messages possibly about Emily's embodied sense of being in the world and a significant change in identity expression. Emily describes how she is:

(...)currently getting a suit made, so someone else is doing it but it's a really great experience and, and I'm thinking later on I can design some stuff and they can make that for me to match in with it all. [] So I'd really like to get to the point where I can make my own dress. (p.24).

Emily may be endorsing her sense of identity through the making of a new suit. This acts as an important communication tool. The suit is significant as it represents communication about being professional and tending to her appearance. Clothes also may act as memory-objects and this becomes important when Emily makes the link between appearance and her interest in the northern soul music scene:

(...)it's the scene I'm into, the Mod seen, so it's the Mod and Northern Soul and it's all about the way you dress as well, And everyone wants to look different and, um, sort of strut their stuff like peacocks really. There's a bit of a peacock in me but not too much, cos I think too much, there's a lot of narcissists on that scene and I don't want to go down that road.(p.24).

This quote represents a complex picture of Emily's current identity formation and points to possible internal psychic processes. Again dress and engagement in this scene is possibly used by Emily to express something important about who and what she is. The image of the peacock is significant, as it represents Emily's own personal feelings of narcissism. For Emily, the peacock may symbolise feelings of being proud, wanting to be seen again. The peacock may also represent possible renewal, as the feathers of a peacock are renewed every year. Therefore a form of renewal could be occurring for Emily. However her indecision might suggest she is unsure about this

aspect of herself. This indecision suggests dressing and engaging in the music might actually signify more of a fluid and dynamic on-going, day-to-day negotiation of self. This may also have been shaped by the internal crisis that she has recently experienced, which has shaken the foundations of her own personal identity.

C. Organizational structures mimic the power and emotional dynamics of family relations.

Repetition of unhelpful familiar patterns and the positioning of the peer.

Although this theme appears in less than half the accounts, its importance is demonstrated by the way in which it was organized around dominant claims made by two individuals. It is significant because it presents an important systemic view on how the peer is viewed in relationship to the individual's current relational system of the family and the mental health system. Participants recalled how they used the relationship with the peer to express strong feelings of abandonment or anger in relation to mental health system. It was striking also how these accounts also resembled the power and emotional dynamics the individuals voiced about their families. Also, there was a process of polarization, in which the peers were sometimes placed in a position outside this system they were critical of, and represented as all good. Others were viewed more critically, much like the Mental Health system.

Alice initially finds a common theme with the peer when discussing family relationships and states, 'Where mine [Alice's family] was really just kind of didn't kind of care, just leaving me to do it. But, still kind of similar because we both felt like our families weren't supportive' (p.8). Alice communicates that possibly her family have left her feeling abandoned. Later on in her account, Alice states that seeking help from mental health services and receipt of that have come too late:

Um, just like cos it took so, so, so long I found my own ways of coping before like the professionals got involved and stuff. So it's like even though the professionals want to help me and that, I'm just kind of like in that mind-set that I've already helped myself. I needed you more then than I do now sort of thing.(p.33).

This extract possibly illustrates Alice's frustration with a system that she has felt let her down - one that has not been supportive, in her eyes. The concluding statement crystalizes Alice's concern that the professional help has come too late. This sense of absence bears a striking resemblance to the pain Alice had to bear when her parents 'left her to it', suggesting this is not the only time she has been in this position, and has subsequently attempted to figure things out for herself. Alice's frustration at being 'left to it' becomes evident when she relates this experience to working with her Community Psychiatric Nurse:

Yeah, I just kind of just thought okay I'm not going to keep going round in circles, let me do my own research and do it myself. I've just kind of like, I've been through so many people, just fed up, don't want to talk to nobody else. So I'm not even giving him [CPN] a chance to get in there, cos he's asking me questions, I'm just like I'm not giving no answers sort of thing, so he can't work on anything anyway. And I know that, and I know what I'm doing so I just like, you know what, I feel so much frustrated for so many years, let me frustrate you now. (p.37).

Patterns set up early in Alice's life through her relationship with her family, where she expresses a sense of abandonment, possibly appear to mirror her relationship with health services. To deal with these potential feelings of helplessness and hopelessness she has actively chosen to close down the relationship with her CPN. Furthermore, she possibly wants him to feel her discomfort too. Alice makes a clear comparison with the peer and the CPN when she states:

And I wasn't believing what he [the CPN] was telling me. It's like I was listening, I was taking it in but it wasn't believable. So I was just like okay, okay, okay, I can't wait to leave. But with Pushpa, [the peer] talking to her and you could just tell that she like understands where I'm coming from. (p.24).

Alice makes a clear comparison between her relationship with the peer and the CPN. Within this claim, Alice attempts to possibly polarize her view of the peer as understanding, and the CPN as unbelievable. This behavior may allow Alice to deal with any discomfort she has experienced when coming into contact with services. Placing the peer at an opposing end allows her to deal with this discomfort.

Similarly, Susie expresses strong concerns of being let down by the mental health system. She expresses anger when she states:

Well, yeah, because you know if someone promises me they're going to do something and it don't happen, that's rejection to me. And you know with professionals, like the crisis team they're always saying they're going to do A, B, C and they don't carry it out. But , I hold grudges so I tell them straight, don't, because the next time I see you, you know I'm going to see you again, I'm going to throw it in your face' [..] (p.15).

Susie makes a clear angry statement about her interaction with MH services and feelings of rejection. This has striking similarity to Alice's earlier account. However, Susie paints an active image of throwing her rage back at them. This account alerts the reader to Susie's possible feelings of rejection and feeling let down. In keeping with this relationship formation, she struggles perhaps to find value in the relationship with the peer, and criticizes the function of it:

(..) she, she, she tried to, she had it in her head that she could do more for me and I said to her you're fooling yourself, because at the end of the day you are not a support worker. So who should I really listen to what is true. And that wasn't me being nasty against her, she was a very educated and in fact she's studying herself to be a psychologist, right? So she's very intelligent and all that. But, but when she did try she got quite upset because she failed and I said to her, well but I didn't tell you. You know, I didn't want her getting upset, she just, she wanted to try and help me more.(p.12).

Susie's account and principal concerns coalesce around one major theme of feeling rejected by mental health services. This becomes more meaningful when placed within the historical context of her experience, as she discloses she has been in care services from an early age. This theme in particular helps in understanding Susie's experience of psychological distress and her relationship with the peer. In this context, Susie is critical of the relationship with the peer, and is certain it will not be helpful to her. She communicates a sense that this relationship is not going to be of value to her, even though she knows she is intellectually capable. Although there is insufficient information to draw a conclusion on Susie's earlier experiences, it is likely that mental health services have been perceived as rejecting; therefore this experience has contributed to the wider experience of later formation of relationship with the peer. Susie may be acting to protect herself from further rejection; therefore it may remain to be safer to reject this relationship, before she anticipates being rejected by it.

10. Discussion

The focus of this study was on how mental health difficulties and the person's recovery became constructed in the dialogue. The following discussion examines the results in light of the wider field of literature concerning identity, mental health disclosure, the recovery model and mental health discrimination.

Ambivalent identification with the peer

The benefits of a peer to peer exchange is based upon an assumption that the peer models personal acceptance of their own mental health difficulties and in turn the recipient may identify positively with this, resulting in a possible acceptance of their own difficulties. Solomon (2004) describes this as a form of 'up-ward comparison' which may contribute towards an incentive to develop skills and challenge beliefs about their own experience of mental health distress. A number of theories have been used to make sense of the psycho-social mechanisms operating in the peer to peer exchange. The social comparison theory (Festinger 1954) suggests that by interacting with others who are perceived to be further along in their recovery are given a sense of optimism and something to strive towards (Solomon 2004).   In addition empirical evidence emphasizes that group identification, defined as feelings of strong ties to a socially-defined collection of people, diminishes the effects of stigma on people with

mental health difficulties (Corrigan, 2002; Jensen & Wadkins, 2007; Verhaeghe, *et al.,* 2008, Penn & Corrigan, 2002). However the current study found that participants were ambivalent rather than straightforwardly positive about identification with the peer. A key finding of this study is the unexpected way in which participants attempted to conceal and use psychological strategies to deal with the discomfort when disclosing experiences of mental health distress with another person who also identified as having experienced distress. External and internal stigmatising attitudes appeared to contribute to this early ambivalence. The following discussion shall proceed to explore both aspects of stigma, starting with the external type.

Participants' actions in attempting to disguise or conceal their distress or experiences of distress through distancing, distraction and concealment of diagnosis may fit with Goffman's (1963) suggestion that individuals make active efforts to transform stigma from the discredited type (an obvious mark easily perceived) to one that is now discreditable (a secret stigma) (Whittley & Campbell 2014). Conflict in identification with the peer here could be seen as an active form of 'discreditable' stigma whereby individuals made concerted and self-conscious efforts to conceal their identity, or struggled with feeling exposed. Similarly a study by Whittley and Campbell, (2014) observed individuals living in a recovery community, and concluded that members made conscious efforts to appear to be acting and looking normal. They discovered that participants possess a benchmark of 'normalcy' to which they regularly compare themselves. It was evident that participants employed a 'normalcy' benchmark to make comparisons about their 'stability', and whether they could be seen as 'crazy'. Both could be interpreted as acts of measures of normalcy. Whittley and Campbell (2014) indicate that individuals use these devices as robust defenses against potential stigma, and that they are deployed psychologically and socially to shore up self-esteem.

In addition to this, most participants discussed stigma related to psychiatric diagnosis. Diagnosis and the medicalised illness model endorsed by psychiatric services have received much criticism (Cromby *et al.,* 2013). Johnstone, (2013) highlights how diagnosis turns people with problems into patients with illnesses. Furthermore, the medical perspective, which attempts to eliminate disease, might recommend that people distance themselves from a mental health identity and might see disclosure as harmful (Corrigan, 2013). Stigma and discrimination are also experienced through imbalances and injustices inherent in social structures, political decisions and legal

regulations. All of these play a large part in the person's attempt to make sense of their distress, and subsequently their identity (Schulze & Angermeyer, 2003). Models such as peer support which offer a role-model to challenge barriers of stigma may be rather optimistic, given the widespread and ingrained societal prejudice that still exists. Findings here suggested that within the dyad there was little opportunity to consider the causal role of social inequality in emotional distress, meaning that underlying material conditions of inequality, stigma and discrimination may have gone un-addressed. (Speed & Harper, 2015).

Previous studies have found a high level of internal stigmatisation in interpersonal interactions among people with severe mental health distress (Schulze & Aangermayer, 2003, Dinos *et al.,* 2004). In line with those findings, results here would suggest that undesirable character traits associated with mental health identity were projected onto the peer, as a way to possibly manage a positive self-image. This form of psychological projection operating as a defensive function was noted when recipients located undesirable characteristics such as mental health instability in the peer and perceived the peer as 'unstable'. Similarly another participant perceived people with mental health difficulties as 'scary' despite experiencing mental health difficulties personally. Classic projection theory (Freud 1936) suggests that individuals may perceive negative characteristics in others to reduce ones own concern that they possess the threatening characteristic (Schimel *et al.,* 2003). Findings here suggest that individuals may have placed negative characteristics associated with their own mental health distress into the peer, thereby defending against the feared trait and reducing the accessibility of that feared trait. This is further supported by the notion that individuals actively suppressed disclosure about their own mental health distress and experienced ambivalent identification. The presentation of another's mental health identity may operate to enhance the person's sense of threat to their own self-esteem and trigger defensive distancing from undesired traits associated with their own mental health distress. Equally protection of in-group comparisons may depend on how central the mental illness self-schema is to an individual's self-concept (Corrigan & Watson, 2002). Thus, the action of identification would appear to be influenced by the person's own stage of identification with the mental illness self-schema. The recent mental health crises experienced by individuals may have also activated more vulnerable aspects of the self and a sense of helplessness, driving an increased need to protect oneself from further threat. Therefore this highlights further important questions as to the timing of such

an intervention.

Constructing a new sense of self

Another important finding from this study was that, despite individuals' attempts to manage discomfort arising from ambivalent identification, the relationship was seen to offer a source of hope for some. This is mostly in keeping with the identified benefits of a Peer Support model synonymous with hope, acceptance and meaningful activity (Repper & Perkins, 2003). For some there was evidence this challenged stigmatising beliefs about mental health distress, leading to outward changes in behaviour. For others, conscious efforts in terms of outward appearance became the main site of significant identity change following a crisis.

Participants spoke of a relationship with the peer that brought key components of hope, increased empathy and acceptance for themselves, consistent with findings of the benefits of a peer support model (Mead & Macneil, 2004). Recipients of peer support have also demonstrated an increase in hope (Davidson, *et al.,* 2006), as found here, when participants spoke of being able to 'participate in society again'. Participants made reference to a relationship where they had shared similar stories, or were on the same page. This appeared to emphasize an important aspect of the peer relationship whereby peer support attempts to work from a different perspective from that of an 'expert-patient' model (Mead, 2004). Language used by one participant symbolized the power-differentials that existed for her. The peer's multiple perspectives possibly softened the power-differentials. It is likely this shared understanding contributed to a more collaborative relationship, emphasized by the participants' reference to the peers being on the same page as them.

Some participants also referred to shifts in attitude to mental health distress. Carlos indicated how he found acceptance for others' mental health distress as well as his own, again in keeping with the significant benefits of a peer model in challenging barriers presented as internal stigma (Repper & Carter, 2011). Emily referred to a shift in identity resulting from the relationship that occurs through an external transformation through her clothes and engagement in a social scene. Emily communicated a clear message of possible transition through her use of clothing. This is consistent with previous studies that indicate that 'clothes become entangled in the events of a person's life and used as a vehicle for selfhood' (Hoskins, 1998, p.2).

Emily's goals formed from this intervention triggered actions to attempt to preserve or bring about change in her identity.

Organizational structures mimic the power and emotional dynamics of family relations.

Participants, albeit less than half, spoke of prior unhelpful patterns in relationship to families, and how these patterns mimic those set-up with mental health services. For some the peer was placed in a position external to this harmful set of patterns, and the relationship was viewed as beneficial. However, for another, in keeping with her criticism of mental health services, struggled to see the value in the relationship with the peer. This theme presents two important points regarding the individual's attachment formation with the peer, family and mental health system. First, participants allude to unhelpful earlier attachments with parents. Further relationship formation may also be shaped by these earlier attachment experiences (see attachment theory, Bowlby, 1988). Recovery involves a community or an extended family (Arenella, 2015). As found here, it is likely that families had been unsupportive or non-existent. Peer interaction does not always account for the relatives and caregivers who are still in their lives, and continue to behave in the same ways that led to insecure attachments (Beck, Mattison & Sampson, 2015). Expressed anger and the need to protect oneself by not engaging in relationships make sense when prior relationships have been unhelpful and even traumatic. These experiences may militantly work against the individual's desire to build reparative relationships, as offered through the peer. Therefore, some enter into the relationship with a misunderstanding or rejection of its core principle (Beck, Mattison & Sampson, 2015).

Secondly, individuals described how experiences with mental health services perpetuated or repeated experience of insecure, damaging attachments. Individuals expressed strong feelings of abandonment, all which mirrored earlier experiences. The conflict between the need for stable attachments and the complexity and pressures affecting mental health services provision has been recognized (Holmes, 1994). Psychiatric practice offers little or no space for the opportunity to recount painful experiences (Adshead, 1998). For some the peer relationship did offer a space to explore painful experiences. However, a climate of ongoing inconsistent care and a focus on targets rather than therapeutic relationships may continue to lead to re-enactment of problematic attachment procedures and may work against any

reparative relationship formations such as peer support. As Marrone (1998) indicates, the "organization and administration of mental health services are often guided by the politics of exclusion rather than by concern with the needs of disadvantaged sections of the population" (Marrone, 1998 cited by Goodwin, 2002 p.50). The peer-support might unknowingly reframe experiences as individualized explanations for emotions and experience, and neglect the systemic impact of prior unhelpful attachment and harmful interactions with mental health services. There appeared to be limited evidence of exploration of those powerful forces within the dyad here. Therefore findings here suggest the theoretical origins of the model are questionable, as they may not address the potential barriers people experience, and may inadvertently offer an individualized notion of human suffering, which is essentially still based on a medical model.

10.1 Limitations

The study has several limitations. As discovered, participants were conscious of how they constructed their accounts surrounding their mental health disclosure and treatment in mental health services. Therefore the Researcher's presence as a white, female, clinical psychology trainee from a middle class background probably affected how participants constructed their accounts. As previously found, the person asking the questions can significantly influence responses: service-users often express understandable concerns that the services they receive may be adversely influenced by their answers (Repper & Perkins, 2003). Given the existing power differentials that exert their effects either indirectly or directly through coming into contact with mental health services, the trainee's status may have also possibly affected the power balance in the retelling of participants' experiences.

When assessing user preference and satisfaction, people often endeavour to please the questioner by saying what they wish him/her to hear (Srebnick, *et al.,* 1990, Rose, 2001). This may have affected the response people gave about the relationship with the peer. However, not all reported positive experiences. Researchers indicate this could be avoided using service user researchers conducting the interviews. Such an approach has been used to good effect in the UK by, for example, user researchers at the Mental Health Foundation (Faulkner & Layzell, 2000) and the Centre for Mental Health (Rose, 2001). Given the research already had a largely collaborative structure with users of services in the construction of the intervention and implementation, it would have been suitable to have users' researchers to conduct the interviews too.

Another limitation lies in the selection of clients who volunteered to take part. Although all had been randomized into the intervention, people later decided whether to participate. Therefore individuals who were willing to take part might have been in some way different from individuals who chose to opt out of the interviews. Thus, they might have emphasized more positive features of their recovering experience. IPA as a method also emphasizes the selection of a homogenous group. As this is a fairly novel intervention, it was felt the topic under investigation itself remained novel and thus defined the boundaries of the sample selection. The group was drawn from a mixed ethnic and cultural background. That may have led to more diversity in views expressed about the intervention, making it difficult to ascertain whether this represents true diversity in the findings, or just diversity of the group selected. Equally, length and frequency of contact with services may have indirectly led to significant differences in views expressed about mental health services, and subsequent construction of how they viewed the intervention.

10.2 Future Research

Given the centrality of shifting of identity in participants' recovery, it would be opportune to conduct longitudinal studies that follow cohorts of peer-support recipients to examine the effects of peer support in light of their progress. Findings also point to systemic issues concerning mental health interventions such as peer support and the co-opted nature within the mental health system. This raises further concerns as to how the recovery movement is brought into the mainstream services, and the danger that it is subject to the same educational and class distinctions as the

current system (Arenella, 2015). As this research focused only on one half of the dyad, future research is required, to explore the tensions that occur also between peer workers and the co-opted nature of this work within a mental health system.

10.3 Implications for the application of Peer support and the recovery model

A core finding was that clients struggled with the ongoing ramifications and complex meanings of stigma and prejudice. As a result training of peers may well benefit from a focused exploration of this potential dynamic and how stigmatizing attitudes may exist within the relation context, but may possibly go unacknowledged.   Further training in this could in turn help peers make sense of the possible discomfort that may arise.

The ambivalence in identification also highlighted an important question regarding timing of the intervention. The type of identification appeared to be influenced by the person's own stage of identification with the mental illness self-schema. Therefore the intervention may be better placed at a less psychological traumatic time, possibly not after a period of treatment with a crisis team. Peer support may be better placed when the individual is further along in their own recovery and possibly accessing community mental health resources.

Recovery also needs external elements such as families, communities and society to be at the same place. This may act against the recovery processes for the individual. Therefore, the findings also alert us to the need to challenge and address stigma, discrimination and inequality at the societal level, to facilitate benefit from individual interventions such as peer-support.

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11. Critical Reflection

11. 1 Starting position in relation to the research

We need a psychology of affirmation, not control; a psychology of witness and recognition, not test and measurement; a psychology of deep commemoration, not superficial prediction. Human presence, not a proliferation of instrumentation. Privacy, not intrusion. A psychology of embrace, not engulfment…… This means human science (Wertz 1986/2000 p.165 as cited in Findley 2008).

Rarely has a quote resonated with me so much as this did at the start of my training in clinical psychology. It seemed to highlight some of my initial concerns when embarking on this journey of research and training. Explicitly, this quote makes the case for a psychology of humanistic values, counter to the experimental psychology tradition. It is something that has remained in my mind when undertaking research in an area that has required me to not only think about the participant's own constructions of their "life world", but also how I interpret what they have interpreted. I hope to have done justice to the personal narratives the individuals have so openly shared and attempted to capture the complex layered nature of their world. Embarking on this journey I discovered as much about me as I did about the methods I employed. The following critical appraisal will capture some of that personal struggle to remain true to the elements established in the above quote. It indeed has been a momentous journey and I hope to share some of that in my writing here.

What follows is a retrospective collection of reflective and decision making processes that have informed and shaped the present thesis. This is drawn from a reflective journal, which has collected and charted important early pre-suppositions, reflections on the development of the research and continued notes made during and after supervision. I hope this appraisal captures the 'reductive-reflexive dance' (Finlay, 2011) that has taken place in my mind, in relation to others and on paper. I have also attended a regional IPA group and used this forum to question the methodology and raise ethical concerns when conducting a thesis.

Prior to embarking on the training journey two main occupational experiences have shaped my approach to working in mental health services as a practitioner and also researcher. I first learnt about the recovery agenda during a research post at the Centre for Mental. Recovery as a concept had just started to be become an important aspect of their work in 2009. It was here that I met inspirational advocates of the agenda and clinicians who were promoting a paradigm shift in mental health services to try and move away from the medicalised and top down nature to much of the mental health services organization and treatment to one of recovery. Peer support has become an important aspect of this agenda and has now been integrated into healthcare systems in the UK. Mutual friendships have always occurred between service users, where two people come together to share in coping strategies and sharing in their own stories, it was felt much value can come from these naturally occurring relationships and formal peer (paid peer support) support has grown in the last decade as a consequence. Nevertheless, the recovery agenda and peer support in the last couple of years has received much criticism. Reservations lie in the ideological, material and practical relations of recovery (Beresford, 2015). Morrow raises the question whether 'recovery is a progressive paradigm or neo-liberal smokescreen' (Morrow, 2013 as cited by Beresford 2015 p.17). Many have concerns that its ideology may also still lie with an individualized notion of human suffering, which is essentially still based on a medical model. These criticisms are not just applicable to this intervention alone; it is possible that all individual psychological interventions in some form may be open to these criticisms. Some individual interventions such as psychotherapy do inadvertently separate the individual from the set of systems that are oppressively creating the stress.

This early experience appeared to lead naturally into a research role where I had become a facilitator of a user research group as part of the peer-support self-management intervention, a joint venture between the user group and also researchers. Looking back, perhaps this role held more significance then I had acknowledged at the time. It is clearly something that has been important to my experience during training. User researchers imparted important wisdom to me as to the importance of remaining human in my work and always meeting people at the same level. This bears great importance to the power held by psychology and potential power inherent in our roles that I have now later become so conscious of in my role as clinical psychologist.

What I take from their wisdom now, is the importance of "human presence" and not imposing or intrusion something which is encapsulated in the quote. Working with this group allowed for open debate on controversial topics that health care professionals may find uncomfortable, such as the direct and indirect power that health care professionals have in determining people's future possibilities. First hand accounts from users really opened my eyes to the inherent and unfair system in which we operate. Only by starting training did I start to really draw on this experience and recognize the true value of working with this group. It seemed like a natural step to return to this group. Other professionals have also stated the importance of working alongside users of services. Beck, Mattinson and Sampson 2015, highlight how 'co-production can help enhance professionals compassion and awareness and understanding of people living with mental health distress'(p12). They add that this experience can go beyond what can be delivered in a 'traditional training course or clinical work' (p12). This would be something I would certainly agree with and it seemed natural to suggest a possible collaboration to be able to explore further how people in receipt of the peer-support intervention experienced it. Something, which started to be evaluated through a randomized controlled trial (RCT).

Therefore my early beliefs and connections have been clearly shaped by a personal connection with individuals who have endorsed this mechanism of support. My initial reflections indicate that I did hold some investment in this peer group. A personal investment and curiosity in attempting to discover what its outcome would be, indicated by a return to contribute towards its analysis. My initial thoughts and beliefs were that the intervention could have a positive impact on people's lives, clearly shaped by the user researchers opinions, but maybe that may have been overly optimistic. I had hoped people's accounts would point to positive outcomes in people's recovery.

11.2 Methods - Epistemological stance

Early on in clinical training and also whilst taking part in a training course of IPA, I identified with the lecturers initial reflections about epistemology and ontology. She spoke predominately of a crisis of consciousness, that crisis much like my own was what Levinas (1969) had so eloquently described as "totalizing". Totalizing is a process of reducing something/someone to something non-unique (p.41). Levinas (1969) describes it in terms of 'doing violence to the other' – killing their otherness by categorizing and stereotyping them' (Finlay, 2011. p.41). Much like the lecturer I felt like I had been operating in a vacuum and felt very guilty that I had used diagnosis's and spent time categorizing people in a research setting. The dichotomous or categorical nature of diagnoses is problematic, particularly within the context of clinical psychology's philosophy (Wakefield, 1992). Consequently ambivalence exists within the profession regarding the majority of the evidence base on which clinical psychologist are expected to base their practice, with one influential view being that diagnoses themselves are not evidence-based (Bentall, 2003; Boyle, 2002). This obviously continues to be a contentious subject. However what it created for me was a clear re-evaluation of practicing as an ethical practitioner and the power dynamics continuing to be reinforced through the use of diagnosis. If that meant making an active choice to carry out a piece of research that would attempt to not re-enact similar previous unhelpful power dynamics through the use of diagnosis, then it seemed like the right decision to pursue. My early reading of phenomenology appeared to reinforce these feelings.

A qualitative approach to this study was influenced by a certain set of early pre-suppositions. I started to recognize that positivist driven research might limit what can be said about the phenomenon I wished to study, but also that reading phenomenology also helped me understand that we are not detached from our work. It has been argued that methods developed that 'remove the subjective element involved in data collection, may be developed as a defense against the anxiety and disorientation created by such an encounter' (Devereux, 1967 p.217 as cited by Midley, 2006). The historical crisis in the natural sciences in 1596-1560 also highlighted important questions as to the need to go back to what it is to be human – captured in the saying "back to the things themselves" (Husserl 1913/1962) and also Heidegger's (1927/1962) view of the person as always indelibly a 'person in context'.

For me, it felt like this crisis can still be felt within psychology today. Sarte (1943/1969) Heidegger (1927/1962) and Merleau – Ponty (1945/1962) 'argued that we all have an embodied sense of self which is always in relation to other' (Finlay, 2011 p.19). Therefore, these early readings transformed my understanding and influenced my steps in deciding on a research approach. An IP approach to analysis seemed appropriate. Given the early origins of peer-support and its connection with social and community driven roots (Clay, *et al.,* 2002). IPA could provide an important framework for interpreting the 'broader social, cultural and theoretical context' (Harper & Thompson, 2012). This framework seemed crucial, given the criticisms of the peer support model. Equally, the aim of this research was to capture accounts that were rich, detailed and reflective to aid the understanding of this experience and complement actuarial claims from the quantitative studies of peer-support. Therefore qualitative methodology accepts the person and society as co-constructors of his or her reality and the synergy of person and society is recognized (Darlaston – Jones, 2007).

In addition to this IPA emphasizes a mostly Heideggerian approach to reflexivity which also engages the concept of the hermeneutic (interpretative) turn. The co-construction became important, I was aware that my own background; (own values, experiences, interests, beliefs, political commitments, wider aims in life and social identity) unique in my own construction would have a large impact on my findings. Furthermore unconscious dynamics out of my awareness would impact on the findings here too. Therefore any findings here would necessarily be a function of the relationship that pertains between researcher and subject matter (Larkin, Watts & Clifton, 2014). Equally, Ricoeur (1971/1979) emphasizes this dynamic process when he states: 'When a text unfolds a new way of seeing a critique of how things are becomes possible, along with a critique of the illusions of the interpreter' (Ricoeur 1971/1979 p.92.). Therefore I understand that what I have offered in my writing does only remain to be one possible interpretation and is neither perfect nor complete.

These early readings and initial reflections I felt gave me suitable grounding in the potential for uncertainty to arise in my work, but to be able to manage that too. These initial assumptions offer guidance and also reassurance when completing research within a post-modern, poststructuralist landscape. I was also conscious that after attempting to grapple with original phenomenological texts, I was mostly left feeling

confused, by some of the obscure and abstract ideas. Finlay, (2011) provides reassurance and confirms that ultimately what these readings offer are a philosophy and not a method. Left for future individuals to work out for themselves. Something, which I think presents an exciting challenge, but also allows for creativity in research. Finally I recognize that as a novice, the limited reading of the original texts and possible misunderstanding may also lead to shortcomings in my research. I do however claim to have tried to hold a phenomenological attitude, which has meant holding, a 'non-judgmental approach: one filled with wonder and curiosity about the world while simultaneously holding at bay (to bracket) prior assumptions and knowledge' (translated Husserl's idea of reduction, Finlay, 2011). This idea of 'bracketing is revisited in reflections of the analysis.

11.3 Interviewing and data gathering process

I was stuck by a number of things during the data collection, the first reflection stems from how my current role as a clinician as well as researcher, meant I was able to see the similarities with the two situations. The interviewers position of listening and witnessing the disclosure of personal narratives mirrors the position held by the therapeutic encounter (Birch & Miller, 1998). This highlighted the ongoing ethical dilemma presented in research settings, the researcher–participant relationship is decisive and constitutes a major challenge, running the risk of being either too close or too distant (Haahr, Nurlyh & Hall, 2014). Previous experience as a researcher may have given me a false sense of confidence. This, coupled with new emerging clinical psychologist identity brought a new perspective; a heightened and conscious awareness of the ethical balance of a research interview.

I made sure that interviews were carried out with due care, awareness and sensitivity and respect to their well-being, but I wasn't able to eradicate the feeling that it felt unethical at moments to enter their world and ask such sensitive questions and then depart. This did highlight the tricky therapist-researcher boundaries, however I was reassured that by the process of consent and debrief following the interview assured both myself and the participant of the roles we were entering and I was not there in my capacity as therapist.

My second point is relevant to the dual identity that I held in my role as researcher as well as clinician. I was moved and struck by the accounts of individuals, and how they voiced feelings, of rage, anger and sense of alienation rising from practices such as being labeled with a diagnosis and also being left without opportunities to voice their experiences. I felt guilty to be also a part of this system. I was concerned that the research interview could be interpreted as a powerful reenactment of the asymmetric power relationship that they had experienced. Interviews conducted in peoples' homes also alerted me to the social deprivation that individuals were negotiating on a daily basis. One interview left me feeling overrun, bulldozed and saddened. The environment (dilapidated social housing) contributed to the person's story of fear, abandonment and rage. This individual was angry with mental health services, but also it seemed evident that early experiences had contributed to her feeling in an inferior position, disclosing that she had grown up in care homes and living in hostels. My position as a psychologist, from a middle class background in paid employment appeared to perpetuate the clear power imbalance and possibly unconsciously perpetuate her feelings of powerlessness. I was aware of this early on in the interview and my desire to escape alerted me to this discomfort. I discussed these feelings of shame in supervision and also personal therapy to try and make sense of the process and used it to inform my next interview.

This had been my first interview and I had been left with a very complex set of feelings; primarily that I had failed in my interview. It was likely that a 'cycle of victimization' (Midgley, 2006) in which shame was being passed from interviewee to interviewer was being re-enacted. This process may also be known as 'projective identification' (Klein, 1946). Using an approach by Hollway and Jefferson (2000) drawing on the unspoken and unconscious dynamics helped to make sense of this experience and it made for a richer understanding of the complex dynamics that occurred. Quite unexpectedly, my view of the interview changed and now I saw this interview as rich and pivotal to my analysis. Studying the disturbance in me and my interpersonal relations was integral to the rest of my work and helped shape the data collection, but also remaining to be mindful of anchoring this in the data.

I was also aware that drawing on psychoanalytic ideas might be incompatible with the current methodological approach of qualitative research. I don't claim to believe that it gives me access to 'inner-world' of those studied, but can be helpful to make sense and offer one possible interpretation of the dynamics of the interview being conducted, but I was also open to the limitations of any approach. I certainly did not view the interview as a therapeutic contract, but I did on occasions draw on my therapeutic skills, which are part of a humanistic approach to this research. Critics have argued whether pointing out contradiction within interviews narrative is questionable, and whether we have the right to question individuals' self-concept (Midgley, 2006). These are controversial questions that bring about questions of validity of findings. I remained mindful of this debate, which I felt was beneficial and used this to develop my analysis with sensitivity.

My last point is concerning date collection and saturation. Saturation and its use in qualitative research remains a controversial subject with little agreement, especially concerning 'how many is enough'. As already set out in my method, a number was defined based upon recommendations of Smith, *et al.,* (2009) and other literature. I reflect on this again here, because it was during the process of supervision that the subject arose, at the point at which I was deciding to terminate data collection. Researchers collectively agree that 'how many is enough is driven' by epistemological, methodological and practical issues (Baker & Edwards, 2015). From a practical and pragmatic perspective a, Doctorate in clinical Psychology (DClinPsy) thesis is limited by time restraints and sadly has the profound effect of possibly adding to anxiety of conducting research. I believe prior research experience helped to ground me when conducting ethics process and also data collection, but I feel if I hadn't had this I may be left with a bitter opinion of research something that peers (trainees) did voice. I also recognize research is mostly a collective exercise something again experienced by working in an academic department. DclinPsy research component fails to recognize this wider collective aspect. Although my research is a collective process and results from an interaction with participants and also supervisor, it does not recognize that the reality of research in academic settings does require larger collaborative teams. Therefore, the sample and resources required to conduct this research remain minimal and this I believe can have a large impact on the trainees need to defend such subjects as saturation.

From a methodological and epistemological perspective, IPA emphasises the importance of smaller samples, staying true to the idiographic nature of the findings. But more importantly it does not claim that findings have empirical generalization. Researchers indicate that 'qualitative research aim is to build a convincing analytical narrative based on 'richness, complexity and detail' rather than on statistical logic' (Baker & Edwards, 2015). Beck, (2015) highlights that questions of saturation are settled not in terms of asking 'how many interviews are enough' but decided theoretically in the analytical framework conferred on what is caught on the digital voice recorder. Beck, (2015) argues passionately that how attentive I have been to my collected accounts is more a worthy measure of validity and reliability then say how many accounts I have collected. Furthermore this operates in both directions he states "Research practices do not simply 'capture' or reveal the world out there; they generate the conditions of possibility that frame the object of analysis" (Skeggs *et al.,* 2008, p.20 cited by Beck, 2015). Thus the success of my analysis depends on the sensitivity to the frame of analysis and my ability to produce a narrative based on the richness, complexity and detail the dialogue that has taken place, rather than a practice to demonstrate saturation of a certain set of phenomenon. I will now turn to the analysis and elaborate further.

11.4 Analysis Process

Before embarking on the next stage in this journey I put into place the use of a pen portrait to help situate my analysis. This allowed me to go back to early emotional shifts and dynamics that later I found became important to analysis. Like any novice IPA researcher I noted my anxiety rise as I stepped into the analysis process. I was all the time aware of remaining to keep open to the new experiences emerging and attempting to bracket pre-suppositions stemming from early formation of relationship with the peers, beliefs held about peer support and also the strong impact of negative feelings about practices in mental health services (also activated by the interviews). This was not a process to be objective – but as Van Manen, (2002) states is 'the unwilled willingness to meet what is utterly strange in what is most familiar'. This also alerted me early on to how little psychological research perhaps misses or avoids the relational aspect to our research role – one where we are seen to be dialoguing with the other (or oneself) rather then it being about applying techniques (Finlay, 2008).

This part of the process was labour-intensive and as there is no prescriptive way in which to carry out analysis. I on one hand enjoyed the freedom, but it was juxtaposed with moments of real anxiety that I was failing to do justice to the accounts. I learnt about the uncertainty of the procedure and this deepened my own intuition. Churchill's (2000, p.164) statement that any one analysis can only be presented as a 'tentative statement opening upon limitless field of possible interpretations' provided real nourishment in this process. As traveling round the hermeneutic circle it was hard to know when to step out and it was possible new interpretations could still exist. At best the process of analysis as identified by Finlay, (2011) becomes an embodied lived experience in itself, not just a cognitive and intellectual exercise. When I was immersed I would find myself in various forms engaging on placement or on the train thinking about alternative interpretations and I followed up cultural references to try and get into the 'lived worlds' of participants. This occurred through listening to music they may have mentioned and also watching films. The film *The Magdalene Sisters* (dir. Peter Mullan, 2002) certainly opened up new and rich textures to my understanding of this person's analogy.

Early on I had felt close to my participants, but later by the stage of the writing process I was seen to step away and I felt concerned that I might loose the subjective co-produced sense making that I had become attuned too. Perhaps the writing process itself contributes to this. Others have speculated that the act of depersonalization occurs in our research work and university culture (which encourages the avoidance of the first person pronoun in scientific texts) also reinforces this process of suppression of the subjective experience (Marks & Monnich- Marks, 2003 as cited in Mideley, 2006 p.228). Haumann, (2005) comments that a 'pernicious ethical challenge of writing up research is the sense of discomfort researchers may feel about treating participants as objects to talk about rather than as persons to talk with' (Haumann, 2005, p.22). I would echo these feelings, as I did feel guilty as I began to write and the way in which it started to lay out on the page didn't quite correlate with the process that I had co-produced. Finlay, (2011) highlights that 'being reflectively aware both of the nature of research enterprise and of our ethical responsibilities is a good place to start' (p.225). It was also unexpected how I had become frozen in my writing process on occasions, by pre-empting how this may be received by my audience, especially the peer workers and also the examiners. Discussion in supervision appeared to ease this tension.

The hermeneutic circle – a fuzzy concept to start out with, started to become more meaningful once I begun analysis. It was once I fully immersed myself did the moments appear to stand out when single words or extracts would illuminate whole narrative structures found amongst the group, which focused on identity, disclosure and stigmatizing attitudes. This circle also existed in the dynamic between myself and the participant. I had some ideas about what fore-structures may be relevant, such as my early relationships with the peer workers, but once interpretation was underway – I only then started to know what my assumptions were when engaging closely with the person in front of me. Fore-structures that I hadn't anticipated were how participants brought into the account there own formation of identity shaped from stigmatising attitudes and the management of disclosure, something that I did not expect. During the process of analysis I had realised that my early assumptions of peer-support as contributing to challenging barriers of stigma was counter to the evidence.

This revealed that maybe I had been pre-occupied with demonstrating that the intervention would have a large impact on people identities, something not to be found for all participants. This understanding would never have occurred if I had not spoken to the individuals. Therefore a possible example of where 'fore-structure understanding lay pretty deep, dormant, implicit'. (Smith 2007, p.5). Smith highlights this further 'confronting the new, the strange and the other, this new data forced a collision of fore-understanding and material not fitting with it and, as a result of the conflict, the fore-understanding dramatically came alive, became apparent' (Smith 2007 p.5). Lastly reassuring comments from Finlay (2011) helped to deal with the complexity and messiness of such an analysis, she states that analysis in her view should be judged not on its ability to present 'answers', but rather on its capacity to capture something of this mess' (p.243).

11.5 Limits of IPA and quality issues

Due to the IPA approach to the accounts, it is acknowledged that 'access depends on and is complicated by the researcher's own conceptions... required in order to make sense of that other personal world through a process of interpretative activity' (Smith, Jarman, & Osborn, 1999, p.218). Therefore what is presented here is shaped by my own conceptions, as already acknowledged this can only be read as one possible interpretation of the findings. To assure the reader of the rigour involved in this

approach, I hope that I have managed to marshal the evidence well and demonstrate that my interpretations are plausible. I would suggest that I have attempted to do this by explicitly using verbatim quotes, situating the quotes within the wider socio-cultural context and supported my findings with further empirical evidence surrounding identity formation, stigma and also current debate concerning peer-support. I have also presented appropriate reflections to demonstrate how my own conceptions may have impacted on this interpretation.

A process of triangulation of data collection could have been drawn upon to add to the reliability and validity of findings. Individuals had also been completing a work-booklet in conjunction with the peer. Extracts from these could have been used as an additional data source to shed further light on the participants account. IPA is inevitably subjective and another more rigorous quality check of findings could have been the use of an independent researcher (external to my university) to carry out further quality check of my analysis. It is also possible that a longer time frame for data collection, would have permitted access to a larger pool of participants which would have been beneficial to have carried out further interviews, however it was felt that this was limited by the time restraints of the doctoral training.

11.6 Closing thoughts

The project's relevance to peer support debate and also evaluation of an intervention is valuable. It sheds further light on the complexity of the exchange that occurs between two individuals who identify as experiencing mental health distress and how findings correlate with previous evidence. Identification with others who concealed aspects of their identity as a way of managing identity threat, may clearly be challenged by such an approach. This holds real relevance to further use of such an intervention in the NHS, and could prompt further studies to explore this ambivalence in identification and the impact.

This has been a truly transformative experience, starting from the heightened awareness and sensitivity associated with the use of certain ideological structures and how they shape and continue to reinforce possible unhelpful power dynamics in our work. To meeting an important set of individuals who were kind enough to share such sensitive narratives concerning their own distress and how this was constructed with another. In addition the willingness to be honest in accounts of the current state of being in receipt of mental health services. This lead to a critical understanding of what

it is that can be achieved and experienced through peer support. Finlay (2011) states that 'research that sets itself up mainly to establish scientific credentials is less appealing and shows a loss of faith in the richness of what human experience and human science can offer' (p.270). I feel this captures eloquently how my values and beliefs have transformed my understanding of the role of research and also how I shall endeavor to pursue research that is closer to humanistic values.

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Reflexive stance of the researcher in relationship to literature review

Meta-ethnography is the sythnesis of interpretative research (Noblitt & Hare 1988). The act of sythesising interpretative literature requires the interpretativist to recognize how they construct explanations (Noblitt & Hare 1988) and provide a transparent "audit trial" (Smith 2003; Yin 1989) which lends itself to a rigorous and replicable approach. Meta-interpretation is underpinned by an interprevitist epistemology and therefore locates the researcher in the analysis process and the researcher is seen as a vital and important part of that process (Weed 2008). Therefore in the process of synthesizing the current studies the author will employ a "triple heurmeutic" "meta-interpretations of the synthesiser are added to those of the original researcher and the research participant" (Weed 2008 ; Geertz 1973). The author therefore identifies herself as a female trainee clinical psychologist with a predominately integrative approach to therapy. Specifically the author was drawn to the current topic as her assumptions about self-disclosure remain embedded in a general positive attitude to a humanist approach which would advocate for the act of therapy relevant self-disclosure. Therefore the author acknowledges that she may hold prior pro-disclosure assumptions and will attempt to bracket these assumptions when synthesizing the qualitative findings.

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All searchers were conducted July 2014

The following limiters were applied to all searches published 1990 -2014, English language only, peer-reviewed.

Database Searched	Search Terms	Number of Articles retrieved
PsyINFO		
	1. disclos*	20,843
	2. therap* OR "psycho-social-interventions"	707,505
	3. counsel*	188,406
	4. "use of self"	900
	5. "real relationship"	76
	6. Combined 1 AND 2 AND 3	980
	7. 6 OR 4 OR 5	1,956
CINAHL		
	1. disclos*	13,205
	2. therap* OR "psycho-social-interventions"	915,179
	3. counsel*	33,645
	4. "use of self"	812
	5. "real relationship"	6
	6. Combined 1 AND 2 AND 3	398
	7. 6 OR 4 OR 5	1,216
Pubmed		
	1. disclos*	74,963
	2. therap* OR "psychosocial"	78,985
	3. counsel*	95,890
	4. "use of self"	1
	5. "real relationship"	94
	6. Combined 1 AND 2 AND 3	30
	7. 6 OR 4 OR 5.	125
Medline		
	1. disclos*	27,831
	2. therap* OR "psychosocial"	407,9534
	3. counsel*	317,122
	4. "use of self"	70
	5. "real relationship"	150
	6. Combined 1 AND 2 AND 3	182
	7. 6 OR 4 OR 5	402
Total Combined		3,699
Total Combined After duplicates removed		2,947
Total Selected for Review[2]		10
Total included for synthesis		7

Hand Searches

Journal of Counseling Psychology - Hand searching retrieved no further articles. Review articles references were also reviewed, but no further articles were found.

Contacting Authors

Contact with the authors of the papers selected for syntheses were made to enquire about unpublished studies, however no additional studies were available for review.

References of Selected Articles

References of the included papers for synthesis were searched and one paper (Wells et al) was included in the review

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[2] Please see figure 1 for more detailed description of study selection.

CASP CRITERIA	Audet & Everall (2010)	Bitar (2014)	Lee (1990)	Hanson (2005)	Knox (1997)	Tsai (2010)	Wells (1994)	Constantine*	Vamos*	Blum[3]
1. Clear statement of aims	2	1	2	2	2	2	2	1	1	2
2. Qualitative methodology appropriate	2	2	2	2	2	2	1	1	1	2
3. Appropriate research design	2	1	0	1	2	2	1	0	0	-
4. Appropriate recruitment strategy	2	2	1	1	1	0	2	0	0	-
5. Consideration of data collection	2	2	2	1	2	2	1	0	0	-
6 Consideration of research relationship	2	1	0	0	2	1	0	0	1	-
7. Ethical issues considered	1	0	0	1	2	0	1	0	0	-
8. Rigorous data analysis	1	1	1	1	2	1	1	0	0	-
9. Findings clearly stated	2	1	1	2	2	2	1	1	2	-
10. Value of the research	2	2	2	1	2	1	2	1	1	-
Total score	**18**	**13**	**11**	**12**	**19**	**14**	**12**	**4**	**6**	**-**

Scoring Criteria:

A score was allocated to each area from 0 – 2. A score of 0 was assigned to each CASP element if the article gave little or no information, a score of 1 was assigned if there was moderate information, but more detail could have improved it and a score of 2 was allocated if there was sufficient information provided and demonstrated a rigorous and replicable method. Articles were compared on the total score out of 20. This allowed for a comparison of the quality of papers to be conducted and incorporated into the synthesis of studies later. Although the selection of studies was small, it was decided to exclude studies on the quality appraisal completed.

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[3] Please see appendix D for further methodological reasons as to why Blum et al (2012) was excluded during critical appraisal stage

1st Author, Title and Year Study.	Aim	Method	Reason for Exclusion
Vamos (1993) The Bereaved Therapist and her Patients	Explore clinical difficulties when confronted with personal bereavement and how disclosure should be managed.	Case Studies (4), but contents discursive professional opinion piece using case studies to illustrate points	No material generated from the perspective of the client, all gathered from the therapist reflection upon the presented case studies. Methodology not adequately explained
Constantine (2003) Cross-cultural considerations of therapist self-disclosure	Explore conditions that may necessitate therapist self-disclosure in cross-cultural situations	Single case presented and formulation followed by discussion	No data on the client's perspective upon the act of TSD. Methodology not adequately explained.
Blum (2012) Therapeutic immediacy across long-term psychodynamic psychotherapy: An evidence-based case study.	To explore immediacy through, frequency of the events, types of immediacy, how they are used.	Mixed method single case study, using quantitative measures Brief symptom inventory (BSI Derogatis 1993) Social Adjustment Scale (SAS; Weissman & Bothwell 1976) coding of the therapeutic interaction.	Insufficient qualitative material from the perspective of the client.

Extraction Item	Details
Country	
Aims of Study	
Ethics – how ethical issues were addressed	
Study Setting	
Theoretical Background of study	
Sampling Approach	
Participant Characteristics	
Data Collection methods	
Data Analysis approach	
Key Themes identified in the study (1st order interpretations)	
Data Extracts related to the key themes	
Author explanations of the key themes (2nd order interpretations)	
Recommendations made by authors	
Assessment of study quality (CASP score)	

Standard Extraction form adapted from Munro et al (2007)

1st Author, Title and Year	Location/ Background of Researcher	Aims/ Research Questions	Epistemology	Typology	Method	Analysis	No/Types of Participants	Therapy Duration	Key Findings/ Themes Relevant to the Review	Casp Score (out of 20)
1. Audet (2010). Therapist self-disclosure and the therapeutic relationship: a phenomenological study from the client perspective.	Ottawa/Canada – MSc thesis and Psycho-therapist in training.	How do clients experience the therapeutic relationship in the context of receiving therapist disclosure during therapy. Clarify disparity observed between theory and ethics upon TSD. Explore this within real-time therapeutic relationship	Not explicitly stated. Adopted stance of "naïve – inquirer", Acknowledged knower cannot be separated from the known. Co-constructors of meaning with the researcher	Conceptual/ Thematic description	Semi-structured open-ended interview format	Phenomenological (Colaizzi, 1978, Merriam 2002, Osborne 1990)	9 clients - 5 males and 4 females, aged btw 22 -56yrs mean age of 35.7, 1 Hispanic and 1 Caucasian Presenting problems mood disorders and addiction.	Duration of therapy ranged from 5 – 100 or more sessions and spanned 3 months to 8 years	1. Early connection with therapist – facilitate comfort, egalitarianism /role confusion uncertainty 2. Therapist Presence – attunement, feeling understood/f eeling misunderstoo d 3. Engagement in therapy – taking risks, closeness/feel ing over whelmed, impeding involvement	18

1st Author, Title and Year	Location/ Background of Researcher	Aims/ Research Questions	Epistemology	Typology	Method	Analysis	No/Types of Participants	Therapy Duration	Key Findings/ Themes Relevant to the Review	Casp Score (out of 20)
2. Bitar (2014) Therapist Self-Disclosure and Culturally Competent Care with Mexican – American Court Mandated Clients: A Phenomenological Study	Pfeiffer University/ USA. Arab American Family Therapist.	Examine impact of TSD in cross-cultural counseling settings and also court-mandated clients Believe unique dynamics within cross-cultural setting important to investigate and inform debate on TSD	Not explicitly stated, but reports interest in social construction of the phenomenon	Conceptual Thematic description	2 Semi-structured interviews. Second Interview used to confirm/revise emerging themes.	Phenomenological (Colaizz 1978)	10 clients aged between 22-60 and mean age of 37.2yrs. Gender and presenting difficulties not reported	Not reported	1. Building therapeutic relationship. 2. Modeling self-disclosing behaviours 3. Lessoning the therapist-client hierarchy 4. Normalising client struggles	13

1st Author, Title and Year	Location/ Background of Researcher	Aims/ Research Questions	Epistemology	Typology	Method	Analysis	No/Types of Participants	Therapy Duration	Key Findings/ Themes Relevant to the Review	Casp Score (out of 20)
3. Lee (1990) A therapists self-disclosure and its impact on the therapy process in cross-cultural encounters: Disclosure of personal self, professional self, and/or cultural self.	Canada, no further details as to background of researcher	How inadvertent TSD occurs in cross-cultural settings How therapists values present in cultural self pervasively embedded as a norm in treatment and assessment selection How therapists understand, examine and respond to clients reactions to TSD.	Not explicitly stated	Analysis includes how clients or therapists position and reposition themselves in narratives (eg., passive or active) to claim their views on TSD as dominant or subordinate	Tape recorded therapy sessions were transcribed and analysed by researcher. Two vignettes from two different client-therapist dyads were analysed for this study.	Critical Discourse Analysis (Fairclough 1993, Foucault 1980)	1 Male and 1 female, both in their 40's. Identified as first-generation immigrants to Canada. Both identified as racial/ethnic minority. Clients presenting problems: Client 1 Depression and stress from conflicts with wife. Client 2: Stress from coping with relative with mental health difficulties.	Not reported	1. TSD used as a method to highlight commonality with client, by overcompensating for racial differences, which could foreclose opportunity for client to explore culturally embedded norms. 2. TSD (cultural view of clients gender and ethnicity) did not make for any visible positive effects that TSD illustrates such as liberating client, or enhancing alliance. 3. TSD create significant impasses in therapeutic relationship, often silently discerned.	11

1st Author, Title and Year	Location/ Background of Researcher	Aims/ Research Questions	Epistemology	Typology	Method	Analysis	No/Types of Participants	Therapy Duration	Key Findings/ Themes Relevant to the Review	Casp Score (out of 20)
4. Hanson (2005) Should your lips be zipped? How therapist self-disclosure and non-disclosure affects clients	Canada. Therapist with interest in feminist/human ist background)	Is therapist self-disclosure useful? Is it ethical? Examined clients views of how therapist disclosure and nondisclosure affected them. Are self-involving statements more less helpful than self-revelations	Not explicitly stated, but described orientation as feminist/humanist	Constant Comparison Method – analyse data by themes	Semi-structured interviews with recipients of therapy. Interviews initially coded for disclosure and non-disclosure episodes, then whether helpful, unhelpful, neutral or mixed.	Grounded Theory (Glaser & Strauss)	Number not stated. Majority were women (16) Mean age 38 (range from 24-57) Identified as white/Caucasia n Canadians, range of social class. Different therapeutic modalities and reasons for being in therapy, but not stated	2 months to 10 years (mean 3.7yrs)	1. Helpful Disclosure contributed to real relationship (1) a sense of connection, intimacy, closeness or warmth, trust & safety, being deeply understood, welcomed or cared about. An egalitarian relationship 2. Unhelpful non-disclosures. Inhibiting clients own disclosure. Role reversal – therapists caretaker.	12

1st Author, Title and Year	Location/ Background of Researcher	Aims/ Research Questions	Epistemology	Typology	Method	Analysis	No/Types of Participants	Therapy Duration	Key Findings/ Themes Relevant to the Review	Casp Score (out of 20)
5. Knox (1997) A qualitative analysis of client perceptions of the effects of helpful therapist self-disclosure in long-term therapy.	Maryland USA, masters thesis. Humanist psychodynamic therapist.	1. Do therapist disclosures influence the "real relationship" 2. Effect of therapist SD on feelings of universality 3. Does disclosing model to clients and encourage disclosure	Not explicitly stated, but described orientation as humanistic psychodynamic approach	Develop categories to describe themes and then carry out cross case analysis. Using five judges to reach consensus on themes	Semi-structured interviews, conducted with participants twice. Second interview used to clarify issues discovered in first interview.	Consensual qualitative research (CQR)	13 (9 women and 4 men) Aged 26 – 50 yrs (M 37.69, SD 6.94) Presenting problems: Depression (8) Anxiety (3) sexuality issues (3) drug-alcohol rehab (1) Personality disorder (1) eating disorder (1) anger (1) relational issues (1)	5 to 192 months (M=60.62, SD=61.41)	1. a)Positive consequence, gave client insight or perspective to make changes b) therapist more real relationship improved or equalized c) normalized or reassured d) client used therapist as model 2. Negative consequence, Clients worried about closeness and boundaries	19

1st Author, Title and Year	Location/ Background of Researcher	Aims/ Research Questions	Epistemology	Typology	Method	Analysis	No/Types of Participants	Therapy Duration	Key Findings/ Themes Relevant to the Review	Casp Score (out of 20)
6. Tsai (2010) Therapist Grief and Functional Analytic Psychotherapy (FAP): Strategic Self-Disclosure of Personal Loss	USA Washington Therapist, no further details as to the background of researcher	To offer guidance to therapists using this technique and to explore the effect of TSD disclosure within FAP	Not explicitly stated	Themes were generated from data of two open-ended questions	Survey asking two open questions about disclosure event	Grounded theory approach	35 clients, aged from 24-63 (M = 40, SD = 9.4) 20% male, 17% ethnic minority. Presenting issue: diagnosis of adjustment disorder, mixed anxiety and depression.	No details reported	1. Appreciation and closeness – thankful recognition and a sense of emotional intimacy was expressed. 2. Helpful modeling – clients felt they were shown how they could talk about grief to others. 3. More equality on the relationship and therapist becoming a whole person – clients view as more real. 4. Enhanced trust 5. Awareness of mortality.	14

1st Author, Title and Year	Location/ Background of Researcher	Aims/ Research Questions	Epistemology	Typology	Method	Analysis	No/Types of Participants	Therapy Duration	Key Findings/ Themes Relevant to the Review	Casp Score (out of 20)
7. Wells (1994) Therapist self-disclosure: Its effects on clients and the treatment relationship.	USA/Massachusetts Social Worker	Intention is to offer guidance therapists to the effects of the intervention of TSD	Not stated	Conceptual thematic description	semi - structured interviews	Not explicitly stated	8 clients in total, 7 women, 1 man. Aged from 24-62yrs	Therapy duration ranged from 5mths – 6 years.	1 TSD & relationship: Mixed reported feelings as to whether TSD effected confidence and trust. 2. Perception of different disclosures; Voluntary disclosure made feel uncomfortable and also build rapport. 3. TSD and treatment effect: clients felt it was reminiscent of re-experiencing of familiar interpersonal dynamics 4. Clients reactions to TSD: mixed from ambivalence to also validating.	12

	Minimizing the Power Imbalance	Modeling – reciprocal Sharing	Humanness and Increased Connection	Blurring of Boundaries and Uncertainty of Roles	Impeding Involvement	Negotiating Cultural Identity	Re-experiencing of Familiar Interpersonal Dynamics
Audet & Everall (2010)	Clients perceived relationship as having natural power imbalance and TSD was perceived to reduce, but not eliminate this. Acted to reduce the power imbalance maybe inherent in the therapeutic relationship.	"Clients perceived TSD as an invitation or permission to respond in kind, made them more willing to discussing their own problems"	Clients perceived TSD has making them real. Therapist was more human, imperfect more "like people". Perceived as "connecting as two human beings" and enhance closeness a "synergistic experience"	TSD interpreted as "odd" or "surprising", this generated uncertainty about roles within the dyad. Minimized therapist's level of professionalism and overwhelmed clients.	TSD interpreted as contributing to misunderstanding as "competitive and superfluous sharing", effecting the alliance in the dyad	_	_
Bitar et al., (2014)	Clients saw the sharing as a way to lessen the hierarchy, a feeling of being on the same level. This was felt very relevant to clients who had been imprisoned previously and feeling disempowered. "the counselor aint way up here and I'm way down here. Perceived to soften the power differential.	TSD interpreted by clients as a model of how to open up, this was possibly seen as a risk at times also to do this.	TSD was interpreted as creating a more relaxed and open and connected environment, to move away from the initial discomfort felt at the beginning of the relationship.	_	-	Working with members of dominant group (Angelo American, educated middle-class may have an important impact on the use of TSD with members from latino culture.	_
Lee, (1990)	-	-	-	-	Cultural assumptions disclosed through TSD creates a significant impasses in the therapeutic relationship. Client actively resists engagement using dialogical strategies.	Therapists unrecognized and unprocessed cultural values and beliefs interrupt the engagement process, these implicit norms questioned clients values.	-

A blank cell indicates that the study did not contribute to the relevant theme. Entries in quotation marks are the original authors own words, those not in quotation marks are based on paraphrasing of the original papers

	Minimizing the Power Imbalance	Modeling – Reciprocal Sharing	Humanness, Increased Connection	Blurring of Boundaries and Uncertainty of Roles	Impeding Involvement	Negotiating Cultural Identity	Re-Experiencing of Familiar Interpersonal Dynamics, Taking on the Role of Care-Giver
Hanson, (2007)	Power imbalances were interpreted to be minimized by the use of TSD which could have a therapeutic effect.	Non-sharing was perceived as unhelpful to the therapeutic alliance, non-disclosure, inhibited clients own disclosure.	client's felt that TSD contributed to a real relationship, "relationship seemed more balanced or mutual; the therapist appeared more human or fallible"	clients interpreted TSD as decreasing trust and safety within the relationship, which resulted in relationship being terminated.		–	clients perceived therapists long disclosure, as role reversal and " felt like it was her job to listen to the therapist as the therapist caretaker"
Knox, (1997)	–	"Clients used therapists as models to make positive changes in themselves or to increase client self-disclosure"	TSD meant clients saw therapist as more real, human, or "imperfect – showed that therapist had flaws like others and did not have all the answers"	TSD evoked negative feelings, clients became wary of therapy boundaries and "another client feared the closeness engendered by the disclosure" Clients became uncertain of therapists intentions.		–	–
Tsai et al., (2010)	"More equality was experienced in the relationship as consequence of TSD, amplifying that the therapist was more real, more natural. "Left the client thinking that the therapist viewed them as an equal in the relationship"	"Helpful modeling, clients felt they were shown how they could talk about grief to others".	A sharing of personal loss was seen to increase closeness, it opened up a more intimate space, which engendered personal growth.		TSD made "clients feel that there problems seemed trivial in comparisons" client felt ashamed to be taking the therapists time to talk about their problems and might burden them with their difficulties as such a time		–
Wells, (1994)		–	"Most if not all, did express feeling that TSD enhanced mutuality and their sense of connection with the therapist". Client felt that the therapist became three-dimensional human by sharing.	Ambivalence about the disclosures was expressed such as feelings of being "ashamed, stunned and offended" Voluntary disclosures made clients feel uncomfortable about boundaries.	TSD made clients feel "pissed off", "humiliated" and "scared"	–	Clients felt that the TSD caused a "recreation of a familiar and threatening dynamic – recapitulated early childhood experiences of boundary violations

A blank cell indicates that the study did not contribute to the relevant theme. Entries in quotation marks are the original authors own words, those not in quotation marks are based on paraphrasing of the original papers.

1st Author, title and year.	Therapist Orientation and Professional Background
Audet (2010). Therapist self-disclosure and the therapeutic relationship: a phenomenological study from the client perspective.	1. Did not state therapist orientation 2. Reported (4) Doctoral level councilors (1) Psychologist (1) Psychiatrist
2 .Bitar (2014) Therapist Self-Disclosure and Culturally Competent Care with Mexican – American Court Mandated Clients: A Phenomenological Study	1. Integrative therapeutic approach 2. Did not state professional background
3. Lee (1990) A therapists self-disclosure and its impact on the therapy process in cross-cultural encounters: Disclosure of personal self, professional self, and/or cultural self.	1. Cross cultural therapist orientation 2. Did not state professional background
4. Hanson (2005) Should your lips be zipped? How therapist self-disclosure and non-disclosure affects clients	1. Reported that there was a range of therapeutic orientation and did not state professional background
5. Knox (1997) A qualitative analysis of client perceptions of the effects of helpful therapist self-disclosure in long-term therapy.	1. Reported orientation as CBT therapist, Psychoanalytic/Psychodynamic, Eclectic, Humanistic 2. Did not report professional background
6. Tsai (2010) Therapist Grief and Functional Analytic Psychotherapy (FAP): Strategic Self-Disclosure of Personal Loss	1. Functional Analytic Psychotherapy (FAP), therapist orientation 2. Did not report professional background
7. Wells (1994) Therapist self-disclosure: Its effects on clients and the treatment relationship.	1. Did not state therapist orientation 2. Clinical Psychologist (4), Psychiatrist (1) Therapist (2)

1st Author, title and year.	Type of Disclosure
Audet (2010). Therapist self-disclosure and the therapeutic relationship: a phenomenological study from the client perspective.	Disclosures were personal, self-disclosing, self-involving and non-immediate to the therapy situation examples were: 1. Therapists discloses leisure activities, past and personal struggles, disclosing information about family, disclosing of marriage status.
2.Bitar (2014) Therapist Self-Disclosure and Culturally Competent Care with Mexican – American Court Mandated Clients: A Phenomenological Study	Disclosures were personal self-disclosing, self-involving, and non- immediate to the therapy situation examples were; 1. Sharing of life experiences and characteristics of own family, such as number of children, sharing that they have problems too, but not giving distinct details, past and current struggles.
3.Lee (1990) A therapists self-disclosure and its impact on the therapy process in cross-cultural encounters: Disclosure of personal self, professional self, and/or cultural self.	Disclosures were inadvertent self-involving and self-disclosing disclosures about non-immediate information: 2. Sharing information about own marriage status 3. Sharing information about a cultural belief, disclosed own view about self – care.
4. Hanson (2005) Should your lips be zipped? How therapist self-disclosure and non-disclosure affects clients	Disclosures were disclosing personal and non - immediate to the therapy situation examples were: 1. Self – involving and self – revealing, therapist's reveals that they are an incest survivors, shared feelings about prior personal difficulties relationships, sharing that they were are also divorced. 2. Revealing something similar such as a similar stigmatized identity that was immediate to therapy situation.
5. Knox (1997) A qualitative analysis of client perceptions of the effects of helpful therapist self-disclosure in long-term therapy.	Disclosures were personal, self-disclosing, self-involving and non-immediate information: 1. disclosures about family, disclosures about leisure activities 2. sharing in similar stigmatized identity
6. Tsai (2010) Therapist Grief and Functional Analytic Psychotherapy (FAP): Strategic Self-Disclosure of Personal Loss	Disclosure focused just on one type of personal disclosure that was self-disclosing, non self-involving and non-immediate information 1. Therapist discloses close relatives (mother) stroke and subsequent death.
7. Wells (1994) Therapist self-disclosure: Its effects on clients and the treatment relationship.	Disclosures were self-disclosing and self-involving, personal, similar and non- immediate and immediate: 1. Personal, similar disclosures such as sharing insight or strategy with a similar struggle such as difficulty in romantic relationship and previous addiction problems or relative with rare physical problem. Immediate to the therapy situation 2. Personal immediate feeling disclosed through physical crying for client, immediate to the therapy situation.

Research Study.

The Peer Support Intervention[4]

The intervention was delivered in a series of up to ten sessions with a peer support worker. The peer support worker offered sympathetic listening and sought to instil hope through appropriate sharing of skills and coping strategies acquired in their own recovery journey. The intervention included the following structured elements in a self-management workbook for participants to complete:

- Setting personal recovery goals.
- Help with plans to re-establish community functioning and support networks.
- Using the experience of recent crisis to identify early warning signs and an action plan to avoid or attenuate relapse.

Meetings took place weekly, as arranged between the participant and the peer support worker, with the aim that the programme of support is concluded within three months of someone leaving CRT care. The self-management workbook was adapted from recovery resources compiled by Perkins, (2007) and also informed by self-management resources such as the Wellness Recovery Action Plan (Cook et al 2009) and relapse prevention interventions (Birchwood, *et al.*, 2000).

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NHS

Health Research Authority

NRES Committee London -

Telephone:

28 February 2014

Miss Hannah Istead
Trainee Clinical Psychologist
Leicester Partnership NHS Trust
104 Regent Road
Leicester
LE1 7LT

Dear Miss Istead

Study title: Co-construction of recovery in a mental health setting:
                      an Interpretative Phenomenological Analysis of how an
                      individual experiences a Peer-Supported
                      Self-Management Intervention.
REC reference: 14/LO/0023
Protocol number: N/A
IRAS project ID: 142592

Thank you for your letter of 25 February 2014, responding to the Committee's request for further
information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair and Eleni
Gerolaki.

We plan to publish your research summary wording for the above study on the HRA website,
together with your contact details, unless you expressly withhold permission to do so.
Publication will be no earlier than three months from the date of this favourable opinion letter.
Should you wish to provide a substitute contact point, require further information, or wish to
withhold permission to publish, please contact the REC Manager Hayley Henderson at
nrescommittee.london-camdenandislington@nhs.net

Confirmation of ethical opinion
On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above

A Research Ethics Committee established by the Health Research Authority

noclor **NHS**

Research Support Service

12 May 2014

Hannah Istead
Trainee Clinical Psychologist
Leicester University
104 Regent Road
Leicester
LE1 7LT

Dear Ms Istead

I am pleased to confirm that the following study has now received R&D approval, and you may now start your research in the trust(s) identified below:

Study Title: Co-construction of recovery in a mental health setting: an Interpretative Phenomenological Analysis of how an individual experiences a Peer-Supported Self-Management Intervention.
R&D reference: 142592
REC reference: 14/LO/0023

This NHS Permission is based on the REC favourable opinion given on **28 February 2014**

Name of the trust	Name of current PI/LC	Date of permission issue(d)
~~Foundation Trust~~	~~~~	12 May 2014

If any information on this document is altered after the date of issue, this document will be deemed INVALID

Specific Conditions of Permission (if applicable)

If any information on this document is altered after the date of issue, this document will be deemed INVALID

Yours sincerely,

Pushpsen Joshi
Research Operations Manager

Cc: ~~~~

R&D approval letter REC reference 14/LO/0023 R&D reference 142592   Page 1 of 2

North East London **NHS**

NHS Foundation Trust

Date: 15 December 2014

Dear Hannah Istead,

Re: R&D ref no 2358 – Co-construction of recovery in a mental health
        setting: an Interpretative Phenomenological Analysis of how an
        individual experiences a Peer-Supported Self-Management Intervention

I am pleased to inform you that the above named study has been granted approval
and indemnity by ~~Professor Martin Groot~~ Director of Research and Development
North East London NHS Foundation Trust. You must act in accordance with the
North East London NHS Foundation Trust's policies and procedures, which are
available to you upon request, and the Research Governance Framework. Should
any untoward events occur, it is **essential** that you contact your Trust supervisor and
the Research and Development Office immediately. If patients or staff are involved in
an incident, you should also contact the Governance and Assurance department, in
Goodmayes Hospital, and complete the Incident and Reporting Form, namely the IR1
form.

This approval is valid until 01 April 2015. You must inform the Research and
Development Office if your project is amended and you need to re-submit it to the
ethics committee, if your project is extended or if your project terminates. This is
necessary to ensure that your indemnity cover is valid and also helps the office to
maintain up to date records.

You are also required to inform the Research and Development Office of any
changes to the research team membership, or any changes in the circumstances of
investigators that may have an impact on their suitability to conduct research.

Yours sincerely,

Sandeep Toot
Research and Development Manager, North East London NHS Foundation Trust

2357 R&D Approval letter – Randomised controlled trial evaluating Cognitive Behavioural Therapy
delivered on an internet platform by Big White Wall   1 of 2

![University of Leicester logo]

Clinical Psychology Dept.
University of Leicester
104 Regent Road
Leicester
LE1 7LT
T: 0116 223 1639
F: 0116 223 1650

Participant Information Sheet

Date:

Version 4. 25.02.2014

Participation Information Sheet

1. **Study Title: Recovery in a mental health setting: an analysis of how an individual experiences a Peer-Supported Self-Management Intervention**

Ethics Number: 14/LO/0023

Researcher: Hannah Istead, Clinical Psychologist Trainee, University of Leicester

Contact: E. hi26@le.ac.uk

2. Invitation to participate

As you have completed the peer support self-management intervention you are being invited to take part in a research interview. Before you decide, it is important for you to understand why we are inviting you to be interviewed and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask me if there is anything that is not clear or if you would like more information.

3. What is the purpose of the study?

As you are aware you have recently taken part in a research study which has involved you participating in a programme of support for people who have recently received support from a Crisis Resolution Team (CRT). This involved support from an individual who has

also used mental health services. Within that time you may have worked with the peer to put together a recovery plan to help maintain your wellbeing and make goals for the future. Very little research has examined why this support might be helpful and we are keen to find out how you have experienced this support and to ask you specifically about how this has impacted on your recovery plan, goals and general wellbeing. We hope that this will give us a rich insight into how you have experienced this programme of support and in turn it can also help us make changes to future programmes of care and inform future service provision in mental health services.

4. Why have I been asked to take part?

You have been invited to take part because you have recently completed the support with the peer and at the beginning of the study you agreed to take part in an interview about this experience.

5. Do I have to take part?

It is completely up to you to decide whether or not you would like to take part. If you decide to take part you will be asked to sign a consent form. If you do decide to take part you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect the care you receive now or in the future, from the CRT or other services.

6. What will happen if I take part?

If you agree to take part in the interview, you will be contacted by myself either by phone or email to organise a suitable place and time to meet to complete the consent form and to carry out the interview. The interview will probably last for an hour, but the time taken will depend on how much you have to say.

7. What will you be asked about?

You will be asked about your experience of receiving this support with the peer and what impact you feel this has had on you. How you felt about the individual that you worked with and how you feel this has contributed to your current recovery goals and future plans. A copy of the interview questions can be provided before completing the interview.

8. What are the possible benefits of taking part?

Some people have found that talking about their experience can be helpful, you may also benefit by talking about your experience. Your feedback about the support will also help

inform any further support programmes and could also help shape mental health services provision.

9. What are the possible disadvantages of taking part?

No significant risks have been identified, if, however, you become distressed during the process, the researcher will be prepared to take action to make sure you are cared for. Phone numbers of professionals you can ring for help will be given to you at the beginning of the interview**.** If you wish to make your concerns known about the research or a complaint then you can contact the independent information resources advice and complaints service (PALS) of Camden and Islington NHS Foundation trust on 020 3317 3117 or telephone or email complaints@candi.nhs.uk.

10. Will my taking part be kept confidential

The interview will be entirely confidential within the study team. Nothing you say will be reported in a way which is traceable to you. The interview will be audio-recorded and will be typed up later to help in the analysis of what was said. The audio recording will be typed up by a transcription company based in the United Kingdom. The peer support workers will not be told what you individually have said, although we will give them overall feedback about what the people receiving the programme of support thought of it, and they will not be able to identify who has given the feedback. CRT or other health service staff responsible for your care, will not be told anything about your responses to any of the questions.

The only situation in which the researcher would pass any information on to clinical staff is if he or she has major reasons to be concerned about your or someone else's immediate safety following the interview. If there are any concerns in the interview about your safety or the safety of others, we will be in contact with the clinical team responsible for your care to ensure that support is available for you. Any information that is kept about you by the researcher will have your name and address removed so that you cannot be recognised from it. When we report on the research, it will not be in any way possible to identify you from the report. Direct quotes may/will be used but they will be anonymised and it will not be possible to recognise anyone from what they have said.

11. What happens to the results of the research study?

The information collected from the research interview will be made anonymous and written up in a report. The report will not contain any personal information from which you could be identified. The audio recording will be destroyed after completion of the study and typed transcripts of the interview will be stored securely at the University of Leicester where the trainee clinical psychologist is based. The results will be used in the thesis to be completed by the trainee clinical psychologist.   This thesis contributes towards fulfilment for their doctoral training in clinical psychology. The results are likely also to be published in a journal read by people planning and researching mental health services, and in articles for journals read by people who work in and who use mental health services. If you are interested in the results, a copy of the report will be made available to all participants.

12. Who is organising the research?

The research is being organised and performed by a student of Leicester University in collaboration with researchers at University College London. Leicestershire Partnership NHS Trust is sponsoring the research.

13. Who has reviewed the study?

The study has been reviewed by researchers and health care professionals at Leicester University and approved by the London Camden and Islington Research Ethics Committee - a committee which oversees research study plans to help make sure studies will be run properly and safely.

14. Further Information

If you require any more information now or in the future you may contact the researcher Hannah Istead (E: hi26@le.ac.uk).

THANK YOU FOR TAKING THE TIME TO CONSIDER TAKING PART.

University of Leicester

Clinical Psychology Dept.
University of Leicester
104 Regent Road
Leicester
LE1 7LT
T: 0116 223 1639
F: 0116 223 1650

Ethics Number: 14/LO/0023
Participant Identification Number:
Date:

Version 4: 25.02.2014

CONSENT FORM

Title of Project: Recovery in a mental health setting: an analysis of how an individual experiences a Peer-Supported Self-Management Intervention

Name of Researcher: Hannah Istead, Clinical Psychologist Trainee, University of Leicester

1. I have read and understood the study information sheet version 4 dated 25.02.14

2. I have had the opportunity to ask questions about the study

3. I understand that my participation is voluntary and that I can withdraw at any time, without giving any reason, without the services provided to me being affected.

4. I understand that the Crisis Resolution Team (CRT) which supported me will be informed that I am taking part in this interview and I consent to this form being entered into my notes as evidence of this.

5. I consent to the research interview with me following the peer-supported intervention being audio-recorded.

6. I consent to a written transcript and audio-recording of the interview being stored securely at University College London and Leicester University

7. I understand my identity will remain anonymous throughout the study and that if quotations are used from my interview, that my identity and the identities of other people I may mention will also be anonymised

8. I understand that my interview will be included as part of a doctoral thesis

9. I consent to the audio recording being transcribed by a third party (transcription company) who will sign a confidentiality agreement.

☐

10. I understand that data collected during the study may be looked at by individuals from regulatory authorities or from the NHS Trust where it is relevant to my taking part in this study. I give permission for these individuals to have access to my records

☐

11. I agree to take part in the study

☐

_____   _____   _____
Name of participant   Date   Signature

_____   _____   _____
Name of Researcher   Date   Signature

Topic Guide for Interview

University *of* Leicester

School of Psychology

DClinPsy Course

Version 3 08.11.2013

Topic Guide for Interview

For the first half of our interview we are going to focus on your initial thoughts and feelings about the experience and then how you felt working with the peer support worker that you met. In the second half of our discussion we will consider how you feel this support has impacted your wellbeing and recovery. There is no right or wrong answers I am just really interested in your experience.

1. Can you tell me what it was like for you at the first meeting with the peer?

   Possible prompts: Can you tell me a bit more about that? Did it change over time?

2. Could you tell me how you felt receiving support with someone who has used mental health services?

   Possible prompts: Before?, During?, After?

3. How do you feel having a person who has used mental health services themselves has contributed to this experience for you?

   Possible prompts: a) how? b) in what ways? c) individual qualities of the person?

   d) shared experience? e) mutual understanding? f) optimism & hope?

4. Could you tell me about the relationship that developed with the peer support worker.

   a) Examples of this relationship that the person felt were important to them

   b) significant changes in the relationship

5. How do you feel this experience has contributed to your general wellbeing

   Possible prompts: (a) understanding yourself? (b) personal growth? (c) purpose in life? (d) understanding of your own mental health? (e) how you get on with other people?

6. Have you made any changes since using this support?

   Possible prompts: (a) personal changes, including living skills and identity, self-esteem? (b) practical changes? (c) social changes? (d) how you get on with other people (e) work (f) understanding your own mental health? (g) recovery process – goals, plans, (h) making new friends?

   Additional prompts:

   a) in what ways?
   b) if so what are these things?
   c) What was that like for you?

7. Is there anything that you would have liked to have changed about this experience?

   Possible prompts: If so what changes would have been helpful? If not why do you think this may be?

APPENDIX A

University of Leicester

School of Psychology – Doctorate in Clinical Psychology

Confidentiality Statement for Transcribers

The British Psychological Society has published a set of guidelines on ethical principles for conducting research. One of these principles concerns maintaining the confidentiality of information obtained from participants during an investigation.

As a transcriber you have access to material obtained from research participants. In concordance with the BPS ethical guidelines, the Doctorate in Clinical Psychology Research Committee requires that you sign this Confidentiality Statement for every project in which you act as transcriber.

General

- I understand that the material I am transcribing is confidential.

- The material transcribed will be discussed with no-one.

- The identity of research participants will not be divulged.

Transcription Procedure

- Transcription will be conducted in such a way that the confidentiality of the material is maintained.

- I will ensure that audio-recordings cannot be overheard and that transcripts, or parts of transcripts, are not read by people without official right of access.

- All materials relating to transcription will be returned to the researcher.

Signed _____ Date 13/10/14

Print Name _____Jo Welch_____

Researcher _____Hannah Istead

Project Title   Co-construction of recovery in a mental health setting: an Interpretative Phenomenological Analysis of how an individual experiences a Peer-Supported Self-Management Intervention.

Interpretive Phenomenological Approach Steps of Data Analysis

Looking for themes in the first case:

Transcript read through several times. The **right hand** margin of the text used to annotate what is interesting or significant about what the person said.

Including: Language, contradictions and echoes in speech, associations, paraphrasing, questions, inconsistencies, and emotive aspects. To resemble stream of consciousness.

Identify and label themes that characterise each section of text in the **left hand** margin.

Checking threads back to original text, and grounded in what specifically said. Use same theme titles if come up more than once. Use reflective diary to note significant feelings emerging.

Connecting the themes: emerging themes are listed on paper and connections between them are sort.
Ordered initially chronological but then clustered together.
Look for subordinate concepts, check back to original to make sure connections work with primary material.
Clusters were labelled either with descriptive labels or drawing on quotes. Drawing on methods of abstraction, subsumption, polarization, contextualization and function to look for patterns across the transcript.

Summary table produced:
Of **structured subordinate themes, themes, quotations, page numbers**.
Grouped under the clusters that emerge. Only including those that are related to the phenomenon under investigation.

Continuing the Analysis with other cases...

First transcript filed away and started from scratch on transcript 2.

Noting how first themes were bracketed in reflective diary and also how this was also still contributing to unconscious process of clustering.

Composed list of the **master themes** that reflected the experiences of the groups as a whole.(see table below)

Ensuring cyclic process; emerging themes were checked with original data.
Analysis continued until the point that all themes had been integrated.

Writing up: All themes were moved to writing up, and expanded. Translating themes into narrative account with verbatim extracts.
Clearly identifying what was said and the researchers interpretation.
Supported by a table of themes (see main text) or the relationship between themes.

Although demonstrated as linear in diagram – noted that this was iterative and reflective writing used to illustrate the iterative and circular nature to writing and revision.
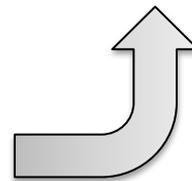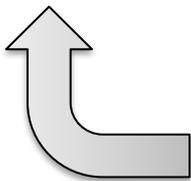
(Adapted from Smith, Flowers and Larkin (2008)

There is considerable variety in the epistemological positions underlying the use of qualitative methods (Guba & Lincoln 1994; Henwood 1996). The orientation adopted in this study is the 'contextual constructivist' position (Solomon 1987; Sutton 1989, and Millar 1989). The collective discourse summarizing contextual constructivist position present a cogent argument for the contextual theory of knowledge where individuals construct knowledge through one another and collaboratively create shared knowledge, in addition to this peoples views are grounded in the cultural milieu (Geertz, 1973, p. 5). There are also multiple discourses within this that may come together and shape how people view themselves. There discourses may be shaped by the persons cultural identify and this "construction takes place in a context - a cultural context created by, for example, social and economic class, religion, geographical location, ethnicity, and language" (Cobern 1993 p.1). However it is argued that this "culture" is still arguably up for debate (Cobern 1993).

The contextual construction becomes important to understanding the relationship between the peer and the recipient because of the inter-subjective enquiry of the proposed project. It has been proposed our understanding of our experiences can be "woven from the fabric of our many and varied relationships with other" (Smith *et al.,* (2009) p.194). These accounts can give us an account of how the situated and related qualities of human understanding of the Peer Support relationship come about. Although a particular orientation as been clearly stated the investigator still hopes to adopt a certain level of epistemological openness which will be revisited in reflective activity.

As previously highlighted it could be argued that a psychoanalytically informed methodological as employed here may not be reconcilable with a contextual constructivist position. Discursive psychologists drawing on a contextual constructivist position have criticized Hollway and Jeffersons (2003) method for its tendency to 'reproduce the essentialist, individualist and normative characteristics of traditional psychology (Parker, 2005). In addition to this they argue that there is a danger that individualizing accounts (seeing society purely as an aggregate of individual psychological process) could occur when employing such a method. This

would appear at odds with the chosen epistemological position that emphasizes the position that individuals' accounts are essentially inter-subjective and also shaped by the cultural milieu. At the heart of this discussion lies the concept of "subjectivity" and how the current researcher has chosen to construct their interpretation of the participant's accounts. Hollway & Jefferson (2003) makes use of the "Kleinian perspective to provide biographical indices marking the development of individuals' subject positions, theorizing this with the notion of a 'defended subject'—an idea consistent with inter-subjectivist as well as object relational perspectives". Frosh *et al.,* (2013) argues that this method contributes to an attempt to provide a 'plausible narrative of why specific participants become embroiled in particular sorts of patterns of anxiety, producing their individualized cocktail of beliefs, behaviours and accounting practices abstracted from those available in the cultural pool, something that may not be possible in particularly discursive positions'. Therefore, the cultural construction of personal identity is also accounted for in this method and also drawn upon in the resultant interpretation offered. Therefore it could be argued that it is possible to reconcile such a methodology with the trainees chosen epistemological position, as such a method does not just offer an individualised notion of the persons account, but also recognizes the cultural construction of identity. All though what may remain important is the recognition that the interpretations offered are speculative and open to revision.

Although the researcher intends to draw on a constructivist/interpretivist epistemology, it is also important to recognize the epistemological underpinnings of a method such as IPA. The theoretical underpinnings of IPA are embedded in a body of works influenced by the phenomenologist Husserl (1927) and his descriptive empirical and transcendental approach to understanding the subjective experience for an individual and Heidegger's (1962) interpretative approach which meant a shift from reductionism to understanding experience by examining the person in context and recognizing the person carrying out the interpretation also plays a part in that interpretation. This approach forms part of what is known as the "enlivened form of bracketing" (Smith *et al.,* 2009, p.25). These are not the only philosophers to have shaped this approach Merleau-Ponty (1962) has also brought an understanding of the embodied experience and Sartre (1948) who explored the existential phenomenological experience of how our world view is shaped by the presence of

others and how we engage in that experience. IPA emphasizes a mostly Heideggerian approach to reflexivity which also engages the concept of the hermeneutic circle. Therefore the orientation adopted in this study emphasis's the hermeneutic process whereby the trainee will bring their fore-conceptions to the encounter and interpret the phenomenon in the light of these, but at the same time also remaining open and non-judgmental and open to the meanings that emerge.

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Themes	Emily	William	Lucy	Alice	Bethany	Carlos	Susie
1.Role reversal I helped her.							X
2.Competition with the peer – rejecting the relationship							X
3.Locating an internal state of mind in external reality					X		
4.Polarization – The Peer is external to MH systems?					X		
5.Finding a voice – re-engaging with mental health services					X		
6.Collaborating – a feeling of being on the same path					X		
7.Absence of a relationship with the peer – difficulties in relating?	X						
8.Soul music: expression or evasion	X						
Struggling to identify with mental health label and disclosure	X						
9.Polarization of cultural identity – feeling less judged.						x	
10.Class Identity – I can sit at the back						X	
11.Constructing a new sense of self.						X	
Integrating mental health identity by identification with others mental health distress						x	
12.Modeling acceptance and understanding of ones own diagnosis						X	
13.Absence/Distraction of mind/self/others		x					
14.Fearing the outside world, relationships and ones own mind		X					
15.Avoiding intimacy in the relationship as a way to manage fear arising			x				
16.Fear of the peers experience and fearing it may return			x				
17.Fearing madness in the peer and in one self. Ambivalence to identify with the peer.				x			
18.Relationships with family and MH systems are dropped from mind or influential unconscious dynamics in organizational structures mimic the power and emotional dynamics of family relations.				x			
19.Admiration of the peer – trying to integrate this into ones own way of coping				x			

Appendix R – Chronology of Research Process

April 2012	Initial meeting with University College London to discuss collaboration. Supervisor agreed.
May – June 2012	Draft proposal drawn up and reviewed by University's
June 2012	Attend service user and carer group (London) to discuss project and receive feedback on topic guide
June 2012	Review of research proposal University of Leicester
July 2012	Amendments made to proposal
September 2012	Lay summary submitted to service user panel/Pilot topic guide with service user rep (Leicester).
January – April 2013	Completion of ethical submission
November 2013	Attendance at ethics committee
April – December 2014	Literature Review Conducted (1st & 2nd drafts reviewed by supervisor)
February 2014	Receive Ethical approval
July – February 2015	Recruitment of participants – liaison with RCT (researchers)
February – April 2015	Analysis of Data
March – May 2015	1st & 2nd Draft of research report completed & Critical Appraisal Final amendments made Submission of thesis
May – September 2015	Results will be fed back to the main research trial, the CORE study and the Service User and Carer group.
May – September 2015	Dissemination Plans The study will be summarised in a poster presentation and will be written up for formal submission to an appropriate peer-reviewed journal. The poster/and/or presentation will be given at any appropriate Recovery- orientated conferences.

Appendix S – Authors Guidelines for Submission to Qualitative Health Research Journal.

Manuscript Submission Guidelines: *Qualitative Health Research* **(QHR)**

Qualitative Health Research (*QHR*) is an international, interdisciplinary, refereed journal for the enhancement of health care and furthering the development and understanding of qualitative research methods in health care settings. We welcome manuscripts in the following areas: the description and analysis of the illness experience, health and health-seeking behaviors, the experiences of caregivers, the sociocultural organization of health care, health care policy, and related topics. We also consider critical reviews; articles addressing qualitative methods; and commentaries on conceptual, theoretical, methodological, and ethical issues pertaining to qualitative inquiry.

QHR is a member of the Committee on Publication Ethics.

This Journal recommends that authors follow the Uniform Requirements for Manuscripts Submitted to Biomedical Journals formulated by the International Committee of Medical Journal Editors (ICMJE)

> **Please read the guidelines below then visit the Journal's submission site http://mc.manuscriptcentral.com/qhr to upload your manuscript. Please note that manuscripts not conforming to these guidelines may be returned.**
>
> **Only manuscripts of sufficient quality that meet the aims and scope of QHR will be reviewed.**
>
> **As part of the submission process you will be required to warrant that you are submitting your original work, that you have the rights in the work, that you are submitting the work for first publication in the Journal and that it is not being considered for publication elsewhere and has not already been published elsewhere, and that you have obtained and can supply all necessary permissions for the reproduction of any copyright works not owned by you.**

1. Article types

2. Editorial policies
    2.1 Peer review policy
    2.2 Authorship
    2.3 Acknowledgements
    2.4 Funding
    2.5 Declaration of conflicting interests
    2.6 Research ethics and patient consent
    2.7 Clinical trials
    2.8 Reporting guidelines
    2.9 Data
3. Publishing Policies
    3.1 Publication ethics
    3.2 Contributor's publishing agreement
    3.3 Open access and author archiving
    3.4 Permissions
4. Preparing your manuscript
    4.1 Word processing formats
    4.2 Artwork, figures and other graphics
    4.3 Supplementary material
    4.4 Journal layout
    4.5 Reference style
    4.6 English language editing services
5. Submitting your manuscript
    5.1 How to submit your manuscript
    5.2 Title, keywords and abstracts
    5.3 Corresponding author contact details

6. On acceptance and publication
    6.1 SAGE Production
    6.2 Access to your published article
    6.3 Online First publication
7. Further information

1. Article types

Each issue of QHR provides readers with a wealth of information - book reviews, commentaries on conceptual, theoretical, methodological and ethical issues pertaining to qualitative inquiry as well as articles covering research, theory and methods in the following areas:

Description and analysis of the illness experience
Experiences of caregivers
Health and health-seeking behaviors
Health care policy
Sociocultural organization of health care

A Variety of Perspectives

QHR addresses qualitative research from variety of perspectives including: cross-cultural health, family medicine, health psychology, health social work, medical anthropology, medical sociology, nursing, pediatric health, physical education, public health, and rehabilitation.

In-Depth Timely Coverage

Articles in QHR provide an array of timely topics such as: experiencing illness, giving care, institutionalization, substance abuse, food, feeding and nutrition, living with disabilities, milestones and maturation, monitoring health, and children's perspectives on health and illness.

Look Out for These Regular Special Features

Pearls, Pith and Provocation: This section fosters debate about significant issues, enhances communication of methodological advances and encourages the discussion of provocative ideas.

Computer Monitor: These are articles related to computers and qualitative research.

Book Review Section: *Qualitative Health Research* includes a book review section helping readers determine which publications will be most useful to them in practice, teaching and research.

Mixed Methods: This section includes qualitatively-driven mixed-methods research, and qualitative contributions to quantitative research.

Advancing Qualitative Methods: Here, qualitative inquiry that has used qualitative methods in an innovative way is described.

Evidence of Practice: Theoretical or empirical articles addressing research integration and the translation of qualitatively derived insights into clinical decision-making and health service policy planning.

Ethics: Quandaries or issues that are particular rot qualitative inquiry are discussed.

Teaching Matters: Articles that promote and discuss issues related to the teaching of qualitative methods and methodology.

2. Editorial policies

2.1 Peer review policy

QHR strongly endorses the value and importance of peer review in scholarly journals publishing. All papers submitted to the journal will be subject to comment and external review. All manuscripts are reviewed initially by the Editors and only those papers that meet the scientific and editorial standards of the journal, and fit within the aims and scope of the journal, will be sent for outside review.

QHR adheres to a rigorous double-blind reviewing policy in which the identity of both the reviewer and author are always concealed from both parties. Please refer to the editorial on blinding found in the Nov 2014 issue: http://qhr.sagepub.com/content/24/11/1467.full.

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Papers should only be submitted for consideration once consent is given by all contributing authors. Those submitting papers should carefully check that all those whose work contributed to the paper are acknowledged as contributing authors.
The list of authors should include all those who can legitimately claim authorship. This is all those who:

- (i) Made a substantial contribution to the concept and design, acquisition of data or analysis and interpretation of data,
- (ii) Drafted the article or revised it critically for important intellectual content,
- (iii) Approved the version to be published.

Authors should meet the conditions of all of the points above. Each author should have participated sufficiently in the work to take public responsibility for appropriate portions of the content.

When a large, multicentre group has conducted the work, the group should identify the individuals who accept direct responsibility for the manuscript. These individuals should fully meet the criteria for authorship.

Acquisition of funding, collection of data, or general supervision of the research group alone does not constitute authorship, although all contributors who do not meet the criteria for authorship should be listed in the Acknowledgments section.
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