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**‘Putting into words my experience’**

**Mental health service users’ experiences of  
therapeutic groups**

by

Christine Barley

Supervised by Dr Jacqui Farrants

Submitted in fulfilment of the requirement for the degree of  
Doctor of Psychology

Department of Psychology  
City University London

November 2015

**THE FOLLOWING PARTS OF THIS THESIS HAVE BEEN REDACTED  
FOR COPYRIGHT REASONS:**

- pp. 199-222:**      **Section C.** Journal article: 'I was walking on private water.' Mental health service users' experiences of their therapeutic group: an Interpretative Phenomenological Analysis.
- pp. 246-250:**      **Appendix 11.** Author guidelines for 'Psychology and Psychotherapy: Theory, Research and Practice.'



## Table of Contents

<b>Table of Contents</b> .....	<b>3</b>
<b>List of Figures and Tables</b> .....	<b>11</b>
<b>List of Appendices</b> .....	<b>13</b>
<b>Acknowledgements</b> .....	<b>15</b>
<b>Declaration</b> .....	<b>17</b>
<b>Preface to the Portfolio</b> .....	<b>19</b>
<b>Preface</b> .....	<b>21</b>
Portfolio sections.....	21
Development of the thesis.....	21
Section A: Research study.....	23
Section B: Clinical study.....	24
Section C: Journal article .....	24
Personal reflexivity .....	24
References.....	25
<b>Section A Research Study</b> .....	<b>27</b>
<b>‘Putting into words my experience’ Mental Health Service Users’ Experiences of Therapeutic Groups. A study using IPA</b> .....	<b>27</b>
<b>Abstract</b> .....	<b>29</b>
<b>Introduction and Literature Review Chapter</b> .....	<b>31</b>
1.1 Introduction.....	31
1.1.1 Language used in this study .....	32
1.2 Ideologies and Paradigms relating to Mental Illness .....	33
1.3 Early Foundations of Psychotherapy Groups.....	34
1.4 Review of Therapy Group Research.....	35
1.4.1 Introducing the review.....	35
1.4.2 Inclusion criteria .....	36
1.4.2.1 Geographic area .....	36

1.4.2.2 Defining severe and enduring mental illness .....	36
1.4.2.3 Facilitated groups .....	36
1.4.3 Exclusion criteria .....	37
1.4.4. Introducing empirical therapy group studies.....	37
1.4.5 Findings from art, activity and music groups for people with severe mental illness .....	39
1.4.6 Introducing talking therapy group research .....	40
1.4.7 Quantitative empirical findings from longer-term therapy groups .....	40
1.4.8 Empirical findings from bipolar disorder therapy groups .....	41
1.4.9 Quantitative empirical findings from borderline personality disorder therapy groups .....	43
1.4.9.1 Outcome measures in quantitative group research .....	46
1.4.10 Empirical findings from quantitative hearing voices groups .....	47
1.4.11 Qualitative empirical findings from hearing voices groups .....	49
1.4.12 Understanding from MHSU case studies and research .....	52
1.4.13 Conclusions from therapy group research and case study findings .....	53
1.5 Contextualising Mental Illness .....	54
1.5.1 Social construction of mental illness - Meanings co-constructed between speaker and listener .....	54
1.5.2 Mental health and social factors.....	55
1.5.3 Mental illness effects.....	55
1.5.4 Mental illness and trauma .....	55
1.6 Stigma and Shame in Mental Health – the Loss of Hope .....	56
1.6.1 Research and stigma .....	56
1.6.2 Legislation and stigma .....	57
1.6.3 Social effects of stigma .....	57
1.7 Problems of Mental Health Diagnosis .....	58
1.8 Psychological Group Theories .....	59
1.8.1 Stage theory debate.....	59
1.8.2 Group theories .....	59
1.8.3 Social Learning Theory applied to therapy groups.....	60
1.9 The Role of Therapy Groups in Alleviating Mental Health Symptoms .....	60

1.10 Situating the present study.....	61
1.10.1 Defining group members' severe and enduring mental illness.....	61
1.10.2 Agenda-led versus agenda-less groups .....	62
1.10.3 Group modality.....	62
1.10.4 Numerous facilitated groups .....	63
1.11 Reviewing the Research Aims and the Research Question.....	63
1.12 Summary of Introduction and Literature Review .....	64
<b>Methodology Chapter .....</b>	<b>67</b>
2.1 Introduction.....	67
2.2 Epistemology and Ontological Considerations.....	67
2.2.1 Benefits of qualitative methodology .....	68
2.2.2 Critical-realism with post-modernism .....	69
2.3 Qualitative Methodology.....	70
2.3.1 Grounded theory .....	70
2.3.2 Discourse analysis .....	70
2.4 IPA.....	71
2.4.1 Phenomenological .....	71
2.4.2 Interpretative .....	72
2.5 Exploring Strengths and Weaknesses of IPA .....	72
2.5.1 Strengths.....	72
2.5.2 Weaknesses .....	73
2.5.3 Subjectivity.....	73
2.5.4 Diverse theoretical influences .....	74
2.6 Rationale for choosing IPA.....	74
2.7 The Impact of Social Construction on Language in IPA.....	76
2.8 Research Approval.....	77
2.9 Pilot Study .....	77
2.9.1 Pilot study reflexivity .....	78
2.10 Ethical Considerations.....	78
2.10.1 Informed consent and right to withdraw .....	78
2.10.2 Confidentiality and risk management.....	79
2.11 Research Participants .....	79
2.11.1 Participant inclusion criteria .....	80
2.11.2 Participant recruitment .....	80
2.11.3 Participant diagnoses.....	81



2.11.4 Participant homogeneity .....	82
2.12 Types of Therapeutic Groups within the Study .....	82
2.12.1 Group homogeneity .....	83
2.13 The Centre .....	83
2.13.1 The setting for the data gathering .....	83
2.14 Data Gathering .....	84
2.15 Reflexivity on Data Gathering .....	84
2.15.1 Scientist-practitioner demands .....	85
2.15.2 Ethnicity .....	86
2.15.3 Participants' use of language .....	86
2.15.4 Relationship with research participants .....	87
2.16 Transcription.....	88
2.17 Transcription Reflexivity .....	88
2.18 Analytic Procedure .....	89
2.18.1 Immersion .....	89
2.18.2 Marking a transcript .....	89
2.18.3 Tentative noting .....	90
2.18.4 Ideographic perspective in IPA .....	90
2.18.5 Emergence of themes .....	91
2.18.6 Convergence and divergence .....	91
2.18.7 The impact of the hermeneutic circle .....	92
2.19 Validity.....	92
2.20 Member Checks versus Independent Audit of Themes.....	94
2.21 Reflexivity on the Analysis Process .....	96
2.22 Summary of Methodology Chapter .....	97
<b>Analysis Chapter.....</b>	<b>99</b>
3.1 Introduction.....	99
3.2 Analysis Key .....	100
3.3 Overview of Themes .....	100
3.4 Superordinate Theme: Emerging from the Maelstrom .....	103
3.4.1 Subordinate theme: Authenticity .....	103
3.4.1.1 Summary of Authenticity.....	107
3.4.2 Subordinate theme: Self-acceptance.....	107
3.4.2.1 Summary of Self-acceptance.....	111
3.4.3 Subordinate theme: Embodiment .....	111
3.4.3.1 Summary of Embodiment .....	115

3.5 Superordinate Theme: Unveiling.....	115
3.5.1 Subordinate theme: Sanctuary from Stigma .....	116
3.5.1.1 Summary of Sanctuary from Stigma .....	118
3.5.2 Subordinate theme: Recovery Competition .....	118
3.5.2.1 Summary of Recovery Competition .....	121
3.5.3 Subordinate theme: Facilitator Rivalry .....	121
3.5.3.1 Summary of Facilitator Rivalry .....	124
3.6 Superordinate Theme: Resoluteness in Life .....	124
3.6.1 Subordinate theme: Self-reliance.....	125
3.6.1.1 Summary of Self-reliance .....	127
3.6.2 Subordinate theme: Reaching Potential .....	127
3.6.2.1 Summary of Reaching Potential .....	129
3.7 Summary of Analysis Chapter.....	130
<b>Discussion Chapter .....</b>	<b>131</b>
4.1 Introduction.....	131
4.2 Research Aims: Contextualising the findings within existing research .....	132
4.3 Emerging from the Maelstrom.....	132
4.3.1 Authenticity .....	132
4.3.2 Self-acceptance .....	135
4.3.3 Embodiment.....	137
4.4 Unveiling – The participants’ experiences of how they appear to others .....	139
4.4.1 Sanctuary from Stigma .....	140
4.4.2 Recovery Competition.....	143
4.4.3 Trauma.....	144
4.4.4 Facilitator Rivalry .....	145
4.5 Resoluteness in Life .....	148
4.5.1 Self-reliance .....	149
4.5.2 Reaching potential .....	150
4.5.3 Hope .....	151
4.5.4 Optimism.....	152
4.5.5 Recovery.....	153
4.6 Ethical Considerations.....	157
4.7 Reflexivity Statement.....	158
4.8 Summary of the Study’s Contribution to the Field .....	160
4.9 Implications for Practice .....	162

4.9.1 Endurance of benefits .....	162
4.9.2 Reviewing research methods.....	162
4.9.3 Group member mentoring.....	162
4.9.4 Stigma awareness .....	163
4.9.5 Goal setting .....	163
4.9.6 Facilitator supervision .....	163
4.9.7 Group therapy assessment .....	164
4.9.8 Authenticity .....	164
4.10 Research Limitations.....	164
4.10.1 Methodological limitations.....	164
4.10.2 Sample limitations.....	165
4.11 Study Validity.....	167
4.12 Further Research .....	169
4.13 Conclusions.....	169
<b>References.....</b>	<b>173</b>
<b>Section C Journal Article .....</b>	<b>193</b>
<b>'I was walking on private water'. Mental health service users' experiences of their therapeutic group: An Interpretative Phenomenological Analysis .....</b>	<b>193</b>
<b>Qualitative Paper for submission to Psychology and Psychotherapy: Theory, Research and Practice .....</b>	<b>195</b>
Abstract .....	197
Introduction .....	199
Method .....	202
Design.....	202
Participants .....	203
Procedure .....	203
Data collection .....	203
Participants' use of language.....	203
Data Analysis .....	204
Results .....	204
Analysis key .....	204
Theme 1: Sanctuary from Stigma .....	205
Theme 2: Recovery Competition .....	207
Theme 3: Facilitator Rivalry .....	210

Discussion .....	211
Theme 1: Sanctuary from Stigma .....	211
Theme 2: Recovery Competition .....	213
Theme 3: Facilitator Rivalry .....	214
Practice implications .....	216
Research limitations .....	216
Further research.....	217
Acknowledgements .....	217
References .....	217
<b>Appendices .....</b>	<b>223</b>



## **List of Figures and Tables**

Figure One: Analysis of the therapy group research studies that were considered and reviewed .....	38
Table One: Therapy group research reviewed highlighting limitations, findings and method .....	223
Table Two: The independent auditor's suggested themes alongside the themes explored in the Analysis Chapter .....	96
Table Three: Themes emerging from the analysis .....	102
Table Four: Highlighting validity throughout the study .....	168



## List of Appendices

Appendix 1: Table One - Therapy group research reviewed highlighting limitations, findings and method .....	223
Appendix 2: Semi-structured research discussion prompts.....	239
Appendix 3: Independent Audit of Themes by Dr Georgina Tory .....	241
Appendix 4: Ethics Release Form from City University London .....	243
Appendix 5: Centre Approval for Research Study.....	255
Appendix 6: Research Participant Informed Consent Sheet .....	257
Appendix 7: Research De-Briefing and Information .....	259
Appendix 8: Participant Demographics .....	261
Appendix 9: Research Flyer and Sign-up Sheet.....	265
Appendix 10: Gerry's initial analytic notes .....	267
Appendix 10: Gerry's later analytic notes .....	268
Appendix 10: Page six of Gerry's marked transcript.....	269
Appendix 11: Author Guidelines for 'Psychology and Psychotherapy: Theory, Research and Practice' .....	271





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## **Declaration**

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## **Preface to the Portfolio**



## **Preface**

This portfolio is focused on the experiences of individuals with a severe and enduring mental illness which are explored from the perspective of Counselling Psychology and the framework offered by a range of theories with a particular emphasis on the experience of attending therapeutic groups. I will begin by introducing the two sections of the portfolio and interlace how the thesis developed and then move on to my reflections about the different sections and their relation to my clinical work.

### **Portfolio sections**

Section A: I present the research study where I explore the experiences of individuals with a severe and enduring mental illness who are describing their experiences of attending therapeutic groups, focusing in detail on their perceptions of their lifeworld and how they navigate and negotiate obstacles, including the intrusive symptoms of their mental illness.

Section C: I present the research paper which has been prepared for submission to the *Psychology and Psychotherapy: Theory, Research and Practice* journal. The research paper focuses on three specific aspects of the group members' experiences of attending their therapeutic groups which have emerged from the research study. The aim of the paper is to contribute new awareness to the field of severe and enduring mental illness and particularly focus on the impact of psychological interventions offered via therapeutic group provision and aspects of facilitating such groups.

### **Development of the thesis**

I became aware during my early clinical work as a counselling psychology trainee that many clients were able to make use of individual sessions and group therapy to increase their awareness of their situation and to ultimately improve their mental well-being. I began co-facilitating many different kinds of



group interventions and as an enthusiastic trainee I was fortunate to work with experienced psychologists who were willing to discuss how their group interventions had been selected, their evidence base and what other alternative interventions had been used.

I found this aspect of the work challenging and stimulating in equal measures and began to study research relating to group therapy in order to improve my conceptualisation of group interventions. I began clinical work involving long-term individual psychological therapy with individuals who have been given a diagnosis of severe and enduring mental illness as defined by Ruggeri, Leese, Thornicroft, Bisoffi, and Tansella (2000). I became aware of some of the many barriers which the clients I was working with were continuing to experience, which appeared to be detrimental to their mental well-being and which seemed to be linked to increasing mental distress. I noticed the clients becoming disconnected from relationships and services and increasing their risk behaviours. One of the NHS services where I worked was setting up a longer-term therapy group for individuals who have been given a diagnosis of severe and enduring mental health and in discussions with the group facilitator about her preliminary plans for the group I began to develop my interest into group research focusing specifically on this client group. I was simultaneously considering how I might conduct a research study of group therapy as I had discovered that there was a lack of existing research focusing specifically on the experiences of attending groups by such individuals. I became occupied locating established therapy groups for individuals who had been given a diagnosis of a severe and enduring mental illness, to explore who would allow me to become involved and carry out research into the group participants' experiences. This process took almost a year and at times it seemed unlikely to happen because of concerns about the stability of the potential participants and their provision for support if the need should arise. I met with the centre manager where the research took place with all these safeguards prepared and demonstrated my integrity and beneficence as a trainee counselling psychologist, following the ethical guidelines established by the British Psychological Society (2009) and the Health and Care Professions Council (2008). I am grateful for her support of this research study and the insights into the participants' experiences which it has allowed me to highlight within this thesis.

## **Section A: Research study**

The research study is an Interpretative Phenomenological Analysis of group members' experiences of their therapeutic groups. The therapy groups in question are run for several months, facilitated by mental health practitioners and appear able to respond flexibly to issues the group members wish to explore. The study participants describe what their therapeutic groups mean to them, in terms of their personal development and increasing their awareness of their mental illness. Their experiences involve their ideographic appraisal of their unique, changeable mental health symptoms, which they negotiate with creativity, dynamism and persistence. The participants became engaged in describing aspects of their mental illness in which they find continuing challenges, illuminating their vulnerability and determination.

Some findings about group therapy experiences are novel and unexplored within existing research, and it is hoped these aspects of the study may illuminate areas of awareness for mental health practitioners and group facilitators. The study aims to contribute detailed examples of the participants' experiences of managing complex mental health symptoms, drawing on the models, suggestions and relationships which have offered positive influences. Awareness emerging from attending therapy groups included exploration of the complexity of engaging authentically in a therapeutic relationship with the group facilitator. Research participants valued others modelling strategies and demonstrated their recovery through competition with their group peers and challenging their group facilitator. It is hoped the clinical implications arising from the study (which are explored within the Discussion chapter) will offer valuable insights and awareness to the field of Secondary Care mental health group therapy provision. Material from this study has already been presented as a training tool to psychologists who facilitate groups to highlight group resistance and defence mechanisms in order to explore ways facilitators might negotiate such behaviour and re-establish the therapeutic space offered by the group. A paper on the research study was presented at the British Psychological Society conference in 2015.

## **Section C: Journal article**

The journal article has been written in the style required of the publication to which it is intended to be submitted. The research study details have been condensed into a shorter paper focussing on only three of the original subordinate themes: *Sanctuary from Stigma*, *Recovery Competition* and *Facilitator Rivalry*. *Sanctuary from Stigma* focuses on how the participants regard humiliation and being undermined and their individual cognitions and insight enhance the reader's awareness into how they choose to respond. *Recovery Competition* focuses on the participants' experiences of appearing to present their recovery as superior, stronger and more complete than their group peers. A range of possible conceptualisations about why this may be so are considered, concluding that there appears to be some evolutionary, social or even psychological advantage to the participants in demonstrating this behaviour. *Facilitator Rivalry* focuses on the participants' experiences of appearing to challenge their facilitator while vying for the leadership of the group with participants seeming to adopt a position of authority among their peers. Other group members challenge their facilitator and then leave their group and seek independence. Although some existing research briefly refers to facilitator challenge, these accounts appear generalised and lacking the detail that the present study offers.

Recovery Competition does not appear to be the focus of existing research and a concern is that facilitators may be unaware of its potential to disrupt the therapeutic relationship and the therapeutic processes within the group.

### **Personal reflexivity**

This thesis represents my personal and professional development during my journey as a trainee counselling psychologist. I have been motivated to research the impact of therapeutic groups for individuals who have been given a diagnosis of a severe and enduring mental illness, having worked therapeutically with this client group and found that many clients who have experienced trauma and intrusive mental illness symptoms describe feeling ill-equipped to maintain

lasting relationships and have described a lack of fulfilment which seems to undermine their attempts to manage uncertainty. I am reminded of my stance as a scientist - practitioner offering evidenced based interventions within clinical practice. I am struck by the similarity between counselling psychology clinical practice and the phenomenological enquiry of the present research study. Both explore how the individual perceives their lifeworld. Within the study it appears that these particular participants are equipped to manage their situation, however, they rely on input and resources, which I am aware, may not be available in different locations. I have aimed to contextualise the participants' experiences within existing systems and by relating the findings to the frameworks offered by research findings. My aim is to highlight particular perceptions which directly respond to the research question '*What is it like to be part of your therapeutic group?*' and which could enhance awareness and offer insight for Counselling Psychologists, mental health practitioners and group therapy facilitators to ultimately improve practice.

## References

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## **Section A Research Study**

**‘Putting into words my experience’  
Mental Health Service Users’ Experiences  
of Therapeutic Groups.  
A study using IPA.**



## Abstract

This study explores the experiences of attending a therapeutic group from the perspective of the group participants who have a severe and enduring mental illness. The study aims to illuminate previously hidden personal experiences of the psychological processes involved in engaging with a therapeutic group, which appear absent from mental health literature and research.

This qualitative research involved nine secondary care mental health service users, five men and four women, aged from thirty to seventy, who took part in semi-structured interviews which were transcribed and analysed using Interpretative Phenomenological Analysis. The analysed data is therefore ideographic, from a bottom-up perspective, consisting of the researcher's interpretations of the participants' experiences. The research participants attended a range of facilitated therapeutic groups which were run for several months or more and which did not include agenda-led, time-limited psycho-education and behavioural groups. An independent audit of themes was included to increase validity.

Three superordinate themes emerged: 'Emerging from the Maelstrom'; 'Unveiling' and 'Resoluteness in Life', and each superordinate theme consists of several interrelated subordinate themes. Participants experienced their groups as 'sanctuaries' and presented their own recovery more positively than their group peers. Participants' experiences included challenging their group facilitators' leadership skills and enacting recovery and independence from their group. Participants experienced managing the intrusion of mental health symptoms and developed shared strategies to deal with feelings of invalidation, allowing them to become future focused and able to fulfil their goals. Participants' experiences of their therapeutic groups are considered in relation to literature, research findings and theoretical models applied to mental health. Limitations, further research and clinical implications for group facilitators are discussed.





## **Section A: Research Study**

### **‘Putting into words my experience’. Mental Health Service Users’ Experiences of Therapeutic Groups. A study using IPA.**

*Florence: Every voice hearer is different, type of voices, you know so if, if you haven’t got that you’re on your own, listening. It can be bad and it can take you down. So that group’s been a great help to me (45-47).*

## **Introduction and Literature Review Chapter**

### **1.1 Introduction**

Therapeutic groups have attracted great interest from Counselling Psychologists and mental health professionals to expedite the ‘amelioration of symptoms’ and ‘personal growth’ (Bloch and Crouch, 1985, p.2), and many group facilitators have attempted, from their perspective as group leader, to clarify exactly what ‘changes’ occur within therapeutic groups (Foulkes and Anthony, 1973, p.47). Rull (2010) offers a definition of therapeutic groups as ‘facilitated’ discussions about ‘relationship difficulties’ in which other group members offer ‘feedback’ (Rull, 2010, p.1). This fascination with the *content* of dynamic therapy within groups has been well documented by the group facilitators (Bion, 1962; Freud, 1921/1955; Corsini and Rosenberg, 1955; Foulkes 1964, 1986; Spotnitz, 1952; Yalom, 1995). However, the experience of being in a longer-term therapy group and the individual changes which may or may not emerge as a result appear harder to discern; they do not appear to be the focus of qualitative research according to a search of the databases EBSCOhost, PsychInfo, PsycARTICLES, Google Scholar and a search of Senate House Library with search terms ‘severe mental\*’, ‘group programme’, ‘lived experience’, ‘phenomenol\*’, ‘IPA’, ‘hearing voices’, ‘voice hearers’;

'psychosis'; 'delusions'; 'recovery programme'; 'schizo\*'; 'personality disorder'; 'bipolar' and 'bipolar'. The question of how groups effect psychological change remains an enigma, according to Rosenbaum (2010) who posits that therapeutic groups are a 'clinical practice that remains in search of a theory' (Rosenbaum, 2010, p.63).

In the UK, therapeutic groups are offered to primary and secondary care NHS patients to address and ameliorate the symptoms of mental distress. It has been proposed that therapy groups can be cheaper to deliver than individual psychological therapies (Hoddinott, Allan, Avenell and Britten, 2010). Guidance from NICE (2009, 2011, 2014) relating to secondary care patient psychological and psychiatric interventions does not appear to focus on the provision of therapeutic groups, or consult with service users.

### 1.1.1 Language used in this study

Following the 1980s there was a move away from institutional hospitalised care of people with a mental illness and the concept of Mental Health Service User (MHSU) began to be used to reflect service users' agency and participation within their community. The term has been used by people with experience of mental illness who became involved in writing and researching from a MHSU perspective, including Reynolds, Muston, Heller, Leach, McCormick, Wallcraft and Walsh (2009); Heller, Reynolds, Gomm, Muston and Pattison (1996); and Romme (2011). The impact of MHSU researching and writing about their experiences of living with mental illness is discussed below. MHSU is purposefully used in this research study to reflect the active agency of MHSU (Kemshall, 2009).

This chapter will begin by outlining ideologies and paradigms which have been used to differentiate and segregate those with mental illness from the rest of their community, suggesting that mental health legislation can be a marker of changing trends and thus embed dominant paradigms relating to those with mental illness. There follows a review of therapy group research, highlighting an apparent preference for quantitative, top-down, outcome-led studies focussing on specific mental illnesses. The aim is to illustrate aspects of therapy groups which appear to be omitted from quantitative research methodologies, highlighting how little is

known about the group members' experiences of attending their group or what the group means to them in living with their severe mental illness. The review offers examples of group research, illustrating the ways in which empirical findings have shaped understanding of therapy groups. The analysis includes MHSU research collaborations, since the experiences of living with severe mental illness offer a specific focus relevant to the present study participants, with some MHSU offering insights which are pertinent to the research question. The discussion includes recent dilemmas relating to measuring the outcomes of groups. The review will then consider the impact of social construction, stigma and diagnosis on the conceptualisation of mental illness. Finally, there is an introduction to the present research study and the apparent research void of the service users' bottom-up perspectives of their experiences of attending therapeutic groups, which could offer new understanding to the field. The review begins with an outline of ideologies and paradigms which appear to have subtly shaped the conceptualisation of mental illness.

## **1.2 Ideologies and Paradigms relating to Mental Illness**

Scull (1993) suggests that during the nineteenth century there was a common belief that mental illness arose from a weakness of character or a lack of self-discipline. Ward (1997) highlights that the 1845 Lunacy Act appears to characterise people with a mental illness as uncouth, lacking self-control or social dignity, seeming to condone harsh treatments such as restraint, beating and cruelty towards mentally distressed people. It seems that these dominant paradigms encouraged the deprecation of people with a mental illness who became further marginalised and were assumed to be unreliable.

The 1930 Mental Treatment Act offered varying lengths of hospital admission for people with different mental illnesses, introducing out-patient and community after-care services (Busfield, 1986). By the 1950s, Reserpine and Lithium psychotropic drugs became available (Royal College of Psychiatry, 2012); however, they appear to have been used to help staff manage patients' violent behaviour, their therapeutic use appearing later (Prior, 1993). Talking therapies, psychoanalysis and therapeutic groups were also being developed (Freud, 1921/1955; Bion, 1959).

A turning point emerged when the 1983 Mental Health Act changed the culture and assumptions about mental illness, reducing institutional care and increasing community care. Gradually, the care of people with mental illness became the shared responsibility of multi-disciplinary teams (MDT) of mental health professionals offering patients *individualised* care and treatment. A defining moment occurred in 1991 when NHS researchers began to involve MHSU in their research, recognising their expertise of living with mental illness and crucially depending on their perspectives to inform service providers (Department of Health, 1998).

In summary, it seems that public opinion challenging the condemnation of people with mental illness was being reflected by changes to legislation. Consequently, MHSU experiences of mental distress are now acknowledged as precise, reliable and authentic (Harper and Speed, 2012), with MHSU pursuing autonomous roles in their communities. It appears that this may not have been the case when the early psychotherapy groups were being developed, as shown in the next section which explores how some early group facilitators documented group process, omitting the involvement of the group members.

### **1.3 Early Foundations of Psychotherapy Groups**

Early psychotherapy group facilitators generally appear to present accounts of group process from a top-down, facilitator-led perspective, without the inclusion of group members' insights into their groups. Many of these accounts pre-date effectiveness measurements as explored below.

The facilitators document longer-term groups meeting regularly, with the same members and without a set agenda, which allowed the group members to explore their relationships, inside and outside the group and with the facilitator (Freud, 1921/1955; Lewin, 1948; Bion, 1959, 1961; Foulkes, 1964).

Freud (1921/1955) suggests that group members initially express ambiguous feelings towards their facilitator, then plan to *challenge* their facilitator's role. Bion (1962, 1967), Spontnitz (1952) and Lewin (1940/1997) suggest that group members bring their everyday-life experiences into the group, which become enacted with

group peers and their facilitator, providing opportunities for insight into relationship difficulties. Brabender and Fallon (2009) comment on the similarity of the psychotherapeutic group theories of Yalom (1975, 1995), Freud (1921/1955), Bion (1959, 1962) and Foulkes (1948/2005, 1964).

Yalom's (1975) facilitator perspective of group processes differs in the introduction of questionnaire data highlighting therapeutic factors objectifying group effectiveness, setting the scene for quantitatively measuring group outcomes. Yalom and Leszcz's (2005) later work proposes quantitative methodologies have limited relevance in group research and they posit *how* a group member makes use of an intervention is more important. This shift suggests that objectifying group experiences and interpersonal interactions with group peers *may not adequately* express how the group is of benefit to the group member. However, it appears that this suggestion to include group members' experiences of their groups has yet to be incorporated into many of the group studies reviewed below.

## **1.4 Review of Therapy Group Research**

A search of group research revealed mainly quantitative studies targeting brief interventions for specific diagnoses, with few qualitative group studies. There was also an absence of qualitative studies of longer-term therapy groups, which are the focus of the present study.

### **1.4.1 Introducing the review**

This review will highlight that current quantitative therapy group research generally focuses on measuring the effectiveness of different interventions, using a variety of quantitative measures of mood, function, symptoms, suicidality and self-harm. Some measures involve group members' self-reports and others are rated by the researchers. The few qualitative group studies mainly present group members' experiences of using the group interventions. In addition, MHSU case study accounts of living with severe and enduring mental illness contribute personal experiences and therefore will be included in the review. The review includes group studies which are empirical, peer-reviewed and recent since they can offer up-to-date analysis of therapy groups.

## 1.4.2 Inclusion criteria

The review includes studies which met with the following criteria.

### 1.4.2.1 Geographic area

Therapy group research has been generated from many different professional perspectives (including sociology, neurobiology, nursing, occupational therapy, psychiatry and psychotherapy) which inform Counselling Psychologists about evidence-based practices when working with therapeutic groups targeting interventions for specific diagnoses or a particular therapy. Many empirical group studies have geographic origins in Europe and North America, on which this review will focus, since research suggests these areas share common mental health treatment and legislation roots with the United Kingdom (Fistein, Holland, Clare and Gunn, 2009).

### 1.4.2.2 Defining severe and enduring mental illness

Much therapy group research focuses on individuals who have been given diagnoses of psychosis, schizophrenia, personality disorders or bipolar affective disorder which are defined as severe and enduring mental illness (Hicks, Deane and Crowe, 2012) and are the focus of this review. Diagnosis is discussed below.

### 1.4.2.3 Facilitated groups

Much research features facilitated therapy groups. Research by Bright, Baker, and Neimeyer (1999) proposed that group facilitators could have positive effects on group outcome. Group facilitators Yalom (1975); Freud (1921/1955) and Foulkes (1948/2005) propose that the root of psychological change in groups could depend on the therapeutic alliance between the facilitator and the group member. Bion (1959, 1961) suggests that as group members experience containment by their group facilitator they develop self-awareness and become able to identify and process their feelings. Taking account of these findings suggests that facilitators could impact on the group member's experiences of their group and therefore this review will focus on facilitated group research.

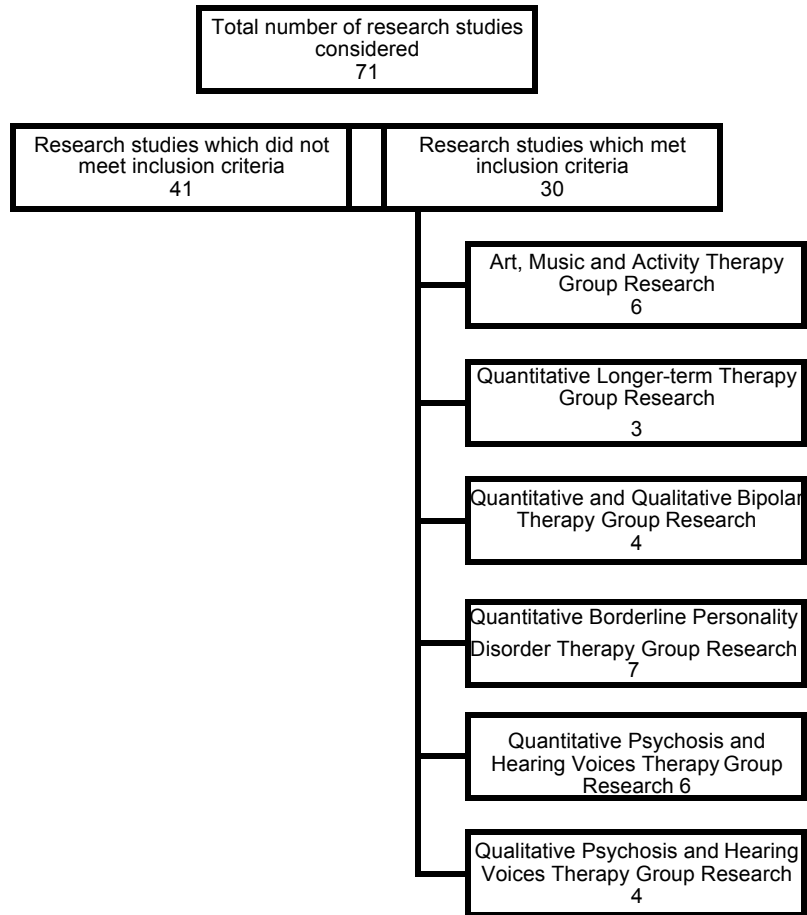
### 1.4.3 Exclusion criteria

Research has been excluded from this review if it consists of individual therapy, or if it involves un-facilitated, peer-led and self-help groups, or if the group research includes in-patients. Primary care group research has been excluded since it omits severe mental illness as defined above. The review begins with an overview of the different types of therapy group studies.

### 1.4.4. Introducing empirical therapy group studies

Seventy-one therapy group research studies were considered and thirty met the inclusion criteria and have been reviewed below (see Figure one). The reviewed therapy group research explores the effectiveness of different group interventions including: art, music, activities, Mentalisation-based, problem solving, CBT, Mindfulness, person-based, open-ended, psychodynamic, Dialectal Behaviour Therapy (DBT), brief DBT skills training and Schema-focused and Systems Training for Emotional Predictability and Problem-Solving (STEPPS). In addition, MHSU research collaborations, case studies and insight into living with mental illness have been included to offer depth of understanding about severe and enduring mental illness. Table one in Appendix 1 illustrates the limitations, findings and method of the thirty therapy group studies reviewed.





**Figure One: Analysis of the therapy group research studies that were considered and reviewed**

The review begins by considering each type of therapy group research in turn beginning with art, music and activity group research.

#### 1.4.5 Groups for people with severe mental illness

This section considers the contributions of art, music and activity group interventions for people with severe mental illness. Table one in Appendix 1 details their key research limitations, findings and method. Overall, the art, music and activity research suggests participants' well-being improves following the groups. Six studies met the criteria. Two of these studies are explored below which highlight questions over their apparent lack of attention to reliability and validity.

Crawford, Killaspy, Barnes, Barrett, Byford and Clayton et al.'s (2012) quantitative randomised controlled trial (RCT) of art therapy and activity groups for schizophrenia suggests there were no improvements to symptoms or function. The study lacks measures of suicidality or self-harm. Conversely, facilitators were asked not to explore participants' thoughts and feelings during the research, which could be considered an unaddressed design confound. Furthermore, Crawford et al. (2012) suggest the attrition rate of 32% was related to the participants' lack of motivation; yet the participants may have become disengaged by their facilitators' lack of response, raising questions about the study's validity and the proposal that such groups are unlikely to improve outcomes.

Moving to music therapy research, Etoile's (2002) quantitative study of six sessions of music therapy for severe mental illness involved listening, creating and improvising music and suggests anxiety decreased and social relationships increased. It is unclear whether the participants' increased social relationships emerged within or outside of their group. Etoile (2002) does not cite the theoretical basis for her methodology; utilising questionnaires designed herself, for which the construct validity and reliability are unclear. Potential confounds such as the dual role of group facilitator and researcher appear unaddressed, raising questions about the integrity of the findings.

Overall, some activity groups for severe mental illness highlight improvements to well-being but unchanged symptoms and function, and generally it appears unclear whether improvements emerged as a result of attending a group with peers or from the activity itself. Some activity studies lack validity and the review continues with talking therapy studies utilising quantitative measures with established validity, in order to explore how the measures have been used.

#### 1.4.6 Introducing talking therapy group research

Finlay (1997, p.232) differentiates activity groups as having a 'task and social' function, from talking therapy groups which she suggests have a 'communication and psychotherapy' focus on one's relationships and managing one's distress. Finlay (1997) suggests talking therapy groups differ depending on the interactions with the facilitator and share commonality in *stimulating change* and creating opportunity for inter-group *social relationships*.

Empirical quantitative group research is often top-down, researcher-led, with the aim of producing replicable, generalisable findings. Research integrity depends on the outcome measures fitting the purpose of the study. Some measures lack sensitivity and this is discussed below. Parkinson (2007) critiques quantifying data, and one could suggest that quantitative findings may not reflect group members' concerns or participatory experiences or the process of engaging with group peers. Next the review focuses on a longer-term talking therapy group study to explore how the researchers use quantitative measures.

#### 1.4.7 Qualitative empirical findings from longer-term therapy groups

Longer-term psychodynamic therapy groups differ from the diagnosis-specific groups, often consisting of individuals who have received a range of severe mental illness diagnoses, focusing on relationships and feedback from one's group peers and the facilitator with the sessions not following a manualised protocol. The search revealed three quantitative studies (see Table one, Appendix 1) exploring longer-term therapy groups lasting around eighty sessions and sharing commonality in their reported improvements to symptoms and function. The review will focus on one of these, which has been selected because of its claim that 60% of the group

members recovered, in order to explore how quantitative measures were used to make this suggestion.

Tschuschke, Anbeh and Kiencke's (2007) quantitative meta-analysis of forty longer-term psychodynamic groups lasting around 80 sessions involved participants who have been given a range of differing severe mental illness diagnoses. The session content was not manualised, being fluid and depending on the concerns and issues the group members discuss, which could limit the transferability of findings. Using the Global Assessment of Functioning (GAF), the Symptom Checklist, the Reliable Change Index and the Inventory of Interpersonal Problems the researchers suggest that 60% of the group members recovered with no remaining mental illness symptoms; however, how the suggested asymptomatic recovery is experienced by the group participants has not been explored. The researchers therefore offer a top-down appraisal of how recovery might be quantitatively assessed, raising questions as to how the process of recovery might appear to the participants themselves and lacking the participants' perceptions of whether or not they have experienced recovery. Tschuschke et al. (2007) suggest equal benefits for individuals with and without a diagnosis of personality disorder. The researchers did not measure whether group benefits endured over time. The present search has not identified any qualitative empirical studies of longer-term talking therapy groups which are the focus of the present study.

In summary, the suggestion of recovery is encouraging; although Tschuschke et al. (2007) have yet to corroborate quantitative recovery scores with the service users' perceptions of their recovery, which remain obscured. These longer-term therapy groups are closer to the type of groups attended by the participants in the present study. The review now turns to the main body of quantitative group research which presents manualised interventions targeting specific diagnoses in order to consider the impact of qualitative and quantitative findings from bipolar affective disorder therapy groups.

#### 1.4.8 Empirical findings from bipolar disorder therapy groups

The search revealed four studies (see Table one, Appendix 1) focusing on brief mindfulness interventions which shared commonality in suggesting that bi-polar

symptoms (where measured) remained unchanged with improvements to mood following the group. However, the qualitative study differed in presenting participants' experiences of using the intervention. The review focuses on two bipolar studies to consider the impact of the methodology on the findings produced. Quantitative research focusing on an eight session mindfulness-based cognitive therapy (MBCT) group for bipolar disorder by Weber, Jermann, Gex-Fabry, Nallet, Bondolfi and Aubry, (2010) indicates no symptom reduction, but reduced anxiety and depression measured using the Beck Depression Inventory (BDI-II) which is discussed below. Moreover, how mood improvements are experienced by the group members is not revealed. Weber et al.'s (2010) study lacks consideration of the 65% attrition, or that three of four quantitative measures are completed by researchers, perhaps raising questions about how accurately the participants' views are represented.

Chadwick, Kaur, Swelam, Ross and Ellett's (2011) qualitative thematic analysis of an eight session MBCT group for bipolar disorder suggests the participants' integrated mindfulness into their lives, developing self-acceptance. The researchers suggest participants adapted their mindfulness practice to help them manage mood fluctuations, finding mindfulness more challenging when they were experiencing depressed mood. In contrast to Weber et al.'s (2010) quantitative analyses, Chadwick et al.'s (2011) study illuminates the participants' reflections about *how* the intervention was used to modify symptoms, and what mindfulness means in their lives. Moreover, in Chadwick et al.'s (2011) and Weber et al.'s (2010) studies the researchers recruited participants experiencing euthymic or low mood and it remains unclear how the group intervention might be utilised when high mood is being experienced. Spermon, Darlington and Gibney (2010) posit that researchers' exclusions can mean findings have limited transferability to other services. Neither study measured the endurance of group benefits. Furthermore, both studies focused on the intervention and are unable to differentiate which benefits arise from attending the group with peers or from the intervention or a combination of both.

In conclusion, the studies differ in their methodologies, influencing whether the researchers foreground the effectiveness of the intervention in improving mood and anxiety as opposed to *how* the skills make a difference and have meaning for the participants. Furthermore, both studies share an approach to bi-polar affective

disorder which encourages service users to become more accepting of their symptoms to help them live with their particular experiences of severe mental illness. However, it remains unclear whether change emerged from learning mindfulness or from the involvement with a group of other service users who may have had similar experiences. The review continues with consideration of the findings from personality disorder group research where the researchers use a variety of quantitative measures to suggest the effectiveness of different interventions of varying lengths.

#### 1.4.9 Quantitative empirical findings from borderline personality disorder therapy groups

The search revealed seven studies (see Table one, Appendix 1) focusing on personality disorder group interventions which shared commonality in suggesting that symptoms, mood and function (where measured) improved following the interventions. There appears to be disparity between the interventions offered, the number of sessions, which effects are measured and whether the measures themselves have sufficient sensitivity. The review will focus on four of these studies of borderline personality disorder group interventions which have been selected to highlight how researchers choose to measure different effects, and their struggle to quantify the effects of attending a group with other service users.

A one year RCT with one year follow-up has quantitatively measured manualised DBT for borderline personality disorder (Linehan, Comtois, Murray, Brown, Gallop, Heard et al., 2006). This consisted of group skills training and twice-weekly individual therapy and suggested improvements to symptoms and mood, and effectiveness in reducing suicidality by 50% and in reducing the use of crisis services, when compared to a control of undefined individual therapy. It appears the DBT participants received over three hours of group and individual therapy weekly as opposed to the hour of individual therapy for the control. The researchers note their difficulty in collecting the suicidality measures as 15% of their participants refused to complete the Suicide Attempt Self-injury Interview, the Reasons for Living Inventory and the Suicidal Behaviours Questionnaire, perhaps suggesting the participants perceived the task as onerous or perhaps they felt ashamed, aspects which do not appear to have been considered by the researchers. The researchers dealt with the refusal by omitting those participants' scores, which could raise

questions about their suggested findings. Furthermore, Spermon et al. (2010) critique self-report measures suggesting they cannot directly assess individual qualities of every mental illness. Linehan et al. (2006) did not measure the endurance of benefits, nor consider whether the impact of attending a group with one's peers for two years may have contributed to the group's effectiveness.

A RCT quantitative study investigating Systems Training for Emotional Predictability and Problem-Solving (STEPPS) for borderline personality disorder combined twenty manualised sessions of group cognitive therapy with DBT skills training and twice weekly individual therapy (Blum, John, Pfohl, Stuart, McCormick, Allen et al., 2008). The effects were compared with treatment as usual (undefined weekly individual therapy) and the researchers suggest that symptoms, function and mood improved (measured using the BDI-II), with unchanged suicidality and unchanged self-harm following the intervention (Blum et al., 2008). Enduring benefits were measured after a year. Unusually the researchers suggest that attending a group with peers may offer additional benefits such as 'social support, hope and therapeutic alliance' in addition to the measured outcomes, perhaps suggesting that additional in-group effects may contribute to group effectiveness, despite their being inadequately addressed by the quantitative measures (Blum et al., 2008, p. 476). It appears that where unexpected effects arise within groups the pre-determined quantitative measures may not offer sufficient flexibility to capture the participants' experiences.

Farrell, Shaw and Webber's (2009) RCT of a thirty session schema-focused group therapy for personality disorder compared to undefined individual treatment as usual, suggests improvements to symptoms and function measured using the Borderline Symptom Index, Symptom Checklist, Diagnostic Interview for Borderline Personality Disorders and GAF. The researchers omit suicidality measures and therefore this aspect of comparability between different interventions is reduced. The study involves women participants which reduces the transferability of findings in some settings. Farrell et al. (2009) suggest 94% of their participants no longer meet the criteria for personality disorder according to their quantitative measures. However, the suggestion of recovery has not been corroborated by seeking the participants' perspectives of the changes emerging from their group. This was also the case with Tschuschke et al.'s (2007) suggestions of recovery following the longer-term groups. Farrell et al. (2009) suggest that group participants reduced

their self-hatred as a result of the intervention, and although this perspective is not reflected within the quantitative measures, it perhaps suggests that participants' were developing acceptance of living with their mental illness symptoms. Chadwick et al.'s (2011) findings also suggested participants appeared more accepting of their situation following the bi-polar group intervention. Farrell et al. (2009) do not consider whether the participants' reduction in self-hatred may have contributed to the group's effectiveness. The study highlights the apparent difficulty for researchers in quantifying the changes in the participants' self-perceptions following the group, particularly when such changes are unexpected.

Soler, Pascual, Tiana, Cebria, Barrachina and Campins' (2009) quantitative RCT compares thirteen sessions of manualised group skills-training for borderline personality disorder, with standard group therapy and suggests improvements to symptoms, anger, irritability, anxiety and depression (measured using the BDI-II) for the skills group participants. Soler et al. (2009), like Blum et al. (2008), suggest self-harm and suicidality remains unchanged. Unfortunately the study's 34% attrition was not followed-up with researchers somewhat dismissively suggesting their absence might be due to medication changes. The endurance of benefits was unmeasured. Soler et al., (2009, p.357) conclude evaluating group effects was compounded by the difficulty in assessing participants' 'active intervention' whilst in their groups, perhaps suggesting that how the group intervention is used or becomes integrated by participants is inadequately addressed by the quantitative measures. Spermon et al., (2010) suggest the *impact* of the therapeutic alliance and therapeutic *process* should be validated by researchers in order to gain awareness of the effectiveness of group therapy.

These four studies highlight how the differing group interventions for borderline personality disorder with or without individual therapy, with varied numbers of sessions and session content, and where a variety of quantitative measures have assessed different benefits can make it difficult to compare the interventions. Blum et al. (2008) suggest additional in-group benefits emerge from attending the group with peers although these effects do not appear to be reflected by the quantitative measures. Farrell et al. (2009) suggest that participants' reduced their self-hatred following the group; however, this was not captured within the quantitative measures. Soler et al. (2009) raises awareness that the quantitative measures do



not acknowledge the quality of participants' interventions whilst in their group. The studies illustrate how different effects are measured and that there appear to be limitations in quantitative measures reflecting the participants' experiences of attending their groups. Having explored the findings from personality disorder group interventions, the review now turns to consider two quantitative measures which have been widely used in order to consider whether the researchers' choice of measures could potentially limit findings and obscure the nuances of in-group effects highlighted by Blum et al. (2008) and Farrell et al. (2009).

#### 1.4.9.1 Outcome measures in quantitative group research

Many group studies have used the Beck Depression Inventory (BDI-II). However, its use with participants who have severe mental illness may lack content validity. It has been suggested the BDI-II may not differentiate single-episode depression from persistent or severe, complex depression (Beck, Steer, Ball and Ranieri, 1996). The reviewed research in Table one (Appendix 1) using the BDI-II includes Bateman and Fonagy, (2009); McLeod et al., (2007); Dijk et al., (2013); Williams et al., (2008); Weber et al., (2010); Soler et al., (2009); and Blum et al., (2008), raising questions as to the validity of these studies, and whether the use of a somewhat insensitive quantitative measure challenges the integrity expected of these studies and is potentially a limitation.

The Global Assessment of Functioning (GAF) scale is completed by *researchers*, who numerically rate participants' functioning; perhaps raising questions about how accurately a third party could express the participants' perceptions of their situation or perhaps suggesting the measure is considered too complex for participant use. The reviewed research in Table one (Appendix 1) using the GAF includes: Crawford et al., (2012); Gajic, (2013); Farrell et al., (2009); Bateman and Fonagy, (2009); Tschuschke et al., (2007); Lorentzen et al., (2005); Wilberg et al., (2003); and Barrowclough, Haddock, Lobban, Jones, Siddle, Roberts et al., (2006). Where the GAF has been used, the participants' own perceptions of their functioning has not been elicited, yet this could illuminate whether or not there are any outcome similarities between the researcher rating and the participants' experiences, and could reveal any additional benefits the participants notice from attending their group.

Williamson and Clarke's (2012) meta-analysis of quantitative outcome measures posits that quantitative studies each measure different things, and therefore outcomes lack equivalence and do not lead to improved service provision. Within this review there are examples including Blum et al. (2008) and Soler et al.'s (2009) studies which lack comparability with Linehan et al.'s (2006) findings, and therefore it remains unclear whether non-standard brief DBT interventions offer equivalent benefits to standard DBT lasting a year. Jacobs' (2009) meta-analysis of outcome measures suggests that the nineteen outcome measures used in quantitative studies result in incomparability and she proposes consulting *users* of therapy groups about their perspectives, an approach that will be foregrounded by the present study. The review now turns to explore the largest body of studies which focus on hearing voices groups. It begins with quantitative findings, in order to consider how researchers explore group effectiveness and present additional effects arising from attending a group with one's peers which other studies have struggled to capture.

#### 1.4.10 Quantitative hearing voices groups

Hearing voices groups appear to have generated the most interest from researchers. The search revealed six quantitative studies of hearing voices group interventions (see Table one, Appendix 1). In three studies the researchers highlight only the findings illustrated by the quantitative measures. However, in the other three quantitative studies, which will be explored, the researchers highlight how attending a hearing voices group with one's peers could offer the advantage of peer support to adapt and use the group intervention, in addition to the social benefits which are highlighted by the quantitative outcome measures.

A quantitative study exploring a thirteen session CBT group for psychosis suggests that social isolation decreased after the intervention; nonetheless, the findings are unclear as to whether this was due to social relationships increasing *inside* or *outside* the group and whether the intervention, *or* attending the group with others, or both factors improved sociability (Landia, Silverstein, Schwartz and Savitz, 2006). Landia et al. (2006) report that their participants experienced reduced auditory delusions and reduced delusional distress and were able to dismiss delusional thoughts having observed group members *challenging each other's delusional beliefs*. However, these peer group effects appear inadequately reflected by the

quantitative measures and it remains unclear which aspects of group effectiveness arose from the intervention and which from the peer group relationships.

A quantitative analysis of an eight session CBT group for voice hearers suggested reduced voice hallucinations and reduced voice omnipotence and an increased control of voices emerged as a result of the intervention (Chadwick, Sambrooke, Rasch and Davies, 2000). The researchers note 14% of participants declined to complete the quantitative measures (the Hospital Anxiety and Depression Scale and the Topography of Voices Rating Scale), perhaps suggesting they found them onerous or intrusive. Chadwick et al., (2000) document a post-group interview consisting of pre-determined questions and, although they omit their method of interview analysis, the researchers highlight that group members shared insight and supported each other in challenging their voices. In common with Landia et al.'s (2006) findings these in-group processes appear under-represented by the quantitative measures, which perhaps inadequately represent the complexity of experiences within groups. Moreover, the researchers suggest that in-group processes may contribute to the group's effectiveness. It remains unclear which aspects of group effectiveness arose from the intervention and which from the peer group relationships.

A quantitative RCT of a seven session manualised CBT group for voice hearers suggested group members' self-esteem and social behaviours increased and were maintained for six months after the group (Wykes, Hayward, Thomas, Green, Surguladze, Fannon et al., 2005). This research adds to existing knowledge of groups by highlighting that voice hallucinations remained unchanged unless facilitators are trained, experienced and supervised in CBT. Rivera and Darke (2012) suggest that although interventions may be manualised they can be delivered in non-standardised ways, and tailored to the group members' needs, perhaps offering support for Wykes et al.'s (2005) findings. Wykes et al. (2005, p.208) propose 'effects within groups' such as group members' peer relationships promote change and reduce social isolation, perhaps suggesting that group effects may be more complex and nuanced than reflected by the quantitative measures. The study is unable to determine which aspects of the group members' voice hearing re-attributions emerged from the group intervention and which from the contact with group peers.

In summary, these quantitative studies appear to illustrate a shift away from reducing psychosis symptoms, towards helping individuals challenge, re-appraise and experience intrusive symptoms less fearfully. The new understanding includes awareness that facilitator training, experience and supervision can positively impact on the intervention's effectiveness (Wykes, et al., 2005). Hearing voices groups tend to consist of differing numbers of sessions and measure different aspects of voice hearing including coping strategies, relationship with voices and self-esteem, perhaps reducing their comparability. Researchers suggest that attending a group with one's peers enhances the effectiveness of the intervention and contributes to the group members' re-appraisal of their symptoms. Moreover, the quantitative studies remain unclear as to which benefits emerge from using the intervention and which from sharing experiences with group peers, suggesting effectiveness could arise from a combination of both factors. One way to further explore the shared experiences of attending groups could be to focus on qualitative hearing voices studies to consider their commonalities and differences in presenting group effectiveness and the effects of in-group peer support and it is to these studies that the review now turns.

#### 1.4.11 Qualitative empirical findings from hearing voices groups

By way of introduction, qualitative group studies are often inductive, exploratory and bottom-up with the participants' expertise being acknowledged. They differ from quantitative studies, often engaging smaller participant groups and their ideographic findings may or may not be transferable to other settings. The studies share commonality in suggesting participants re-appraise their voices so that the voice intrusions are perceived as less distressing. The search revealed four qualitative hearing voices group studies and three have been selected that illuminate the participants' perceptions of their group's effectiveness, and in particular how the participants use and integrate the intervention into their lives and how the effects of attending a group with one's peers appear to contribute to the group's effectiveness.

Thematic analysis has been used to qualitatively research a twelve session person-based cognitive therapy group for distressing voices, consisting of mindfulness and Acceptance and Commitment Therapy (ACT), (May, Strauss, Coyle and Hayward, 2014). The researchers used semi-structured individual interviews and participants described what it *means* to them as their self-esteem and social relationships

improve and *how* they begin to distinguish positive aspects of themselves, as they perceive their voice hearing as less dominant. This emerging new understanding has been harder to discern from quantitative studies, relying on researchers' observation and post-group interviews. The researchers consider how 'non-specific group factors' which are undefined but may include the experience of being in a group, socialising with group members, and perhaps feeling understood by others who share similar perspectives, may contribute to the group's effectiveness (May et al., 2014, p.17), highlighting commonality with Chadwick et al.'s (2000) and Landia et al.'s (2006) suggestions.

Grounded theory qualitative researchers explored the experiences of attending an eight session mindfulness therapy group for distressing psychosis (Abba, Chadwick and Stevenson, 2008). The findings highlight participants learning to decentre and consider their voices from an alternative perspective, and changing their voice hearing attributions. The researchers suggest that participants supported each other during the 'group process' and that this *and* the intervention jointly contribute to the group's benefits (Abba et al., 2008, p.85). The study offers the immediacy of the participants' utterances, directly expressing their relief as they experience a reduction in the domination of their voice hearing, drawing the reader into their group experiences. The researchers highlight that the participants' views contradict case report findings that meditation could exacerbate psychosis symptoms (Yorston, 2001) with this qualitative study offering insight and awareness into *how* the participants' adapted and changed their relationship with their voices, which appears harder to discern from some quantitative studies.

Focus groups were used to elicit discussion about the experience of attending an eight session person-based cognitive therapy group for distressing voices, consisting of mindfulness and ACT, which suggested the emotional demands of voice hearing could be diminished by group discussion with peers who have similarly experienced voice hearing (Goodliffe, Hayward, Brown, Turton and Dannahy, 2010). Emerging themes suggest the participants are constantly managing their stress and negative emotional reactions to voice intrusions and that social isolation can arise from voice hearing. Additionally, the focus groups revealed that participants regarded their group as a safe place in which to explore their negative self-appraisal, developing a sense of group coherence in which they

accommodated and challenged their voices with the support of group peers, perhaps illustrating a mechanism of change in this group. The researchers posit that the in-group relationships contribute to the effectiveness of the mindfulness intervention (Goodliffe et al., 2010).

In conclusion, the three qualitative studies differ from the quantitative group studies in focusing on what the interventions mean to the participants and how they use and integrate the intervention into their lives to moderate aspects of their voice hearing. The studies contribute new awareness to the field about how potential mechanisms of change may become enacted within groups. Both qualitative and quantitative studies highlight that the experience of being part of a group with peer support appears to be an important aspect of group therapy, seemingly contributing to the effectiveness of the group and in helping the group members integrate and use the intervention. Nonetheless, despite the volume of group studies, aspects of group effects remain somewhat elusive. The present study could offer new awareness of the processes experienced within groups by foregrounding service users' perspectives.

It has been suggested group processes could be complex to research, requiring awareness of the facilitator's attributes and relationships with each group member, the group member's peer relationships, the group's features and the integration of aspects of the group into the group members' lives (Miles and Paquin, 2013). Current studies seemingly target the group's features, and the facilitators attributes with less research focusing on the qualities of the group members' peer relationships, or the integration of the group experiences into the participants' lives. The early top-down facilitator-led case studies highlighted group processes but excluded group participants' perspectives (Lewin, 1948; Foulkes, 1948/2005; Spontnitz, 1952; Bion, 1961). The present study will shift the focus to bottom-up; exploring the group member's perspective of their group and the experiences it offers, perhaps offering awareness of peer group relationships and the impact of peer support. Service users' accounts of living with mental illness can offer specific insight into managing symptoms and negotiating obstacles and the review now turns to consider the impact of MHSU case studies and collaborative research and the perspectives they present.

#### 1.4.12 Case studies and research

MHSU research collaborations and published case studies have focused professional awareness on their *individual* experiences of living with mental illness, perhaps changing mental health professionals' perceptions (Wallcraft, Schrank, and Amering, 2009; Campbell, 1985; Rose, 2001). Unhelpful paradigms suggesting MHSU may be difficult to reach and withdrawn from society (Tait and Lester, 2005) have been overturned by the publication of *On Our Own Terms* (Wallcraft, Read and Sweeney, 2003) which documents MHSU facilitating groups; initiating peer-support and advocacy networks for newly diagnosed individuals; and providing training and education to mental health professionals.

Rose (2001); Faulkner and Layzell (2000) and Sweeney (2009) document their traumatic experiences of being sectioned and diagnosed with a mental illness and Read (2005); Trivedi and Wykes (2009) have informed the field about withdrawal from psychotropic medication. Heller, et al., (1996) and Reynolds et al., (2009) illuminate their unique experiences of living with a severe and enduring mental illness. Pitt, Kilbride, Nothard, Welford and Morrison's (2007) research involved MHSU as interviewers, and their findings suggested that individualised care and peer access to other MHSU could be beneficial, offering support for the positive experiences of shared social relationships noticed by some researchers. Drury, Birchwood, Cochrane and Macmillan's (1996) research suggests reduced symptoms could be linked to mental health recovery. However, Rapp and Goscha's (2006) findings differ suggesting recovery can be related to increased control and to the re-appraisal of symptoms. Davidson, Schmutte, Dinzeo and Andres-Hyman (2007) challenge these findings, suggesting that living purposeful lives becomes the focus of individuals' recovery from severe mental illness.

As voice hearers, Romme (2011); Chadwick (1997); Chadwick Sambrooke, Rasch and Davies (2000) and Coleman (2014) offer insights and strategies into living with hearing voices, offering support for Wykes et al.'s (2005) findings focusing on re-attribution rather than removal of symptoms, and in challenging fears and stigma to promote acceptance and awareness in the field. MHSU document stigmatising experiences within public services where they have received treatment (Fisher, 2001). Most importantly, MHSU research is acknowledged as informing practice by policy makers (Grove, Lockett, Shepherd, Bacon and Rinaldi, 2009; Oliver, 2002).

In summary, understanding from MHSU research and case studies could inform the field via unique individual perspectives of severe mental illness: offering support for empirical findings which highlight the value of social relationships for MHSU in reducing isolation and the impact of symptoms, and in contributing valuable insights for professionals and carers, and in driving policy. However, the search has highlighted an absence of MHSU group experiences which the present study will foreground.

#### 1.4.13 Conclusions from therapy group research and case study findings

Overall, therapy group research integrity could be improved by defining the theoretical foundations: of the study methodology, the intervention and control, and in considering reasons for attrition and measuring the endurance of benefits. Facilitator training, experience and supervision could improve therapy group effectiveness (Wykes et al., 2005) and re-appraisal of mental illness symptoms (not just symptom reduction) could have a positive impact on managing symptom intrusion (Landia et al., 2006; Chadwick et al., 2000). A body of research highlights that benefits from attending groups with peers sharing similar experiences may be inadequately reflected by quantitative measures and yet researchers suggest these group effects may improve the integration and effectiveness of an intervention (May et al., 2014; Abba et al., 2008; Goodliffe et al., 2010). It appears that qualitative group studies could contribute awareness of *how* interventions are used and integrated into the participants' lives and highlight how therapy groups may offer potential mechanisms for change. Nonetheless, the group processes which encourage these changes remain relatively unexplored and therefore the present study aims to offer awareness to the field about this aspect of therapy groups.

The present study aims to explore group peer relationships and the experiences of attending a therapy group from the perspectives of the service users, complementing existing awareness by giving a voice to group members, validating their understanding and consulting them as experts in living with mental illness. One way to contextualise service users' experiences of mental illness is to consider the impact of social construction on the meanings associated with mental illness and it is this that the review now considers.



## 1.5 Contextualising Mental Illness

### 1.5.1 Social construction of mental illness - Meanings co-constructed between speaker and listener

Hepburn (2008) suggests social construction includes situations where 'judgements are bound up with assumptions' (Hepburn, 2008, p.124), proposing that unconscious meanings could influence speakers and listeners framing and shaping mental illness values and sentience. Weedon (1987) posits that social construction acknowledges that the meaning of language describing mental illness is a dynamic co-construction between the speaker and listener, depending on their place, time, context and intention. Rogers and Pilgrim (2010) suggest that mental illness is not a definite, fixed or definable entity, more a continuum of dynamic and fluid symptoms assumed by the social construction of the concept of mental illness. Lucey (2007) proposes language is not neutral and always has an active function and that the *function* of language relates to the *construction* element (Lucey, 2007). Thus seemingly hidden views of mental illness may constantly evolve and imperceptibly influence how mental illness becomes conceptualised.

Key to the social construction view of mental illness is that psychiatry occupies a seemingly powerful role, which could be moderated by other mental health professionals or people with a mental illness (Rogers and Pilgrim, 2010). Central to Rogers and Pilgrim's (2010) perspective is that 'external social reality impinges on human action and shapes human consciousness', and therefore subtly influences and defines mental illness (Rogers and Pilgrim, 2010, p.17). Lucey (2007) suggests that the impact of social construction on mental illness can only be fully understood within the context of the time and place in which it is situated.

Szasz (2010) suggests that mental illness is a concept, which depends entirely on where one subjectively positions mental illness on a wellness-illness continuum. Szasz (2010) posits that mental illness symptoms may not always gradually deteriorate until a person is unable to function, and that an individual's symptoms may also become less intrusive, perhaps interfering less in their lives.

### 1.5.2 Mental health and social factors

Research correlates mental illness with isolation, poverty, poor physical health and an impoverished, unsupportive social environment (Faris and Dunham, 1939; Goffman, 1963). The findings could perhaps indicate a growing awareness that mental illness could be intensified by social deprivation. Laing (1960, 1961) and Linehan (1993) propose that a respectful, containing social environment could positively impact on mental illness symptoms, modifying distress. The Social Exclusion Unit (2004) more recently suggested people with mental illness are still the most socially isolated.

### 1.5.3 Mental illness effects

The distress of mental illness could contribute to some people self-harming and taking their own life. Beresford (2010) suggests that this could be avoided, if individuals experiencing mental illness are engaged in external commitments although he does not specify how this might be encouraged. In the UK, 6,045 adults (0.01% of the population) committed suicide in 2011. Around seventy million working days are lost annually due to mental illness (Donnelly, 2014). Mind (n.d.) suggest that 25% of the population experience mental illness annually (including anxiety, depression, OCD (obsessive compulsive disorder), panic, phobia, PTSD (post-traumatic stress disorder) and eating disorders); conversely, this figure excludes severe and enduring mental illness. It has been suggested severe and enduring mental illness involves a further 3% of the population (Coid, Yang, Tyrer, Roberts and Ullrich (2006); Perala, Suvisaari, Saarni, Kuoppasalmi, Isometsa, and Pirkola (2007), although the figure is likely to be higher because prison and hospital populations have been omitted.

### 1.5.4 Mental illness and trauma

Numerous research studies have suggested a link between trauma, such as physical, emotional or sexual abuse, and mental illness, with some researchers highlighting that early-life trauma could contribute to mental illness and a disruption to one's sense of identity (Goodman, Rosenberg, Mueser and Drake, 1997; Davidson and Strauss, 1992; and Gunn, 2009); unfortunately, interventions that may diminish trauma effects are not suggested. Rogers and Pilgrim (2010) propose

that the self becomes fragmented during mental illness without offering clarification about how this process occurs. Conversely Frankl (1963) suggests how trauma is appraised affects how it becomes assimilated into life experience, perhaps suggesting that individual differences rather than the intensity of the trauma experience contribute to trauma processing.

There are suggestions that mental illness may have a detrimental effect on physical health, perhaps clouding clinical judgement regarding treatment options (Rethink, 2013). Major, Mendes and Dovidio (2013) highlight a link between people who have faced mental health discrimination and higher incidences of cancer, cardiovascular illnesses, stress and depression; moreover, it remains unclear whether these illnesses contribute to mental illness, or whether mental illness experiences prompt physical illnesses. In addition, Saleh and Millar (2014) suggest regular physical health monitoring for severely mentally ill individuals to avoid premature avoidable death from physical illness, although they fail to address implementation. Overall, it appears that social construction subtly influences how mental illness is conceptualised, compounding the effects of social deprivation and physical ill-health. The association between stigma and mental illness has also attracted research interest and the review now turns to explore the effects of stigma.

## **1.6 Stigma and Shame in Mental Health – the Loss of Hope**

People who experience mental illness symptoms might hide them because of shame, secrecy and stigma (Byrne, 1997, 2000). It has been suggested that mental illness could undermine and invalidate one's social position, leading to 'hopelessness resulting in helplessness' (Gullekson, 1992, p.12) and whether this could be redressed remains unclear. Mental health stigma has been described as feeling 'outcast' (May, 2009, p.236) and humiliated (Goffman, 1963).

### **1.6.1 Research and stigma**

Phelan, Bromet and Link's (1998) research interviews with relatives of people with mental illness suggests 50% hide their relative's mental illness from others. Ostman and Kjellin's (2002) research suggests that individuals associating with people who

have a mental illness may also be stigmatised themselves. Brugha, Wing, Brewin, MacCarthy and Lesage's (1993) research suggests that individuals with severe mental illness may experience reduced social contact as a result of their stigma experiences. One could surmise how a cycle of withdrawal and increasingly intrusive mental health symptoms could ensue, as suggested by Mind (n.d.) and Rethink's *Time to Change* programme, which encourages isolated individuals who are experiencing severe mental illness to use on-line opportunities to connect socially with other MHSU.

Beresford's (2010) experiences as a MHSU led him to suggest that media bias presents people with mental illness as weak, marginalised or dangerous. Research exploring media coverage of violence (Crisp, Gelder, Goddard & Meltzer, 2005) suggests 70% of the public regard people with schizophrenia as violent, even though empirically violence occurs most often among individuals who do not have a mental illness (Walsh Buchanan and Fah, 2002). Unfortunately Walsh et al. (2002) and Crisp et al. (2005) omit discussion of how public opinion might be moderated.

### 1.6.2 Legislation and stigma

The Disability Discrimination Act (1995) includes mental health discrimination. Moreover, the later Equality Act (2010) includes age, race, sex, sexual orientation, pregnancy, gender reassignment, religion, civil partnership, disability, but omits mental illness. Byrne (2000) notes the absence of a term for mental health discrimination and suggests introducing the word 'psychophobic' (Byrne, 2000, p.67) to enable mental illness discrimination to be named, challenged and conceptualised; although the integration and use of the term 'psychophobic' remains uncommon.

### 1.6.3 Social effects of stigma

It has been suggested that stigma leads to individuals losing jobs, homes, and relationships, all of which could compound mental illness symptoms and distress (Byrne, 2000). MacKeith and Burns (2008) suggest individuals with severe mental illness could reduce stigma by joining community activities and relating positively with others; however, they appear to disregard the obstacles to reaching such

goals. Byrne (2000) proposes mental health professionals relate positively to MHSU to enhance their self-belief and promote community involvement, thus engendering opportunities for recovery. Laing's (1960) research suggests that positivity shown to people with mental illness influences their recovery. Unfortunately, neither author includes service users' experiences of such positivity from professionals, and therefore the effects remain unclear. In summary, stigma can have devastating effects on people's lives, work, relationships, recovery and social networks, compounding the effects of mental illness. Many service users have been given a diagnosis naming their mental illness and research has been organised around diagnosis-specific interventions; therefore, in order to contextualise the service users' experiences it is important to consider the debate around mental health diagnosis and this will be the focus of the next section.

## **1.7 Problems of Mental Health Diagnosis**

Diagnosis offers a way for mental illness to be named by mental health professionals and commissioners (Szasz, 2010). It has been proposed that diagnostic naming is a construct, suggesting the individual has a generalisable fixed state and will always be like this, rather than embracing an individual's dynamic response to a particular situation (Parker, 1999). It has also been proposed that reliance on diagnoses positions individuals who have a mental illness passively, generalising their needs to 'predict the patient's prospects and the likely effects of treatment' (Bentall, 2004, p.103). Bentall (2004) and Moncrieff (2007) posit that people with the same diagnosis will experience their symptoms differently and that outcomes differ depending on individual factors. Moreover, diagnoses have been used to plan specialised mental health services (Department of Health, 2013-4; NHS Choices, n.d.).

Research suggests psychiatrists could respond negatively towards diagnosed individuals (Lewis and Appleby, 1988), with Byrne (2000) suggesting shared-beliefs could influence professionals in perhaps perceiving the symptoms they expect, and Byrne proposes specific MDT training. Szasz (2010) suggests professionals may disregard social inequality when conceptualising mental illness, perhaps reinforcing shared ideologies and positioning the individual passively.

The British Psychological Society (BPS) (2011) criticised the Diagnostic and Statistical Manual (DSM-V) (2013) authors, suggesting the top-down categorisation of mental illness which lacks service users' views appears to rely on 'subjective judgement' instead of assessing the impact of symptoms on function (BPS, 2011, p.2). Fink and Tasman (1992) illustrate this point listing negative mental health symptom labels observed from their patients' behaviours, including delusions, hallucinations, disorganised speech, suicidality, catatonic behaviour, blunted affect and avolition; and they suggest the existence of symptoms does not indicate *how* they are experienced, or their effect on functioning.

In summary, the debates surrounding mental health diagnosis question the objectification of symptoms as opposed to the effects of symptoms on functioning. Nevertheless, some researchers appear to rely unquestioningly on diagnosis to suggest the effectiveness of a group intervention. It has also been suggested that group effectiveness arises as groups pass through particular stages and the review now turns to explore group theories, beginning with stage theories.

## **1.8 Psychological Group Theories**

### **1.8.1 Stage theory debate**

Psychological stage theories appear to suggest that human behaviour in therapy groups follows a particular pattern. Brabender and Fallon (2009) review stage theories of groups, contrasting MacKenzie's (1997), Wheelan's (1997) and their own stage theory. Each theorist uses specific terms to relate to the suggested stages and there appears disagreement about where the psychological change process takes place, with Bion (1959; 1961) suggesting fluidity between stages and Brabender and Fallon (2009, p.252) concluding rather vaguely that the work stage 'does not establish that it occurs invariably', perhaps alluding to the complexity of groups which appears inadequately represented by the stage theory framework.

### **1.8.2 Group theories**

There are a number of psychological theories about groups. Billig and Tajfel (1973); and Tajfel and Turner (1986) contribute to group theory by discussing the processes

that take place ordinarily when children join social groups at school. Instead of continuing to have a sense of themselves as omnipotent and autonomous, children learn to experience themselves as others see them, forming hierarchies, becoming rivals and resolving conflicts. Learning about oneself in this way seems to be an important process for cognitive and social development, promoting reflexivity and an internalised sense of themselves (Mead, 1934). Bion (1959, 1961) posits that this process could also occur in therapeutic groups, allowing adults to gain a sense of themselves as they appear to others, whilst also developing an inner sense of themselves.

### 1.8.3 Social Learning Theory applied to therapy groups

Social Learning Theory (SLT) suggests that through social contact, observing others, and instruction, individuals could learn new skills and strategies (Bandura, 1977). SLT could be a helpful framework from which to explore social support within therapeutic groups for MHSU. SLT suggests that groups which model supportive behaviours and encourage participants to learn from observing others could be very effective. SLT could therefore enable MHSU's sense of group coherence (Goodliffe et al., 2010) to be understood within the context of their shared experiences and mental illness awareness. Perhaps SLT offers a way of conceptualising the 'non-specific group factors' which appear to complement the effectiveness of groups (May et al., 2014, p.17). It appears that therapy groups for those with severe mental illness may fulfil a key role, which the review now explores.

## **1.9 The Role of Therapy Groups in Alleviating Mental Health Symptoms**

There appears to be considerable demand for psychological therapy. Mind (2013a) suggest 20% of people with severe mental illness wait a year for individual and group therapy. For the purposes of the present study, severe and enduring mental illness is defined according to the Department of Health (1996) discussed below. IAPT (Improving Access to Psychological Therapies) was Professor Lord Layard's (2006) vision of therapy for all, whereby Counselling Psychologists and mental health professionals offer empirically based individual and group interventions to improve psychological well-being and distress (Orlans and Van Scoyoc, 2009), for

primary and secondary care clients (Department of Health, 2012). Quantitative analysis of IAPT outcomes (Clark, Layard, Smithies, Richards, Suckling and Wright, 2009) suggests cost-effective, positive outcomes post-intervention; however the endurance of the benefits was unmeasured. The review focus now narrows to situate the present study.

## **1.10 Situating the present study**

The present study aims to fill gaps in understanding about the experience of attending therapy groups by adopting a participant-led bottom-up perspective. This is approached from a post-modern sceptical stance which could enable some previously unknown and unreachable group experiences to emerge (Willig, 2008), perhaps offering alternative perspectives from which therapeutic groups might be conceptualised and re-evaluated. The researcher acknowledges such awareness could be co-constructed and provisional, being situated in time and place, as Hollway, Lucey and Phoenix (2007) suggest. Langdridge (2007) highlights the apparent link between post-modernism and social construction, suggesting that meaning emerging between people is dynamic, not fixed, and always situated 'somewhere' (Langdridge, 2007, p.50). There is further discussion of the impact of post-modernism on the research in the Methodology chapter below. The review now moves on to discuss the group members and the type of therapeutic groups included in the present study.

### **1.10.1 Defining group members' severe and enduring mental illness**

The group members in the present study have received a diagnosis of severe and enduring mental illness which has been defined as: suffering substantial disability (such as an inability to care for oneself, sustain relationships or work); currently displaying florid symptoms; suffering from a chronic enduring condition; suffering frequent crises leading to in-patient admissions; or whose own or others safety is at risk (Department of Health, 1996). It was suggested that defining severe mental illness contributes to service planning (Mental Health Foundation, 1994, para 1.1).

In 2000, a confounding definition suggested severe mental illness had similarities with other brain disorders: 'any disability or disorder of the mind or brain, whether



permanent or temporary, which results in an impairment or disturbance of mental functioning' (Department of Health, 2000, para 3.3). Moreover, this has been disputed by Rogers and Pilgrim (2010) and Szasz (2010) who suggest the Department of Health (2000) definition confuses mental illness with neurological illnesses and metabolic impairment which have a biological origin. Researchers Lawson, Reynolds, Bryant and Wilson (2014) propose individuals experiencing brain disorders such as acquired brain injury differ to those individuals experiencing severe and enduring mental illness. Thus in the present study, the 1996 definition of severe mental illness will be used.

### 1.10.2 Agenda-led versus agenda-less groups

The review now narrows its focus onto the dilemmas directly relevant to the present study of therapeutic groups. From the research review of therapy, groups appear diverse, mainly consisting of brief, agenda-led, manualised intervention groups which may include psycho-education with a behavioural or cognitive focus, with the longer-term, agenda-less groups perhaps having a psychodynamic focus. Brabender and Fallon (2009) use their experience of facilitating and researching groups to highlight that brief agenda-led groups tend to focus more on conscious content, whereas longer-term psychodynamic therapy groups tend to focus on unconscious communication and the negotiation of relationships *within* the group, with their *facilitator*, and *with themselves*. There appears to be agreement between facilitators that longer-term psychodynamic therapy groups develop group members' self-awareness; and that inter-subjective relationships with group peers could enable group members to become aware of how they appear to others, offering the opportunity to appraise themselves differently and therefore the focus of the present study will be longer-term dynamic therapy groups. (Yalom, 1995; Bion, 1961; and Foulkes, 1948/2005). The therapy groups involved in the present study have no fixed agenda or psycho-educative purpose other than to explore conscious and unconscious issues emerging from group members.

### 1.10.3 Group modality

Another concern is the theoretical underpinning of the therapy groups under consideration. McDermut, Miller and Brown's (2001) meta-analysis proposes equivalent outcomes between CBT and psychodynamic group therapy modalities.

Roth and Fonagy's (2005) and Stiles, Barkham, Mellor-Clark and Connell's (2008) research posits that theoretical modality in individual therapy has equivalent outcomes, therefore it appears that differing therapy group modality in the present research is not expected to be a significant factor.

#### 1.10.4 Numerous facilitated groups

The groups in the present study are facilitated following evidence from Yalom (1995) and Foulkes (1948/2005) suggesting facilitators may have an impact on psychological change in groups. A range of groups are included to avoid producing a review of a specific group or facilitator as Brabender and Fallon (2009) and Arrow, Poole, Henry, Wheelan and Moreland (2004) suggest. Appendix 8 contains information about the different therapy groups participants attended including: time to talk, men's, mixed, women's, and the voice hearer's group.

In summary, the therapy groups included within the present study are evidence-based, longer-term therapy groups following a psychodynamic psychotherapy model, which are facilitated and run by a variety of third sector service providers in different locations. It is intentional that these groups could be considered to have some homogenous characteristics as suggested by Smith Flowers and Larkin (2009). In this study, group homogeneity relates to the groups running for several months and focusing on conscious and unconscious communication and relationships. Participant homogeneity is discussed below. The chapter now focuses on the rationale for the present study.

### **1.11 Reviewing the Research Aims and the Research Question**

It has been suggested that mental health research could focus on 'the most devalued and least documented' MHSU who 'have unique experience, knowledge and understanding to offer' (Beresford, 2010, p.1). It appears that there is a dearth of research accounts of therapeutic group experiences from the perspectives of secondary care MHSU. This research aims to address that absence.

This research will focus on MHSU experiences of therapeutic groups. As a researcher-practitioner I have been involved in facilitating over a hundred and fifty hours of groups, including NHS in-patient, community and NGO groups for primary and secondary care individuals with mental illness, and I would like to discover how being in a therapeutic group is experienced by the group members. I am curious about whether attending a group with other MHSU offers a helpful way of reflecting on and exploring mental health experiences and I am interested in why individuals choose to become part of their therapeutic group with the aim of offering unique novel awareness about therapy group experiences, process, and the sensations and cognitions associated with being part of a group to the field. The research question is: *What is it like to be part of your therapeutic group?*

## **1.12 Summary of Introduction and Literature Review**

Reviewing the historical paradigms shaping beliefs about mental illness exposed negative trends and associations that highlighted the marginalisation and invalidation of people with mental illness. The review captures research from the perspectives of different service-provider and facilitator-led studies, featuring mainly quantitative methodology and includes: art and music therapy groups, groups targeting specific mental illness symptoms, longer-term therapy groups, qualitative therapy group research and MHSU's research collaborations and case studies, combining empirical findings with unique insight into living with severe mental illness.

The research and literature review highlights that some participants rejected completing quantitative measures, perhaps finding them onerous or the questions relating to suicidality and self-harm intrusive. A body of research highlights that group effects could be inadequately addressed by quantitative measures and that group peer support was observed and suggested by post group interviews, with the researchers illustrating how the group members' interactions supported the adaptation and use of the intervention, thus contributing to the groups' effectiveness. Quantitative and qualitative studies focus on the effectiveness of an intervention and the researchers comment that group factors and peer support enhances the integration of the intervention, although these aspects of groups were unexpected and not the focus of the studies. The review reveals an absence of

qualitative studies focusing on service users' experiences of longer-term therapy groups, which will be the focus of the present study. The review contextualises mental illness and explores diagnosis, stigma and group theories highlighting that longer-term groups tend to focus on the inter-subjective relationships of the group members'. The study now turns to the Methodology chapter.



# Methodology Chapter

## 2.1 Introduction

This chapter begins by setting out my epistemological and ontological position in order to explore why I consider IPA to be the most effective methodology to consider the research question: *What is it like to be part of your therapeutic group?* My aim to produce a critical-realist discussion of the experience of being in a therapeutic group is considered. The chapter then considers the strengths and weaknesses of IPA, including the social construction of language in IPA, concluding the first part of the chapter with a rationale for choosing IPA. The second part of the chapter focuses on the method and the research design, including the ethical considerations, and concludes with my reflexivity on the data collection. Finally, the chapter focuses on the analytic procedure, including validity and the integrity of the research, and incorporates an audit of themes and reflexivity on the data analysis to increase transparency. I begin the methodology chapter by discussing my epistemological and ontological position.

## 2.2 Epistemology and Ontological Considerations

Langdridge (2007) defines epistemology as knowledge of 'human nature', (Langdridge, 2007, p.24). McLeod (2007) refers to epistemology as 'natural attitude' (McLeod, 2007, p.49) and Willig (2008) suggests epistemology is about 'how can we know?' (Willig, 2008, p.13). Defining my epistemological perspective offers an explanation of my assumptions and suggests a framework for the way knowledge is produced by this study.

Ontology is defined as 'what is there to know?' (Willig, 2008, p.13) incorporating the assumptions one makes about the world. As a counselling psychologist I am interested in how people make sense of the world and in this study I am exploring how MHSU experience their groups and how they regard themselves within the world.

Positivist researchers use quantitative methods to objectify and measure data, so that results can be compared. It is generally assumed that the results represent a truth. In psychology many randomised controlled trials (RCT) rely on positivist epistemology and the National Institute of Health and Clinical Excellence (NICE) (2007) supports the implementation of RCT to compare outcomes. One advantage of positivism using systematic measures *of the same events* could allow data to be easily compared and RCT could be used to decide where resources might achieve the best outcomes. However, positivism has been dismissed by Langdrige (2007) who suggests it may not accurately reflect the complexities of human nature. Parkinson (2007) suggests that objectifying data to reduce it to a measurable and therefore comparable component could obscure unique aspects of the data. Rutan, Stone and Shay (2014) suggest that therapeutic groups can be complex, focusing 'on the individual's internal life', their 'interpersonal' and 'relational styles', and the 'social structure of the group' (Rutan, Stone and Shay, 2014, p.35), perhaps suggesting that research of group processes may require sensitivity to engage with such complexities. As this study intends to explore the direct experiences of attending therapeutic groups including complexity and diversity a qualitative methodology has been selected to best illuminate such awareness, despite the absence of comparability.

### 2.2.1 Benefits of qualitative methodology

Some qualitative methodologies could enable novel aspects of human experience to be explored (Langdrige, 2007). There appear to be some similarities between qualitative methods and the therapeutic encounter between counselling psychologists and their clients, as both research and therapeutic exploration demand being open, curious and non-judgemental, or congruent, empathic and with unconditional positive regard, as Rogers (1974) expounds. Bion (1967) also suggests therapists approach patients' situations openly, paying attention to their clients' nuances (Bion, 1967), and this appears to be required of qualitative researchers engaged in gathering data, perhaps suggesting a qualitative method fits well with counselling psychology.

## 2.2.2 Critical-realism with post-modernism

My post-modern epistemological position is that human experience and reality cannot be verified, measured or known objectively, and I question the existence of a single knowable *truth*. My post-modernist perspective considers that knowledge could be created through experience and that there could be different or even contradictory perceptions of the same event (Stainton Rogers, 2007). I acknowledge that meaning depends on language and that there may be provisional, situated social constructions influencing language and interpretation as Langdrige (2007) suggests. Social construction has been defined as the biases and assumptions implicitly influencing one's life experiences according to Cooper (2015). Hepburn (2008) suggests that pre-existing socio-cultural customs and values could affect how language is used by participants, and Hollway, Lucey and Phoenix (2007) posit that utterances are always situated in time and place. There is a discussion of the impact of social construction in Section 2.7.

This study aims to produce a critical-realist perspective of the participants' experiences, taking account of human 'complexity and unpredictability' (Hepburn, 2008, p.8). Critical-realism could be positioned on a continuum with extreme relativism at one end and extreme realism at the other. An extreme relativist could suggest that meaning is always an interpretation, depending on the historical and political paradigms influencing society, with an extreme realist denying subjective, implicit influences on meaning and holding a view that a single truth exists (Burr, 1998). Neither extreme position fits with my epistemology. As a critical-realist I propose that the research participants' accounts are treated as real, and I actively discern meaning by accessing my own subjective experiences, acknowledging that there may be implicit influences from the use of language (Burr, 1998). I posit that critical-realist awareness could be dynamic, inter-personal and co-constructed, fitting with a qualitative method where I take an active role in data interpretation. Therefore my epistemology fits with my aim to elicit previously unknown insights into the experiences of attending therapy groups.

In summary, my critical-realist post-modern epistemological position fits with a qualitative methodology such as a phenomenological approach focusing on the participants' experiences, being rooted within the data, while allowing multiple converging and diverging meanings to emerge, and acknowledging my impact on



interpreting the data as Smith and Osborn (2007) suggest. IPA utilises a phenomenological approach to the data, and the section now turns to explore why IPA could produce the kind of knowledge best suited to answer the research question.

## **2.3 Qualitative Methodology**

### **2.3.1 Grounded theory**

I considered using grounded theory for this study. Although grounded theory aims to generate *novel theory* (Glaser, 1992), it has been suggested that grounded theory could objectify 'social processes' which are drawn from pre-existing socio-cultural narratives (Willig, 2008, p.45). Strauss and Corbin (1990) suggest that grounded theory suits research seeking an overview of a situation whereas the present study aims to highlight the *detail* of the participants' experiences. Willig (2008) suggests grounded theory could focus on individuals within their social and political context, and as such could become another study 'from the outside in' (Willig, 2008, p.44). O'Hara and O'Hara (2012) suggest that grounded theory researchers are required to conceptualise the research topic *before* commencing, in order to engage with evolving ideas; however the emerging issues are as yet unknown and therefore I have rejected grounded theory. Instead, IPA offers an open exploration of MHSU lived experiences of their therapy groups from the inside out, focussing on the participants' unique perspectives.

### **2.3.2 Discourse analysis**

I then considered using discourse analysis for this study. Discourse analysis explores the purpose and function of language (Wetherell, 2006), and how speech persuades and has fluid meanings depending on how speakers position themselves, who is present and what sort of impression the speaker aims to create (McLeod, 2007). Wetherell (2006) suggests that individuals always use language for a purpose. This suggests that discourse analysis is likely to produce information about the *functions* of the participants' language use as opposed to their lived experiences of attending groups, and therefore I rejected using discourse analysis.

## 2.4 IPA

I recognise that IPA suits this research question better than the other two qualitative methodologies because of the non-directive focus on the participants' lived experiences. IPA's dynamic characteristic could allow coexisting diverse meanings to emerge, as the same event could be viewed through a different lens depending on the participant's perspective in time and place. It has been suggested that using a phenomenological lens through which to view the participants' data could generate *suspicious* interpretations, perhaps additionally illuminating unconscious meanings within the participants' data (Willig, 2013). I propose that I approach the phenomenological analysis from 'somewhere', as suggested by Langdrige (2007, p.50), because of my ethnic background (white British) and training as a counselling psychologist, and not from a neutral position, which Langdrige (2007) posits is unachievable.

### 2.4.1 Phenomenological

Phenomenology has been described as the exploration of experience (Langdrige, 2007), which Husserl (1936/1970) describes as noticing perceptions. Husserl (1950/1999) posits that conscious awareness relies on one's idiosyncratic view and is subjective. Giorgi (1989) suggests that the strength of phenomenology is its ability to transcend critical-realism and social constructionism. In terms of weakness, McLeod (2007) suggests phenomenology is an interpretative method, involving researchers in a process of 'immersion' and engagement until the 'essential features reveal themselves' (McLeod, 2007, p.56). Clearly an undefined phenomenological research method could appear vague and lacking integrity. However, Langdrige (2007) suggests defining phenomenology, by acknowledging my own subjective involvement within the data gathering and analysis, such that its use is transparent about the co-construction of meaning between me and the participant. I have addressed this concern by including my own personal reflexivity of the data collection and analytic process to improve the study's methodological transparency.

## 2.4.2 Interpretative

The interpretative component of IPA requires my engagement with the data on more than a descriptive level (Langdridge, 2007). Hermeneutic interpretation to highlight spontaneous meaning was initially suggested by Husserl (1950/1999). Smith (2004) and Ricoeur (1996) then suggest making deeper critical, suspicious interpretations of the participants' use of idioms and metaphor, which may allow unconscious meanings to emerge.

However, McLeod (2007) offers a solution to this debate suggesting that IPA robustness is improved by researchers accessing meaning through hermeneutic *and* suspicious interpretation. Therefore this was how I approached the data, engaging with multiple conflicting and diverging meanings as they emerged, with constant linking back to the participants' utterances and fitting with my critical-realist epistemology. The process is described below.

One critique of IPA methodology is that it appears somewhat open to my integrity to guide the research (Smith, 2004; McLeod, 2011). Therefore, I shall now address the strengths and weaknesses of IPA and discuss how I shall resolve them.

## 2.5 Exploring Strengths and Weaknesses of IPA

### 2.5.1 Strengths

IPA was developed by Smith (1996) to foreground participants' expertise and focus on how the participants make sense of their life experiences. Smith (1996) engaged health psychologists to use this method suggesting the findings could offer transferable insight to other mental health professionals.

One advantage of IPA appears to be the suggestion that the data could be more detailed and free from my direction compared to other quantitative methods (Pringle, Drummond, McLafferty and Hendry, 2011). IPA findings may raise awareness of mental health issues: for example, Flowers, Duncan and Frankis' (2000) research highlighted some implicit meanings associated with having an HIV test for their participants. It has been suggested IPA data could offer rich,

ideographic, unique knowledge, perhaps offering the field novel or diverse perspectives of MHSU experiences which may be difficult to discern using other methods (Smith, 2004). Pringle et al., (2011) suggest that IPA research may 'improve service provision' where it has demonstrable validity and thoroughness (Pringle et al., 2011, p.20). Validity is a key concern and is discussed in Section 4.11 and presented in Table four.

### 2.5.2 Weaknesses

Compared to quantitative research, IPA data is inductive and cannot be generalised, replicated or compared easily, as each participant speaks about their unique experiences at that moment, with me, perhaps generating shared meaning between us. Although it may not be possible to extrapolate IPA findings to other settings, which could appear to be a weakness of IPA, it is hoped that the data from this study could offer transferable insights into the experiences of attending groups and that this novel awareness and attention to detail could outweigh the lack of generalisability.

### 2.5.3 Subjectivity

IPA's subjectivity relates to any personal biases and assumptions I might make which could perhaps influence meaning. Husserl (1936/1970) attempts to address this apparent weakness by urging researchers to suspend their own prejudice and pre-suppositions by bracketing them separately from the data (this act of suspending judgement is called *epoché*), to access veiled or not immediately apparent concepts. I am aware that I bring assumptions that attending therapeutic groups could be helpful, nonetheless I intend to be open and curious to alternative perspectives and I will encourage the participants to freely express both positive and negative experiences of groups. I consider that this may not always be possible with preconceptions outside my conscious awareness as Langdrige (2007) suggests. McLeod (2007) and Smith, Flowers and Larkin (2009) suggest it is unlikely that researchers could fully suspend their own preconceptions. In this study I aim to be transparent about my role within the data and throughout the research processes wherever I am aware of it.

#### 2.5.4 Diverse theoretical influences

IPA has been criticised because there appear to be multiple theoretical influences on the lens through which IPA is viewed. Some suggest that IPA data and findings could be shaped by phenomenology (Husserl, 1936/1970; Langdridge, 2007), which appears to foreground individuality and specificity, which may be obscured using other qualitative methods. Others claim that narrative theory influences IPA (Gergen and Gergen, 1984), an example being Ihde's (1986) descriptive IPA. Some suggest social constructionism shapes language use (Wetherell, 2006) and as IPA data depends on the meanings attributed to language it could be argued that social construction may subtly influence the language used in IPA. Since the participants rely on shared meaning to communicate their experiences of therapeutic groups, such meanings could therefore be fluid. This suggestion fits with my critical-realist epistemology that multiple meanings and perspectives could emerge. The data in this study will be explored using a phenomenological framework focusing on individual perceptions of the world, fitting my interest as a counselling psychologist into how individuals live in the world. It appears that the sophistication of IPA depends on my *integrity* and *awareness* of my subjective involvement throughout the study, which I address through validity and reflexivity sections below. This section now turns to explore the rationale for using IPA in this study.

### 2.6 Rationale for choosing IPA

There appears to be a precedent for using IPA to explore aspects of unknown psychological distress from Finlay (2003, 2006) and Eatough and Smith (2006), with the potential to offer mental health professionals novel insights, to inform and moderate practice and perhaps raise awareness. Such depth of knowing and comprehending may not have emerged using other qualitative methodologies. IPA appears to access participants' experiences *in the moment*, without judgement, valuing an individual's unique perspective of their world, for example Smith (1999, 2004), and Flowers, Duncan and Frankis (2000). According to Butt (2007), and Henriques, Hollway, Urwin, Venn and Walkerdine (1984), IPA could illuminate previously unknown aspects of the participants' lifeworld, defined as one's lived experiences in the world (Husserl, 1950/1999). Highlighting these perhaps unknown aspects of the experiences of attending a therapeutic group is the aim of the present study.

Yardley (2008) posits that IPA researchers demonstrate research integrity and transparency by rooting their interpretation in the participants' data and demonstrating research validity, both of which will form the foundation of the present study. Furthermore, I acknowledge that my subjectivity in the research process as a white, educated, female, counselling psychologist, who has not experienced severe and enduring mental illness, could unconsciously influence the nuances of the research interviews and the interpretations I consider. As someone who may have different life experiences from the participants I am likely to have different values from them and I aim to remain open and curious about their situation and try to avoid making assumptions. As a reminder of my presence within the study I use the first person 'I' to refer to my subjective, reflexive, interpretative contributions and to demonstrate transparency in the research process, which I discuss below.

Toukmanian and Rennie (1992) suggest that MHSU experiences could offer unique access to 'private experiences' which may have been unexplored (Toukmanian and Rennie, 1992, p.165). Primarily, IPA uses open-ended prompts instead of pre-set questions, allowing the participants to interpret the prompts in idiosyncratic ways, perhaps encouraging spontaneity and idiosyncrasy (Smith, 2004). Smith (2003) suggests that IPA could be 'especially useful when one is concerned with complexity, process or novelty' (Smith, 2003, p.55). Miles and Huberman (1994) suggest that participants' responses to the research question could evoke rich information about their experiences. Research suggests that MHSU experience discrimination (Thornicroft, Rose and Huxley, 2002) and may not be valued as experts in their own mental illness (Borrill, 2000). Notably, IPA values participants' experiences as real. Todorova (2011) suggests that IPA is particularly good for exploring multiplicity of meanings and illustrating converging and diverging perspectives. It is hoped these IPA findings could inform mental health professionals about the obstacles which MHSU are managing and the impact of attending therapeutic groups. Therefore, I chose IPA to research the question: *What is it like to be part of your therapeutic group?* The section now turns to explore whether social construction has an impact on language in IPA.

## 2.7 The Impact of Social Construction on Language in IPA

Taking a social constructionist perspective of language has been described as foregrounding fluid cultural expressions which could influence attributed meanings (Willig, 2008). Some suggest that social construction is not a concern for IPA researchers because humans have experiences as infants before the mechanics of producing language have been conceptualised (Velmans, 2006). I am making the assumption that because IPA depends on the participants language use to relate their experiences, perhaps a more transparent approach could involve considering the impact of social construction on the language of IPA. Eatough and Smith (2008) propose that language is used purposefully in IPA to fulfil particular functions and express changing meanings, suggesting that language use is not coincidental and that a researcher could consider it as a potential further clue to meaning. Lucey (2007) suggests that language could be the foundation for inter-subjective, co-constructed meaning which invests the speaker in a particular position within society and culture. However, Willig (2008) posits that 'language prescribes what we can think and feel' (Willig, 2008, p.63), suggesting that even though an experience may not be couched in words as it occurs, it is through language that meanings are discerned and conveyed. This perspective appears to suggest a possible limitation of IPA because of its reliance on language and I shall aim to overcome some of that constraint by being transparent and exploring social construction's potential impact within this study.

Willig (2008) and Spinelli (2007) highlight that the participants' use of language may be construed in novel or different ways that the researcher may not grasp and that researchers can never truly *know* something. In response, I aim to be transparent about my role within the data collection and analytic processes, remaining aware that there may be multiple meanings, and that the participants' experiences may be provisional and situated, fitting with my critical-realist epistemology. It appears that the dynamics of language could epitomise both the beauty and intricacy of IPA, highlighting the constant dilemmas which human beings are constantly negotiating, transcending and moderating during their everyday inter-subjective interactions.

Willig (2008) highlights that there cannot be 'unmediated access to someone else's personal world' (Willig, 2008, p.66). My response is to keep returning to the participants' data and to highlight the subjectivity of my role in interpreting meaning. Therefore, I suggest that social construction may impact on the language used in IPA and that attributed meanings may be inter-related within the culture and context in which they were uttered, and that meanings could depend on the time, place and the people who are present. It appears that language may perform a dynamic role in IPA which some may interpret as a weakness; others may see it as strength. The chapter now turns to explore research approval.

## **2.8 Research Approval**

Having decided that an IPA qualitative design could best answer the research question exploring the experiences of attending therapy groups, approval for the research was obtained from City University London and a copy of the signed ethics release form is available in Appendix 4. The centre where the research was conducted also approved my research and their signed agreement is available in Appendix 5. There is a discussion about the research centre in Section 2.13. The research was conducted in line with British Psychological Society (2009) and the Health and Care Professions Council (2008) ethical guidelines. This section now turns to consider the pilot study.

## **2.9 Pilot Study**

Open-ended prompts (available in Appendix 2) were drafted based on my own experiences of facilitating groups. Yardley (2008) suggests validity could be improved by researcher commitment and rigour, which I interpreted as careful data collection via enabling participants to contribute their perspectives freely. A pilot study was conducted with a colleague who had experience of a therapeutic group but was not a MHSU and the decision to involve her was pragmatic and influenced by her availability. My colleague gave informed consent to take part in the pilot study and the data was used for learning purposes and not included in the study. I wanted to find out whether the semi-structured prompts elicited sufficient information about therapeutic groups. I noticed that I did not follow the prompts exactly as they were written, but did use the structure. Smith (2004, p.50)



encourages researchers to be flexible and 'follow up interesting and important issues'. I interpreted this as a suggestion to be dynamic and curious during the pilot study and data gathering. A huge amount of data was generated about groups, and I noticed that it was important not to turn off the recording prematurely, as the individual spoke more freely at the end of the pilot study.

### 2.9.1 Pilot study reflexivity

The pilot study data gathering resembled an encounter with a client. In my scientist-practitioner role as a counselling psychologist (Strawbridge and Woolfe, 2003), I used my practitioner skills to gather data, adopting Rogers' (1974) core conditions of congruence, empathy and unconditional positive regard, to build my rapport. The open-ended prompts were revised to elicit details about which therapeutic groups the participants had attended. The discussion now turns to the ethical considerations of the study.

## 2.10 Ethical Considerations

### 2.10.1 Informed consent and right to withdraw

I explained the informed consent form (available in Appendix 6) to the individual research participants, highlighting that the research interview was not a counselling session and that choosing whether or not to participate was voluntary and would not affect their group attendance. Research participants were informed that identifying details would be removed and that they would be allocated a pseudonym in the study. They were told they could drop out up to a month after their research interview if they chose and if they withdrew, their group involvement would be unaffected and their data would be removed from the research and destroyed. None of the participants dropped out. The research participants were not deceived during the research. I explained that the research analysis would consist of a composite of all the research data, which would be disseminated to inform mental health and counselling psychology practice. The research participants were considered competent to consent to the research by the centre staff and were given a copy of their informed consent form which included the research supervisor's contact details.

### 2.10.2 Confidentiality and risk management

It was explained to the research participants that confidentiality was limited to myself, my supervisor, and examiners but could be broken if the discussion raised concerns about the participant's safety or the safety of others. I was able to contact the centre staff if concerns arose and the staff could contact me during and after the research. The staff were available to provide ongoing support for the participants after their research interview if the need arose. None of the participants raised concerns after their research interview. The participants were given a de-briefing sheet including mental health crisis numbers and the contact details for my supervisor, the university and myself for participants to contact if they wished. A copy is available in Appendix 7. The discussion now considers the research participants.

## 2.11 Research Participants

Nine participants with severe and enduring mental illness gave informed consent to be part of this research studying their experiences of attending therapeutic groups. Ruggeri, Leese, Thornicroft, Bisoffi, and Tansella's (2000) research defines severe mental illness (SMI), although their research includes only people who experience psychosis. In this study, SMI includes people who have experienced schizophrenia, psychosis, personality disorders and bipolar affective disorder where mental illness symptoms have interfered with functioning, following the definitions of SMI offered by the Department of Health (1996).

The number of participants was influenced by Smith (2004), who suggests between five and ten participants could be considered a suitable sample. Nine participants were selected as a middle option, balancing Smith and Osborn's (2007) suggestion that 'a detailed interpretative account' is the aim of the research, with few participants 'sacrificing breadth for depth' of analysis (Smith and Osborn, 2007, p.56).

### 2.11.1 Participant inclusion criteria

The criteria for inclusion in this study were that participants speak English, have participated in their therapeutic group at least twice, and not to be felt to be experiencing overwhelming mental health symptoms by the centre staff. These criteria were arrived at following discussion with the staff and group facilitators who felt that attending their group twice enabled participants to settle into their groups and to reflect on their experiences of being in such groups. In fact, all the research participants had attended their therapeutic groups for longer than two weeks, as recorded on the participant demographic sheets in Appendix 8.

### 2.11.2 Participant recruitment

I made weekly visits to the centre (discussed in Section 2.13) and left flyers and a sign-up sheet (available in Appendix 9) with details of the study and my research contact details for participants to discuss any stage of the research process. In fact potential participants spoke to me in person as I visited each week. The participants were known to the centre and were a self-selecting, opportunistic sample who voluntarily signed the informed consent form agreeing to their data being recorded, transcribed and disseminated.

Potential research participants were informally screened by me as they made enquiries about the study before they were interviewed for the research, to assess whether any of the individuals might have been experiencing current mental health difficulties, such as symptom intrusion, medication side effects or other preoccupying circumstances and to minimise the potential for distress. The screening took place at the centre. My screening assessment was not scripted and resembled an informal discussion about confidentiality, recording and dissemination where the individual asked questions and I was curious and open about whatever emerged. I discovered that the participant criterion to attend a therapeutic group twice before participating in the study allowed participants to feel settled in their groups. If an individual had wanted to participate when the staff or I considered them mentally unwell, it had been decided I could meet them privately to discuss their safety and stability. In fact, none of the potential participants were unable to participate because of mental health difficulties.

Some research participants described experiencing more than two decades of in-patient and out-patient treatment, spanning changes in mental health legislation (including increased patient agency, user-led assessments and the Care Programme Approach (CPA)), which was operationalised following the Department of Health (2008) policy review. The participants described experiencing community service teams such as Home Treatment, Community Mental Health, Assertive Outreach and Early Intervention. They described vital mental health care and support from friends and family. The participants' ages spanned from early thirties to early seventies, and their ethnicities included British, Irish, European, Mixed-Race, Caribbean and Persian. The participants were not intended to represent all ages, ethnicities and experiences of MHSU as IPA data is ideographic and not intended to generate universally applicable theories (Smith, 2004). Four participants were women and five were men. Four participants were employed part-time, one was retired, one was a volunteer and three were on courses. One participant had a degree and another participant was a carer for another MHSU. Participant demographics are included in Appendix 8.

Participants spoke of knowing others in their groups and of being known by their group facilitator. Some participants described re-joining their therapeutic groups after receiving mental health treatment and re-engaging with some of the original group members. Other participants discussed taking part consistently in their therapeutic groups.

### 2.11.3 Participant diagnoses

I did not actively collect diagnoses from research participants, having become aware they could reinforce the researcher's power and become another lens through which to view the research data. Parker (1999) suggests diagnoses 'lure the reader' since they constitute labels (Parker, 1999, p.2) and could be limiting and distract attention away from meaning. Research participants chose whether or not to discuss their diagnosis and I remained curious but did not ask directly about diagnoses. My ontological position is that diagnosis may not signify common elements between individuals and that the research participants are unique and unclassifiable, as Bentall (1993) and Byrne (2000) posit. During data collection research participants reflected on the conflicting and changing diagnoses they had received, expressing confusion and ambiguity about their possible meanings.

#### 2.11.4 Participant homogeneity

The participants in the present study could be considered a homogenous group according to Smith and Osborne (2007), since they could all respond to the research question in particular depth from their experiences of attending therapy groups and from their shared insight into being diagnosed and living with severe mental illness.

In the present study, homogeneity extends to the participants' shared experiences of severe and enduring mental illness symptoms, being sectioned, in-patient and out-patient treatments, living with severe mental illness in the same local community and attending group therapy; however their individual differences mean they do not view their groups the same way. Thus, the present participants appear to constitute a 'purposive' sample who have sufficient common knowledge of their therapy groups to respond meaningfully to the research area as Smith and Osborne (2007, p.56) suggest. Moreover, the participants attend different longer-term therapy groups, (Appendix 8), and have differing relationships with their facilitators and each other and this could be considered somewhat less homogenous than the participants all discussing the same group. Homogeneity and the extent to which there may be transferability of the findings are discussed within the Research Limitations below. On balance, Arrow et al. (2004) and Brabender and Fallon (2009) suggest avoiding researching a single group since it may review only the facilitator's style with those particular group members. The chapter now moves on to explore the therapeutic groups within the study.

### **2.12 Types of Therapeutic Groups within the Study**

The therapeutic groups involved in this study ran for several months. The groups focused on relationships and the issues the group members brought to the group, without the groups having fixed agendas. The groups in this study did not include psycho-education, behavioural, time-limited or solution-focused groups. Furthermore, the groups in the present study did not focus on the delivery of an intervention.

### 2.12.1 Group homogeneity

Some research participants spoke about attending several different therapeutic groups underpinned by dynamic and behavioural psychological modalities, and run by different service providers; however, all were *longer-term* and *facilitated* following Yalom (1995) and Foulkes' (1948/2005) suggestions. Group modality was not considered to be consequential following McDermut, Miller and Brown's (2001) meta-research suggesting equivalence between CBT and psychodynamic group modality. Therefore the longer-term, facilitated groups in this study could be considered somewhat homogeneous. The chapter now turns to discuss the centre where the data gathering took place.

## 2.13 The Centre

I engaged with a third sector centre which introduced me to their members attending a range of longer-term therapy groups. The group members were invited to consider becoming involved in the present research as participants. The centre takes referrals from GPs and psychiatrists and offers cooking courses and longer-term therapy groups for men, voice hearers and a Time to Talk group for those living with severe and enduring mental illness in the community. The staff are psychotherapists and they supervise trainees, co-facilitating groups and offering mentoring to resolve practical issues such as housing difficulties. The centre offers a nutritious affordable meal and has laundry and shower facilities. The centre has been anonymised to preserve the privacy of the research participants and is in a vibrant urban area containing a large NHS mental health teaching hospital. The local population is ethnically diverse, containing White British, Irish, Black African, Black Caribbean, Indian, Pakistani, Bangladeshi, Chinese, Orthodox Jewish, Turkish and Eastern European inhabitants (NHS, 2013). In the locality a range of longer-term therapy groups are facilitated by therapists employed by voluntary organisations including groups targeting women and a mixed group, which were attended by participants in the present study (Appendix 8).

### 2.13.1 The setting for the data gathering

The centre provided me with a room in which to conduct the research interviews. The participants knew the centre and they valued the centre staff. I posit that data

gathering in the centre may have shaped and influenced the data content because the participants appeared relaxed in a familiar environment and appeared to discuss their experiences candidly. The chapter now explores datagathering.

## **2.14 Data Gathering**

My regular weekly visits to the centre seemed to keep the research in the minds of potential participants. Participants used the sign-up sheet or spoke to me if they were interested in participating. Research interviews lasted between 31 and 83 minutes. Participants decided which therapeutic groups to focus on in their research interview. I used my counselling psychology skills to engage and contain the participants during their research interview process, approaching the research participants in an open and curious way, as Rogers (1974) suggests for therapeutic encounters.

The sound quality of the individual research interviews was variable as the room where the data was gathered was next to a communal area where other activities were taking place. I experienced this as the research becoming enmeshed alongside other activities at the centre which I perceived as an apparent endorsement of the research by the centre staff.

It seemed that the research interviews had similar qualities to the beginning of a therapeutic encounter with a client. This observation is documented by experienced IPA researchers Lavie and Willig (2005) who suggest a strong 'rapport' between the researcher and participant encourages full engagement and reflection on 'private' implicit material (Lavie and Willig, 2005, p.117), qualities encouraged by Flowers, Smith, Sheeran, and Beail (1997) in their study of gay sex. The section now considers my reflexivity on data gathering.

## **2.15 Reflexivity on Data Gathering**

Reflexivity has been a central component of my counselling psychology training, both as a learning tool to improve my practice and trouble-shoot difficulties and to promote my personal development (Woolfe, Strawbridge, Douglas and Dryden, 2010).

### 2.15.1 Scientist-practitioner demands

A decision was made with the centre staff for me to attend one therapeutic group to discuss this research with potential participants before they decided whether or not to take part in the research. This decision was informed by the literature suggesting that MHSU participants may be hard to reach (Tait and Lester, 2005). Woolfe et al., (2010) discuss the different demands of the *scientist-practitioner* elements of counselling psychology. Reflecting on my relationships with potential participants, I regarded my position as being fully in *practitioner* mode and in hindsight this may have made it difficult to detach myself from the participants' emotional distress as they discussed mental health trauma in their research interviews. As a counselling psychologist I prioritised providing containment for the research participants' distress; conversely in the *scientist* researcher role, I needed a level of detachment to collect (and ultimately analyse) data. On balance, my *practitioner*-led relationships with the research participants may have encouraged their intimate reflections about their groups and produced rich, quality data. Eatough and Smith (2006) suggest that researchers utilise their professional skills to fully engage participants; however, they omit discussion of their personal reflexivity. There is further discussion about this issue below.

I was aware of points in the research interviews at which there were changes in the participant's emotional state and in my own inner response and conceptualisation of the participant's distress and I felt my *practitioner* mode helped me process the information and make sense of the research interview. These sensations appeared to offer an additional layer of awareness of the participant's situation. An example of the dynamic nature of the research interviews occurred as Georgina described piercing migraines and suddenly I experienced sharp pains shooting through my temples which did not seem to originate organically and subsided as soon as the research interview ended. Klein (1957) refers to this as projective identification with the participant, and from her suggestions, could offer me an opportunity to experience what Georgina was feeling. I used this experience to inform my interpretation of Georgina's experiences in her therapeutic group.

Shaw's (2004) IPA research highlights the importance of therapists and researchers processing their bodily sensations, to make sense of the emotions being expressed by the other person. Kvale (1996) suggests that participation in research could



change participants' awareness of their situation. Lott (1999) suggests that research participants confide in qualitative researchers and may find the experience supportive. My intense involvement with the data may have contributed to my protective feelings towards the research participants; for example, I noticed that I did not pursue a response if the participant appeared unwilling.

On reflection, the research interview's focus on trauma and difficult relationships experienced and explored in therapy groups was consistent throughout. At times there seemed an uncomfortable dichotomy between *practitioner* authenticity, (congruence), empathy, and modelling unconditional positive regard towards the research participants, as Rogers (1974) suggests in therapy, and the *scientist* data collection and analysis. Such conflicts are the focus of McGourty, Farrants, Pratt and Cankovic's (2010) paper, which suggests that this duality attracts insufficient researcher attention yet it could offer useful reflexivity. With this awareness in mind I gained support for myself during data gathering by discussing my reactions to the participants' distress with my supervisor.

### 2.15.2 Ethnicity

I am aware that being a white British woman involved in research interviews with participants from different ethnicities to my own, five of whom are men, may have impacted on the data. I am aware of the perceived differences in power and language use between the participants and myself. Contemplating my work with clients from different ethnicities over several years it would appear they feel comfortable with me and the participants seem able to tolerate our differences, judging by the candid and personal experiences they discussed.

### 2.15.3 Participants' use of language

On reflection, it appears that some participants in this study use language unusually during their research interviews. Rule (2005) suggests that individuals with severe and enduring mental illness can appear to discuss two subjects in parallel (condensation) and sometimes use unusual idioms and metaphors to describe complex concepts. Findings from Garety (2014) and Lemma, Target and Fonagy (2011) propose some MHSU language may be difficult to follow and disorganised.

Some of the participants in this study demonstrated pressure of speech, which Rule (2005) defines as rapid speech with interchanging ideas. I listened to those research recordings eight or nine times in order to transcribe them accurately. Garety (2014) suggests that some individuals with severe and enduring mental illness could experience 'blunted' affect, which she defines as a difficulty accessing emotions (Garety, 2014, p.6). I noticed that participants might recall events to help them explain their feelings. Silverman (1993) posits that participants use any way they have available to help researchers to capture their meaning and this might involve the novel use of language, perhaps collapsing two words together, or in unusual use of vocabulary or in linking sounds of words. Parker and Spears (1996) comment that unique and particular speech by participants is their 'version of reality', which they suggest transcends differences between participants and researchers (Parker and Spears, 1996, p.13). This fits with my epistemological position that the participants' accounts in IPA are regarded as real and that utterances may have multiple meanings.

I was inspired that Laing (1960, 1961) discovered ways to conceptualise and capture the essence of the unusual use of language of patients with schizophrenia. I became aware that the screening conversations with potential participants before their research interview enabled me to discern multiple meanings expressed concurrently and that participants appeared to convey complex concepts succinctly and eloquently. This is in contrast to the Royal College of Psychiatry's (2012) suggestion that taking anti-psychotic medication could slow down cognition and may diminish language processing.

#### 2.15.4 Relationship with research participants

The research interviews felt like a conversation, and I have reflected on the reasons for this. Willig (2008a) posits that the rapport between participant and researcher has many features of an informal conversation. Gadamer (1975/2004) suggests conversation could be at the heart of shared meaning, although he does not focus on situations where that may not be the case. Finlay and Evans' (2009) reflexivity on their data collection promotes relational responses and reactions by researchers to engage their participants. Finlay's (2006) study of the experience of multiple sclerosis involves Linda Finlay's friend as the participant, which some might argue constitutes a genuine pre-relationship within the research process; however, others

might suggest their intimacy and co-construction perhaps offers Finlay a unique opportunity to illuminate her friend's obscured experiences of multiple sclerosis. The chapter now turns to explore transcription.

## **2.16 Transcription**

Before I began transcribing the interviews, each research participant was given a pseudonym. I transcribed all the research interviews myself, becoming familiar with each speaker and *hearing* the utterances as I read their transcript. Polkinghorne's (1989) study, cited by Langdrige (2007), suggests that transcribing one's own data could improve validity. I was able to reflect at length during the transcribing: on the transcribing processes, on my developing insights into seemingly converging and diverging meanings, and my emotional reactions to the data.

Each speaker's utterances were faithfully transcribed, including mispronounced words, conflicting phrases, repetition and novel use of words as suggested by Smith, (2008); Langdrige (2007) and Gee (2011), to retain the authenticity and accuracy of the data. I avoided subtle changes to tidy the data which Langdrige (2007, p.74) warns against. It seemed that transcribing the participants' actual spoken utterances could offer the reader a more intimate experience of the participants' speech. An example of a page of Gerry's marked-up transcript and notes, with initial thoughts about meaning, are included in Appendix 10. The transcribing required me to listen repeatedly and intently to the recordings, which perhaps contributed to my strong connection with the data in this study. The section now turns to explore the transcription reflexivity.

## **2.17 Transcription Reflexivity**

As I transcribed the data I noticed when a participant became anxious or their speech became pressured so that sentences seemed condensed. This awareness led me to check and re-check the transcription multiple times. The re-checking exposed seemingly hidden or conflictual comments, and comments uttered really quietly, which were also transcribed, suggesting to me that maybe unconscious thoughts may have been vocalised during the research interview, and the iterative

process of going back over the data allowed the jumbled-up meanings to emerge clearly.

During transcribing I was reminded of my own bias in favour of therapeutic groups. In the transcripts I appear to be acquiescing when participants comment on their group's positive features. I became concerned I had encouraged only positive experiences about groups and I was relieved to find, on balance, that some participants make negative and critical comments about their groups and facilitators. On reflection, this awareness highlighted my implicit role within the study's data collection. Being aware of this potential bias allows me to be transparent about it. The section now considers the analytic procedure.

## **2.18 Analytic Procedure**

Marks and Yardley (2010) and Smith and Osborn (2007) suggest that the researcher engages in a form of triangulation by looking at the data repeatedly, making free associations, getting a sense of the participants, and reflecting on the participants' utterances. Yardley (2008) suggests that researchers remain alert to considering new ways of interpreting their data, particularly noticing 'complexities and inconsistencies' which attract one's attention (Yardley, 2008, p.248).

### **2.18.1 Immersion**

I began by studying the transcripts multiple times to become accustomed to salient meanings which were then linked back to the participant's own words, as Langdridge (2007) and Marks and Yardley (2010) suggest.

### **2.18.2 Marking a transcript**

I explored the convergence and divergence of an emerging theme in an individual transcript. Initially I marked the transcript using different coloured pens. In order to illustrate my paper trail and establish the transparency of my analysis, an example of a marked transcript is available within Appendix 10. An unusual utterance which caught my attention has been highlighted in yellow and is included in Section 3.5.2. I then created an Excel spreadsheet to note the participants' utterances and write

comments. Nonetheless, I experienced the transition to the computer as a constraint to my free association and analytic processing. I became aware that making lengthy written comments about my thoughts regarding the transcript data was more suited to my analysis style, and following suggestions by Gee (2011), I used two A4 notepads, which allowed space for my tentative suggestions, ideas and interpretations. I referred to my research journal notes about the details of each research interview which helped me to review a transcript while *hearing* the participant's voice, following Willig's (2008) suggestion.

### 2.18.3 Tentative noting

I then noted initial associations, thoughts about interpretation and the possible significance of participants' comments that appeared unusual or noteworthy, such as metaphors, descriptive or linguistic comments as suggested by Smith et al. (2009). An example is available in Appendix 10 where I noted in *green* the emerging psychological comments Gerry made about the group process, including temporal and conflictual comments that Smith (2004) suggests could illuminate meaning. Each item was marked in a different colour pen so that it became easy to recognise, for example, *descriptive* comments were written in *purple*. I then considered the same comments across a whole transcript and later across a range of transcripts, following an inductive process suggested by Smith (1999, 2004), returning to the transcripts individually and exploring whatever emerged without judgement or direction.

### 2.18.4 Ideographic perspective in IPA

Smith et al. (2009) define the ideographic perspective in IPA as foregrounding the detail of an individual participant's perspective in a particular context. I became fully absorbed in analysing individual transcriptions and was surprised that when I left the analysis and then returned to it after several days that other phenomenological themes and unconscious layers of meaning seemingly emerged from within the utterances, which Husserl (1936/1970) and Merleau-Ponty (1945/1962) discuss. These phenomenological and unconscious layers of meaning seemed to have been initially obscured by my intense focus on the conscious stated meanings. Becoming aware of these two intertwined perspectives of meaning led me to a more interrogative stance within the data, recognising that multiple meanings could

emerge just by re-visiting the data and being curious, which then led me to review other transcripts one by one, to explore emerging meanings. An example of this is available within Appendix 10.

#### 2.18.5 Emergence of themes

After all the transcripts had been similarly scrutinised I returned to the first transcript to review the emerging themes, noticing new associations, exploring and thinking about the converging and diverging themes, and going between the particular detail of one participant's utterances to other participants' expressions, which Marks and Yardley (2010) suggest could improve validity. The stronger themes were clustered together and later formed the basis of the superordinate themes. These dominant themes appeared to have salience and seemed to draw aspects of the analysis meaning together, suggesting congruent meanings to me, and as Smith (2003) suggests, I became immersed in the inductive nature of IPA. Other themes supported and added nuances of context and experience, and these themes were clustered into subordinate themes. I added new thoughts and awareness to my initial notes about meaning, interpretation and associations with the data. Studying each transcript multiple times during different stages in this process thus allowed new discoveries that lay within the data to emerge.

#### 2.18.6 Convergence and divergence

The superordinate themes were given a title to try to capture the essence of the expressions. The same process was repeated for each subordinate theme. These themes were clustered and re-checked against the transcript quotations. I became aware that repeating this process between the different transcripts and by constantly rooting the themes within the data enabled the quotations to illuminate interconnected themes. I included divergent themes which present an alternative viewpoint and reflect different opinions. I also included a diagrammatic representation of the themes within Table three. This model of analysis appears to fit well with the conceptualisation of the hermeneutic circle.

### 2.18.7 The impact of the hermeneutic circle

The hermeneutic circle relates to my checking the data in parts, noticing a word, a phrase, a sentence, and returning to the data as a whole (Smith, Flowers and Larkin, 2009). The data was studied repeatedly, looking initially at the whole (bigger picture), and then at parts of the data (the detail of the participants' use of language), and then returning to the whole, following an on-going circular exploration of the separate transcripts (Langdrige, 2007). I became aware that the data appeared constantly alive with different meanings being foregrounded and contemplated, within a dynamic process, as Van Manen (1990) suggests. I encountered the *double hermeneutic* where I was making sense of the participants' descriptions as the participant themselves was grappling to understand their experiences (Smith, 2004). I reflected on the similarity between the double hermeneutic and situations in therapy as a counselling psychologist, where one may be clarifying meaning and simultaneously constructing a working formulation with the client (Johnson and Dallos, 2006). The section now turns to consider how incorporating elements of validity into IPA could improve the integrity of the study.

## 2.19 Validity

Phenomenology has been criticised for lacking validity (McLeod, 2007). One criticism is that using IPA alone could be considered a limitation (Marks and Yardley, 2010) and as such has been balanced against the opportunity of accessing previously unknown experiences of therapeutic groups which may be unavailable using other methods. This section now explores potential pitfalls of using only IPA and how they have been addressed in this study.

Regarding the challenge of using a single method, Yardley (2000) suggests that IPA is really three theories in one: existential, sociological and psychological. Existential philosophy discussed by Sartre (1943/1956) focuses on the here and now, thus in IPA an existential focus could include noticing, perceptions and awareness. This detailed focus appears to complement the somewhat wider sociological focus of IPA situating experiences within the context of existing cultural, social and political norms (Gergen and Gergen, 1984; Langdrige, 2007) to enhance awareness. The psychological focus of IPA focuses on how people interact in the world (Milton, 2011) and seems to be detailed *and* take account of the impact of bio-psycho-social

influences, perhaps suggesting that Yardley's (2000) model of IPA in fact offers a composite theoretical model, countering her *single method* critique.

When IPA is compared to quantitative positivist methods it has been critiqued for not appearing empirical (Willig, 2008). To counter this Yardley (2000) proposes IPA researchers retain their 'sensitivity to context' which involves contextualising the study within existing research to avoiding repeating research weaknesses and in addition she suggests that IPA researchers reflect on their own position within the data (Yardley, 2000, p.219). Existing literature regarding MHSU considered within the literature review suggests that contemporary mental illness dialogues and paradigms are dynamic, constantly evolving and subtly shaping thinking about mental health through 'normative, ideological, historical, linguistic and socio-economic influences' (Yardley, 2000, p.220).

It could appear that subjectivity within IPA is another weakness. Hepburn (2008) suggests that researcher subjectivity within IPA could be navigated by situating the study 'historically and culturally' (Hepburn, 2008, p.243) and by being transparent about the impact of external social paradigms on the study. Moreover, this fits with my epistemology that the participants' experiences occur somewhere and could have multiple meanings. Thus, situating the study could transcend IPA's somewhat inherent subjectivity and contribute towards the study's validity. There is further discussion of the study's validity in Section 4.11.

Langdrige (2007) questions whether IPA analysis could become fully transparent and whether different interpretations could be made. I have responded in three ways by: including researcher reflexivity on each stage of the research process as Finlay and Evans (2009) suggest, regarding the data with openness and curiosity as Rogers (1974) suggests of therapists, and including my earliest transcription notes and later thematic notes (in Appendix 10) to map my analytic processing. I am aware that researching alone I might foreground particular interpretations; however, the next section considers whether involving a colleague as an independent auditor of themes could transcend this potential limitation.



## **2.20 Member Checks versus Independent Audit of Themes**

First I considered member checks. Some researchers (Stiles, 1993; McLeod, 2007; and Marks and Yardley, 2010) suggest validity and credibility could improve by offering research participants member checks (an opportunity to shape the analysis concerning their own transcribed data). In practice, member checks could lead to disputes between the research participant and the researcher's own analysis (Barbour, 2001; Rolfe, 2006). Furthermore, it could appear that the study of IPA epistemology underpinning the data analysis becomes somewhat redundant if participants are to become involved in member checks.

McLeod (2007) also suggests that member checks could be problematic, citing Bloor (1997), who proposes that some research participants could be reluctant to challenge the researcher because of demand characteristics or a perceived power imbalance between the researcher and the participant. In fact, the analysis in this study is a composite of all the research participants' combined data, limiting the usefulness of individual member checks, and therefore member checks were not incorporated following Barbour (2001), Rolfe (2006) and Bloor's (1997) suggestions. Marks and Yardley (2010) suggest that researchers improve validity by 'seeking and analysing deviant cases' such that divergent participant experiences contrast with the other themes and with the researcher's data prejudices and preferences (Marks and Yardley, 2010, p.17). I adopted this suggestion to challenge my own preconceptions about therapeutic groups being positive, and noticed that some participants described their difficulty in attending groups or found their group unhelpful.

I then considered using an independent audit of themes as McLeod (2007) suggests. I arranged for my colleague who studied IPA epistemology but was unconnected with this study to prepare an independent audit of themes. The audit involved presenting my colleague with Andre's unmarked transcript and requesting her thematic analysis. Sandelowski (1993) posits that quality and validity become evident when there is agreement about themes, without explaining how such parity might be achieved. Furthermore, it could be considered somewhat unexpected for another individual to perceive precisely the same themes. Therefore multiple

meanings may emerge, fitting my critical-realist epistemology and improving validity through attending to 'commitment and rigour', in demonstrating the depth of analysis (Yardley (2008, p.219). McLeod (2007) suggests that researcher integrity, coherent discussion and skilled implementation combine with the independent audit to produce respected, valid research. Research validity and integrity are addressed throughout this study and shown in Table four. The independent auditor's suggested themes are documented in Appendix 3. Table two highlights how some of her suggested themes appear to overlap with my own analysis, with her comments set alongside some of the themes explored below. This section then turns to the analysis reflexivity.

	Independent auditor's suggested themes	Themes explored in Analysis chapter
1	Initial feelings as he attends the centre for the first time: feeling anxious about being questioned, not knowing who's who, feeling staff might be on another level to him.	Embodiment Self-Acceptance
2	Initial feelings within the group as he begins to attend (anxiety about talking)	Embodiment Self-Acceptance
3	The good qualities and experiences he has gained from the group experience: being able to help others, being heard, shared experience, not feeling so alone existentially, self-transformation and personal strength, a real experience of connection. The way he views it as a whole (like a family/secure attachment).	Self-Acceptance Authenticity Self-Reliance
4	The difficulties he has experienced with the group: including how his gender beliefs affected his experience of the group at times, possible difficulty in being the one who is helped by others, lack of time, watching others struggle with talking.	Authenticity Embodiment

**Table Two: The independent auditor's suggested themes alongside the themes explored in the Analysis Chapter**

## 2.21 Reflexivity on the Analysis Process

Heidegger (1927/1962) suggests thinking about the construction of the research question as a self-reflexivity exercise: noticing the choice of words, assumptions and meanings. The research question: *What is it like to be part of your therapeutic group?* could be seen as socially situated in recovery from mental illness, and temporally situated in the assumption that individuals with mental illness are agentic (Hollway, 2007). I am aware that my use of words with each participant during their research interview seems to have been largely unconscious and pragmatically led by the participants' responses.

McLeod (2007) cautions that by asking one question instead of another, researchers' assumptions might suggest how they expect participants to respond. I acknowledge that my use of language may have unconsciously shaped and simultaneously been shaped by the participants' responses. This effect could have been moderated by involving another researcher in data collection and analysis; however, as an individual researcher this was not a pragmatic option.

## **2.22 Summary of Methodology Chapter**

Having discussed my critical-realist epistemological position within the study, I have attempted to illustrate how IPA could appear pragmatic in foregrounding participants' utterances and validating them. I have demonstrated IPA's theoretical underpinning of phenomenology, and considered the influence of social construction on the language on which IPA depends. I have considered the social context in which the participants' utterances are created to further validate IPA as a methodology which could foreground the participants' psychological experiences of their groups.

I have been transparent about my subjective, interpretative position within the data and how the care of the potentially vulnerable participants has been considered. I have commented on the type of therapeutic groups involved in the study and demonstrated transparency through the detailed reflexive sections. In summary, I found Smith's (2004) words inspiring: that through qualitative research one could become aware that 'we share a great deal with a person whose personal circumstances in many ways seem entirely separate and different from our own' (Smith, 2004, p.43). The study now turns to the Analysis Chapter.



## Analysis Chapter

### 3.1 Introduction

In this chapter I present a full and detailed account of the participants' experiences of attending their therapeutic groups. The interpretative nature of the analysis means that some themes have been selected because they particularly illuminate the research question, with other themes appearing striking and noteworthy, adding insight and explanations about what the participants' experienced their groups. The themes have been selected with the aim of responding thoroughly to the research question *What is it like to be part of your therapeutic group?* These themes do not appear as fully separate from each other, but rather appear to overlap, which reflects the complexity of the research question and the idiographic ways that different participants think about aspects of their groups as they embrace the study.

I recognise the subjective impact of my interpretation of this co-constructed data which I conceptualise through a phenomenological lens. I have carefully selected from the wealth of the participants' utterances to present relevant and interesting quotations within each theme, and to highlight particular aspects of the analysis. Again, my subjectivity is apparent in which quotes have been selected and which have not. The participants' quotations include the use of condensed language (where different subjects are discussed simultaneously), unusual phrases, idioms and specific word usage. These are faithfully represented in the analysis to preserve the authenticity and integrity of the study. The selected quotations are rooted in the data with the participants' voices emerging from the hermeneutic circle process of exploring data parts and whole repeatedly to establish meaning. My position is that these themes emerge from my interpretative stance within the data and are provisional, subjective and co-created with the participants.

The themes presented in the analysis highlight how the participants describe using strategies and concepts they have learnt in their groups to help them manage aspects of their mental illness in their everyday lives. The themes conceptualise how their group experiences appear to have become enmeshed within their everyday lives, and how strategies learnt in their groups are being used to transcend

some of the obstacles of their severe mental illness in ways which suggest aspects of recovery. The themes highlight the ways in which group experiences appear to shape this process with some participants continuing to use strategies learnt in their groups after they no longer attend. The themes therefore express ways in which the participants continue to use the strategies learnt in their groups as on-going resources that help them negotiate challenges, thus some themes focus on the participants' pursuit of goals which appear life enhancing and could be considered to constitute aspects of recovery. There follows further discussion of the participants' utterances with regard to psychological theory, literature and research within the Discussion chapter below.

### **3.2 Analysis Key**

*Italicised* speech denotes direct quotations from participants with underlined words indicating emphasis, {curly brackets} indicating emotions expressed by the participant, [words] in brackets indicating detail that has been removed to preserve confidentiality and (numbers) in brackets referring to the transcript line numbers. The chapter now turns to an Overview of Themes.

### **3.3 Overview of Themes**

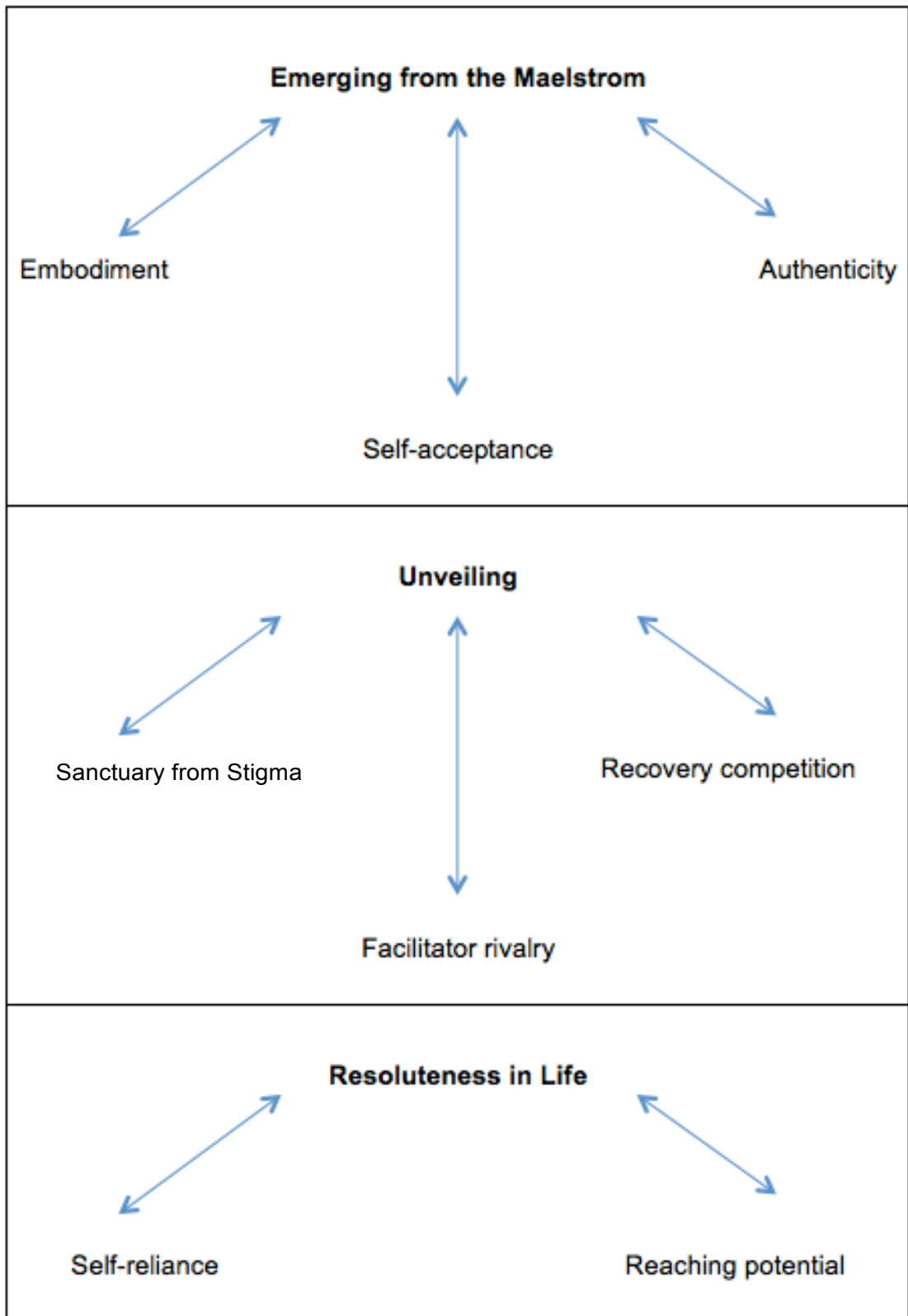
Three superordinate themes emerged: Emerging from the Maelstrom, Unveiling, and Resoluteness in Life. These are diagrammatically represented with their subordinate themes in Table three below.

The analysis begins with the superordinate theme *Emerging from the Maelstrom*. A maelstrom has been defined as turbulence and confusion (Collins English Dictionary, 1980, p.844). *Emerging from the Maelstrom* involves the participants discovering aspects of their individuality and uniqueness arising from their personal introspection.

There are three subordinate themes: the first, *Authenticity*, centres on the participants recognising and valuing their individual attributes and developing motivation to care for their mental health needs and attend their groups. The second

subordinate theme, *Self-acceptance*, focuses on participants' experiences of their groups to share knowledge and strategies to manage their mental health symptoms and acknowledge their experiences of mental illness, beginning to reconcile their mental health symptoms as inherent aspects of themselves. The third subordinate theme, *Embodiment*, explores the participants' experiences of their physical bodies, which at times may be limiting or over-active, and how the perspectives of their embodied experiences-in-the-world shape their self-beliefs. Participants use the support of their therapy group to challenge aspects of how their body appears to others and to manage their body-in-the-world. The first superordinate theme is *Emerging from the Maelstrom*.





**Table Three: Themes emerging from the analysis**

### 3.4 Superordinate Theme: Emerging from the Maelstrom

*Emerging from the Maelstrom* is a key focus of this study of MHSU experiences of therapeutic groups. It incorporates an exploration of the participants' experiences and perspectives of mental illness and the dynamic changes they notice emerging from within themselves since attending their therapeutic groups. Participants appear to suggest that the connection with the self has become detached during their mental illness and their outlook appears focused on past mental health trauma. Participants scrutinise the self, accessing inner thoughts through introspection to consider authentic, perhaps novel knowledge of themselves. Participants notice sensations that had seemed beyond knowing and they begin to notice their unique dynamic and agentic qualities which they acknowledge and value. The analysis now turns to explore the three subordinate themes: *Authenticity*, *Self-acceptance* and *Embodiment*.

#### 3.4.1 Subordinate theme: Authenticity

*Authenticity* relates to the participants getting to know themselves and engaging in a relationship with themselves. *Authenticity* relates to what one implicitly knows about oneself, including one's unconscious knowledge and the concept of oneself held in mind, according to Wallin (2007). The participants appear to notice their self-awareness developing through their participation in their therapeutic groups.

Gerry describes how he experiences his self-awareness emerging within his therapeutic group.

*Gerry: Just kind of a connection to myself. A deeper connection to understanding about the condition. And connecting inward, and really focusing thoughts and putting into words my experience, sharing it, sharing it within the group. So that was probably a big thing I think (116-19).*

Gerry reflects on seemingly new awareness about himself emerging since he attended his group as he engages with the effects of his mental illness. He describes a sense of connection to himself, noticing that he can express his inner thoughts and emotions to his group peers.

Gerry reflects on his experience of being sectioned against his will.

*Gerry: Some really horrific things that happened to me, in my 10 years within that hospital (37-8). Psychological and psychiatric rape actions. Can be held down by nurses and my trousers pulled down and injected. In some circles it is known as that (39-40). Totally without your consent. It's a complete violation. It's extreme (47-8). Having it happen to me was humiliating (48). It was quite yeah scary, horrendous; you know extremely frightening (61).*

Gerry reflects on offloading aspects of his traumatic experience to his group peers, initially using a third-person description as though he may be distancing himself from the trauma, and then he using first-person direct speech to describe his feelings about being sectioned. Gerry describes the violence tainting how he regarded himself. He speaks very fast, suggesting he may still feel anger at the way he perceives he was defiled by mental health professionals.

Gerry reflects on his changing relationship with himself as he began attending his therapy group.

*Gerry: When I first started I had no avenues of confidence, I was shattered personally. I was fractures (201-2).*

Gerry recalls that through attending his group he feels he has begun to reconnect with fragmented parts of himself, noticing he relates to himself differently, perhaps in a more attuned way, becoming aware of aspects of himself which once were obscured.

Gerry reflects on his recent experiences of his therapy group.

*Gerry: Men my age, sharing stuff that they cry. They kind of get really emotional. You know, I do less of that now I'm understanding more the experience (324-6). I learn from lessons within them (326). Not a real conscious kind of thing, just kind of lighter, kind of less of a load on the back*

*(285). I'm liking myself more doing well and for having found the different things of recovery (403). Less frightening times (940).*

Gerry notices how his awareness has changed since he attended his group, and that he negotiates his mental illness symptoms by managing his fear. Gerry's metaphor of having a load on his back suggested to me an image of Sisyphus who pushed a heavy stone uphill only to have it roll down and the whole process begin again, with Gerry perhaps using all his effort to process his distress, only to become aware of other painful feelings emerging during his group. He appears to regard himself as less distressed now and the '*lightness*' may suggest he has begun to process some difficult emotional awareness about himself. Gerry reflects on how these subtle changes appear to help him feel positive about himself and acknowledge his progress.

Andre notices how attending his group helps him to be himself, describing his new awareness about the way he relates to himself.

*Andre: My mind, body, spirit and soul are all getting connected together as one, as a group (488). There is something happening in me that is really coming out, really blossoming well (574). There's been a lot of things inside I've been wanting to get, but it's been stuck in there (585). Because this is what happens when you get this mental, this mental stuff. There's nothing to, maybe it's a part of paranoia (576-7).*

Andre reflects on his changing perspective of himself since attending his group, appearing to notice getting in touch with parts of himself that were detached and '*inside*'. He recognises the relatedness of his thoughts and feelings on how he perceives himself, noticing he has changed, expressing a sense of being liberated from something which had appeared '*stuck*' or blocked inside him, and perhaps letting go of something unpleasant or constraining. Andre describes himself '*blossoming*', suggesting the imagery of blossom coming to life and bursting into colour from dark wood branches after the dullness of winter, perhaps seeming transformational. It brought to mind how Andre's group appears to enrich his experience of himself, allowing brightness to emerge from within him, perhaps

illustrating that he senses attending his group has changed his awareness of himself.

*Andre: It's like I've been put on a level that has to be, has to be opened up by my conscious feelings, by being supported, and by making me feel, making me understand that I could be competent, I could be confident enough to let myself go (582-4).*

Andre appears to highlight his new awareness of emotions that he was unable to access before attending his group, suggesting that with the group's support he is getting to know himself authentically. Andre notices his self-confidence and agency developing, which he finds positive and liberating. Andre suggests he is more able to accomplish things than before he attended his group. He seems to have a realisation that his present situation is undetermined by his past saying 'let myself go' suggesting a defining moment on his journey of self-discovery.

David explores his experiences of attending his voice hearing group.

*David: It's a nice feeling. It was 'at last other people to relate to who have similar difficulties' {sighs}. I'd never been in a voice hearing group. I very rarely talked about it outside of the psychiatric circles (189-191). That's another thing about groups: they're not judgemental if you feel secure (217). It all relates to trauma in early life (219). It takes a lot of the anxiety completely that I end up hearing now (341-2).*

David describes his relief at being able to discuss his voice hearing in his group with other voice hearers. He describes relating to his voices differently as he now relates to himself less anxiously, perhaps embracing himself as a voice hearer and moderating his fear into acceptance since attending his group.

### 3.4.1.1 Summary of Authenticity

Since attending their therapy groups, Andre, Gerry and David appear to experience the processing of their mental health trauma and seem to have developed self-awareness, changing their outlook of themselves to one of compassion and self-belief. The participants notice insights and the ability to reflect on aspects of themselves that were not known but have emerged during their attendance at their groups. The participants appear to utilise their groups to moderate some of the socially debilitating constraints of their mental illness symptoms. They value their progress, focusing on their mental health improvements and acknowledging subtle ways in which they have developed personal control through their agency. Since attending their groups the participants appear to regard themselves less critically and more holistically. The section now turns to consider the subordinate theme *Self-acceptance*.

### 3.4.2 Subordinate theme: Self-acceptance

*Self-acceptance* is defined as tolerating oneself (Collins English Dictionary, 1980). This subordinate theme explores how the participants experience negotiating and managing their mental illness symptoms with support from their therapeutic groups, actively seeking out what they need to remain mentally well and being compassionate towards themselves. Galvin appears to be a divergent voice, expressing that he does not feel ready to acknowledge his mental illness symptoms.

Adam reveals that through attending his group he has learnt to recognise ways he could modify his mental illness symptoms.

*Adam: This is an on-going condition and I'll be on medication for the rest of my life (327-8). I am actually subject to certain amounts of levels of stress, more so than most people, so that's something that I recognise (329-30). I have to sort of take in the possibility that perhaps at some point in my life I might have a relapse (324-5). I would come through (326).*

Adam appears to accept that the impact of stress may be detrimental to his mental health since attending his group. His acceptance appears to help him recognise that

he could take action to diminish the intrusion of his mental health symptoms by taking medication and reducing stress.

*Adam: It's very important if you've got this condition that you try and face things, face up to things in a small way to start off with. To try and build your confidence up (128-30). Part of that process involves things like attending groups and being with people (130-1).*

Adam describes learning to negotiate his symptoms by utilising his group peers' suggestions. He notices that his self-confidence and self-awareness have developed, and appears to regard the group support as beneficial in helping him to 'process' his situation and reflect on the positive changes he has made. Adam's perspective seems to be to accommodate his mental illness as part of his individuality and uniqueness.

Gerry explores how through attending his group his insights into his mental illness appear to have changed his view of drinking alcohol.

*Gerry: When I was ill I had experiences which I had to make changes, for example I was drinking, binge drinking heavily, and one of the changes I made was stopping alcohol (366-8). I knew that the alcohol was causing the extremes, the extremes of the mania, the extremes of the depression (371-2). A lot came from that decision, a lot of positive motivation (369).*

Gerry appears to reflect on facing up to his mental illness, noticing the negative effects of alcohol. Gerry's decision to avoid alcohol seems to have become a turning point for taking control and increasing his awareness that his action could produce positive results.

*Gerry: I've got very strong memories of very bad self-acceptance. I mean, you know, really testing myself. Me not liking who I was, being very self-conscious of myself, whereas in recent times I kind of learnt more of accepting myself (393-5).*

Gerry seems to have become less critical and less hostile towards himself since attending his group.

Florence regards receiving different diagnoses as conflictual in terms of what they mean about her mental health.

*Florence: Say for instance you're being diagnosed as bipolar and you're not, you're just clinical depression. That can go down on your medical thing and that can harm you, through the years, that you're this, which is wrong (107-9). I've been labelled different types of things like manic depression. What was the other one? I was personality disorder, which I never had. The later one was bipolar, which I'm not. I was just simply clinical depression, severe, severely clinical depression (112-15).*

Florence appears to accept her depressive symptoms but regards the other mental health diagnoses being at odds with how she experiences herself with mental illness. Florence disapproves of the diagnoses being recorded for years.

Andre outlines how his perceptions of his mental health have changed since attending his group.

*Andre: I know I have to keep myself active because when I get into that depressive side again (which I don't want to get into), because I'll fall down (277-8).*

Andre seems to accept the potential uncertainty of his future living with severe depression. He notices that keeping active helps him to stabilise his mood by managing his symptoms. He creates a poignant image of 'falling down', perhaps suggesting he fears becoming overwhelmed by managing his oscillating mood and symptoms.

David regards the impact of his anti-psychotic medication as beneficial.



David: *I still need medication (373). Some people say 'come off medicine'. It's not as simple as that. I'd rather have a little bit of medicine and talking therapies (375-6). Because without medication I'd probably be feeling extremely inferior and God knows what else (369). Once you're stable on medicine you can, you can look at other ways, other treatment, other issues (370-1).*

David accepts that his stability and symptom control have been supported by taking psychotropic medication, which enables him to continue attending his therapy group; however, he accepts others in his group may feel differently about medication. David seems to tolerate there may be future uncertainties, saying '*God knows what else*'.

David's awareness of his voice hearing appears to have changed after using the interventions suggested by his group.

David: *We explored strategies. It's necessary for hearing voices. But we all explored trauma (317-8). We all hear voices and some of the voices can be very distressing (318-9). And that was like a light bulb going off (320). I used to get terribly anxious as you would but when [facilitator] clarified that I thought "that's good isn't it?" Things like that really he gave us pointers. He's a voice hearer (323-5).*

David appears to adopt the interventions the group facilitator suggests because the facilitator uses them successfully himself. David's *light bulb* metaphor suggests he becomes aware of less critical ways to relate to his voices and to himself, offering him a sense of control over his voice hearing.

Galvin describes a somewhat divergent perspective of *not* accepting or facing-up to his negative mental health symptoms. He experiences returning to the same therapeutic group after a break of ten months.

Galvin: *Most of 'em said 'it's fantastic to see you come back, we're stuck with you ha!' And yeah it's amazing how when I felt low, they won (1147-8).*

Galvin's utterance '*they won*' seems somewhat ambiguous, perhaps referring to his mental health symptoms which may have seemed overwhelming to him so that perhaps he senses losing the battle against them. Alternatively, maybe Galvin is referring to the other group members who may appear to have won over their mental illness symptoms, as they continued to attend the group when he was absent. Galvin appears to minimise his perception of his mental illness saying '*I felt low*'.

#### 3.4.2.1 Summary of Self-acceptance

Some participants notice their mental illness symptoms diminish, as they seem to develop agency and experience control in their lives. Some use group interventions; others develop self-awareness, perhaps as a consequence of attending their group, noticing that changes they make could have positive effects, maybe experiencing themselves more compassionately. Galvin's focus seems perhaps more competitive and self-critical, seeming to minimise rather than acknowledge his situation. The analysis now turns to explore *Embodiment*.

#### 3.4.3 Subordinate theme: Embodiment

*Embodiment* relates to the impact of the participants' physical body-in-the-world, the body's responses to mental illness shared within the therapeutic groups, and focuses on how the participants experience and perceive their bodies. Heidegger (1927/1962) defines embodiment as the root of being and existence, a physical presence which impacts within the world. The participants appear to experience their physical body as simultaneously offering information and receiving cues from the lifeworld, so that an individual's embodied presence in the world influences their experiences *and* how they are perceived.

Tania's embodied presence in the world is beset by her voice hearing. Tania reflects on the different ways her group have supported her managing her voice hearing.

*Tania: Sometimes I just try ignoring them and doing my artwork (317). Or just have your headphones on, like before. I used to wear two headphones to listen to my music but one of the people in the group said 'why don't you put one there and just have one on?' See if that helps, and yeah it does help (318-20).*

Tania experiences the impact of her voices as an intrusion on her concentration and she uses her group peers' suggestion to modify her strategy to manage her voice hearing differently and focus her attention on her chosen activities.

*Tania: Like if I'm on a bus, with screaming kids, I have to get off because the voices get really worse and then I get so annoyed that I've got off the bus, because I'm late for an appointment, so I'm really angry by the time I get to the appointment, so I have to stand outside for five minutes and have a cigarette. Calm myself down before I go in (345-9).*

Tania's experiences of voice hearing suggest that in situations where she feels unable to control her voices she is prepared to remove herself from such unhelpful or invalidating environments. In her lifeworld it seems she is constantly monitoring her environment to moderate the impact of her voice hearing.

Georgina describes her experiences of constant bodily pain which appear to make it difficult for her to physically attend her group.

*Georgina: With my headaches, the way to not have it thumping all day is to go back to bed (153). I've got chronic fatigue as well. At the moment, I can hear it in my ears, I've got tinnitus. I can hear it whistling (156-7). It's hard to get here, it really is but I'm trying (158). I've got a thing called fibromyalgia which is like chronic all-over body pain. It's like in your muscles. I've also got arthritis. I've got lots of other things that go wrong (306-7).*

Georgina seems to experience her struggle with pain and the limitations of her bodily movement as a conflict she constantly negotiates, in order to balance

physically attending her group against resting, which appears to keep her headaches in check.

Georgina describes her experience of depression, disengagement and dissociation, which seems to negatively influence her cognitions.

*Georgina: Since I had my depression I don't really get inspired or what do you call it? I can't think of the words, no I can't think. It's like you don't want to do things because there's no exploration and stuff. Just, it's like there's nothing there, there's no feeling in there (50-3). I feel distant because I can't concentrate on stuff (57).*

Along with her physical bodily pain, Georgina simultaneously describes her experience of being given a diagnosis of major depressive disorder, which she notices as a sense of withdrawal and detachment, perhaps disengaging her from creativity and discovery which might add enjoyment, variety and interest to her life. Georgina's powerful imagery '*nothing there*' seems to describe a kind of nihilism, an absence of embodied experience.

Georgina reflects on her experiences of attending her group.

*Georgina: I never came until then. [Friend] has been coming for a while and she said to me 'why don't you come' so I came (394-5). My friend said I'm less stressed and I'm happier but I don't know if that's true or not (274).*

Georgina appears to experience her group peers as supportive, encouraging her physical activity and group attendance. Georgina seems aware of her embodied limitations which she overcomes with her friend's support to participate in her group. Mental health professionals could encourage existing group members to accompany new attendees to help them settle into groups. Georgina's embodied pain appears chronic and it is unclear whether it could be a primary contributor to her depressive symptoms, or whether her depressive symptoms emerged first, perhaps influencing how Georgina regards her pain.

Andre reflects on his severe anxiety, which could prevent him from speaking within his group.

*Andre: I used to go awake, I had this hot hot sweat, I know, and then lots of clothes off. I couldn't say anything (182-3). You had to use your mind to communicate, that's one of the things I used to have difficulty in, talking amongst, talking about something amongst people in the same line (176-8).*

Andre describes how physical anxiety in his group used to prevent him sharing his thoughts with his group peers. With their support, Andre has developed a strategy to communicate with his group by writing his contributions.

*Andre: I wrote down a list of all the things. I wrote about the previous week, about what I wanted to say that I couldn't, I wasn't in the right spirit at the time, but I actually wrote down and I, and I said to them 'this is what my feelings are' (348-50).*

Andre reflects on overcoming his embodied constraints, and by acknowledging his difficulty he generates a strategy to resolve it. His successful group participation appears to motivate him further.

Florence reflects on her embodied experiences of voice hearing and how she used to swear at her voices in public and people might stare, which appears to have led her to avoid going out.

*Florence: I find it difficult to socialise with people outside, and especially when they find out that you're mental health (64-5). I've always been a voice hearer yeah and I've learnt since I've been in the voice hearing how to cope with the voices, you know (18-9). Different strategies you can take when you do get the voices. Say for instance if you're on the bus and you hear voices you want to answer back, and the best way to do it is to make out that you're on your mobile, then you can answer back to the voices, and tell them to f\*\*k off {laughs} (20-23). You get the sense that nobody is looking at you then,*

*because before that, before I learnt that strategy (28-9). I used to swear. But I don't do that now (30). I had voices of suicide and I've learnt how to deal with that now (31-2).*

Florence uses a strategy suggested by her voice hearing group to manage her voices. She notices her self-confidence appears to have improved, enabling her to use public transport. It seems that Florence regards her suicidal voices as being within her control since attending her group, thus improving her quality of life.

#### 3.4.3.1 Summary of Embodiment

The participants appear to experience embodied pain, distress, anxiety and intrusion, where their body functions, looks or feels at odds with what they expect. The body-in-the-world continues to be the interface within which the participants perceive and process bodily cues and limitations, and is how they are seen by others in their groups as they try new approaches to manage their body-in-the-world. Tania and Florence describe socially hostile environments. The participants' experiences focus on alleviating the intrusion and restriction of mental health symptoms within their bodies. Strategies shared within the group seem to enable the participants to perceive their embodied reactions from a different viewpoint, which they experience as liberating, improving their self-confidence and increasing opportunities for social interaction. This section now turns to consider the superordinate theme of *Unveiling*.

### 3.5 Superordinate Theme: Unveiling

*Unveiling* explores the participants' experiences of themselves as they are perceived during their interactions with others in their groups. The participants continually review aspects of themselves as new insight emerges. *Unveiling* suggests aspects of the participants emerge and become unmasked simultaneously to themselves and to others. *Unveiling* includes the subordinate theme *Sanctuary from Stigma*, exploring how the participants perceive and manage humiliation and discrimination from stigma by seeking refuge within their groups, where they can discuss their experiences with other service users. The participants appear to be constantly comparing themselves to others they encounter and this is explored in

two subordinate themes. *Recovery Competition* involves the participants comparing their own experiences of recovery in a more favourable light than those of their MHSU group peers; *Facilitator Rivalry* focuses on the participants' experiences of their relationships with facilitators, including their apparent challenge of their group facilitators' leadership in a somewhat rivalrous dynamic, while simultaneously striving for independence away from their groups.

### 3.5.1 Subordinate theme: Sanctuary from Stigma

*Sanctuary from Stigma* explores the participants' experiences of discrimination, marginalisation, rejection or rudeness because of others' perceptions of them as MHSU. The participants express relief that their group offers a sanctuary to reflect on how stigma has affected them. Group peers also describe similar experiences and the fear of re-emergence of mental health symptoms arising from the stress of stigma.

David describes experiencing ostracism.

*David: I know I'm different, but not feeling so much strange like. I hate being called weird or strange. People do (296-7).*

David experiences distress and humiliation when he feels he has been undermined by others who appear to treat him with disdain. David suggests he differs from others.

Andre experiences the impact of his stigmatisation as loneliness.

*Andre: No one wants to talk to you, everyone tries to avoid you. You try to be human and speak to people. None of the people, you know, don't want to know you, and you get so isolated, you tend to freak out, and make it even worse (200-3). My neighbours even hate me (447). They don't know me, they think I'm a complete headcase (449). The ones who've been living on*

*my estate, here, for quite a long time who I know well, they don't even want to talk to me, so I'm really isolated. And this is my only sanctuary (450-1).*

Andre describes experiencing his group as a refuge and a safe place to get support when he feels spurned by others. He describes his ensuing isolation *freaking him out*, perhaps suggesting that his mental illness symptoms re-emerge or become overwhelming in response to being ostracised.

Andre reflects on his solitude resulting from stigma before joining his group.

*Andre: I was walking on private water (394). It's taken me a long time, to finally, to get to my senses (432-3).*

Andre uses a striking metaphor, '*walking on private water*', which seems to epitomise his isolation; perhaps he assumed he was alone in struggling with his mental health difficulties. The metaphor could suggest that perhaps his recovery feels temporary and that he could fall into the water, with the water imagery suggesting something moving and unstable beneath him. Andre describes his group helping him find stability.

Florence experiences her friend severing contact with her after discovering Florence has experienced mental illness.

*Florence: She said something about mental health, and I said 'yes I am', you know and she put the phone down and never talked to me again. And we'd been friends for a couple of years. And she didn't know I was mental health (499-501). You've got kids on the estate saying 'there's a loony there' you know, when they found out. Kids can be very cruel (505-7). There's a stigma that still goes on (65-6).*

Florence reflects on the dilemma that she and others with mental illness negotiate in terms of choosing whether or not to hide their mental illness from others who may ostracise them, and she experiences rejection from someone she knows. Florence



describes being invalidated by local children and her stigma experiences reveal a somewhat precarious element of her lifeworld, as she negotiates on-going uncertainty.

Galvin experienced being denigrated and marginalised as a child, explaining he found a professionals' attitude stigmatising.

*Galvin: The psychiatrist said to my dad, he said nothing to me (495). He said 'you shouldn't have been born'. He said 'you've got a, you're so mixed up, you'll be in and out of institutions, God knows what' (498-9). He was right. (503).*

Decades later, Galvin experiences distress from such negative predictions for his future and his view seems to be that those negative expectations somewhat shaped him: '*he was right*'. Galvin is speaking very fast as he expresses his anger about being invalidated when he regarded himself as a vulnerable child.

### 3.5.1.1 Summary of Sanctuary from Stigma

The participants appear to be experiencing exclusion from their communities arising from painfully invalidating encounters with others. The participants notice that they feel safe to explore their discriminatory experiences with peers in their groups, among people who may have been similarly undermined and marginalised, which they experience as *Sanctuary from Stigma*. Their perceptions focus on loss and solitude, with some participants adopting a somewhat tenacious stance. The analysis now turns to *Recovery Competition*.

### 3.5.2 Subordinate theme: Recovery Competition

*Recovery Competition* explores how the participants mediate the view others have of them by appearing to position their mental health recovery in a more favourable light than that of their group peers, presenting their experience of recovery as superior and more comprehensive compared to the other MHSU.

Gerry compares his experience of mental health recovery to that of his group peers.

*Gerry: I'm kind of doing very well within the mental health system of recovery, sometimes upwards of the higher echelons of people doing well. Some are really doing not so well and it makes me feel like: so maybe I am doing well within a system that's of people that are not doing so well (397-400). Kind of gone really far down the roots to recovery, in relation to other members mainly (301-2).*

Gerry seems to compare his recovery against that of his group peers, positioning his achievement positively in '*the higher echelons*', which perhaps suggests that he perceives a hierarchical system where he occupies a superior position. The '*roots to recovery*' image suggests a stable, firmly fixed and solidly placed object (like a tree), which could promote Gerry's continuing recovery and future growth. Gerry seems to suggest that other MHSU may not be so firmly rooted and as such their recovery might not be as robust. The image of recovery as a tree with strong roots has been adopted by mental health bloggers (Prs, Inc.'s Blog, 2009).

Andre appears to elevate his own recovery experience by highlighting that he now speaks in his group.

*Andre: I feel, I feel guilty that maybe they can't talk because they are frightened because I'm saying too much (228). I find that very difficult now because I used to be (223). I used to be like them myself, wanting to say something (224).*

Andre perhaps finds his group peers' silence uncomfortable and he appears to question his own contribution to his group, wondering whether he is '*saying too much*'. Andre could perhaps be establishing that speaking-out positions his own recovery as superior compared to that of his non-speaking peers. He questions whether the other MHSU may be frightened, as he used to feel, seemingly putting himself in their place in an attempt to become aware of what their silence might mean. There may be many reasons why Andre's group peers may not be participating.

Andre: *But some of the people I tend to imagine they can't do much, you know the people that don't talk much, there can't be much in their lives (288-9).*

Andre seems somewhat dismissive of the silent group members, assuming they are disengaged and inactive compared to him, which appears to further heighten his recovery compared to theirs.

David compares his experience of recovery to that of others in his group.

David: *People don't have the capability to understand the therapeutic process. It's not their fault really. It's just the stage they're at. We're all at different stages of recovery (67-9).*

David seems to elevate his recovery related to his group peers, seemingly suggesting that he benefits more from the group process.

David appears somewhat intolerant of his group peers seeming lack of recovery.

David: *I don't want to be nursed all my life. There is an investment in being unwell. And that's the trouble, you don't take responsibility. You don't have to do anything. Once you take responsibility it's not that bad and awful. I think they'd be much better off these guys. I worry about them really (358-63). There's voice hearers here who won't go in the group, because they don't know about the group, because they don't listen half the time, or they are too intense. They don't want to accept they are hearing voices or don't realise they hear voices (496-499).*

David appears to suggest his recovery is superior to his peers who choose not to attend his group, seeming to suggest that their non-attendance may be irresponsible. David's apparent detachment from them perhaps enables him to escalate aspects of his recovery, such as his acceptance of himself as a voice hearer.

Galvin seems somewhat contemptuous of the other members of his group.

*Galvin: I'm saying to myself 'Oh these are like robots in there'. You know they're too frightened to talk because they don't want to know what the hearing voices is (345-7).*

Galvin refers to the other group members as 'robots', perhaps suggesting his indifference to them. Galvin seems to accept his voice hearing. Galvin's suggestion that the other MHSU may be afraid perhaps obscures his own fears of some of the uncertainties of his mental illness. Andre and Galvin seem perturbed by the silence of others in their group, perhaps perceiving their silence as unnerving.

### 3.5.2.1 Summary of Recovery Competition

The participants appear to experience their recovery as superior and detached from that of the other group members, seeming to somewhat understate their peers' recovery while boosting their own recovery achievements. The theory of downward social comparison (Tedeschi and Calhoun, 1995; 2004) offers a possible framework within which this phenomenon might be explored and is considered in the Discussion chapter below. The next subordinate theme is *Facilitator Rivalry*.

### 3.5.3 Subordinate theme: Facilitator Rivalry

*Facilitator Rivalry* explores the participants' interactions and rapport with their group facilitators, which seem somewhat rivalrous and challenging, as the participants appear to vie for leadership of their group.

Gerry reflects on directly challenging his group facilitator's leadership.

*Gerry: That kind of kicked off the group really (497). I found it an empowering thing to have directed a group really. It affected me afterwards that it had been me that suggested it. The group went quite well(498-9).*

Gerry's experience of apparently assuming his facilitator's role seems to enable him to emerge as an alternative authority within his group, such that he appears to raise his hierarchical status above that of the other group members, perhaps highlighting his sense of recovery and emerging self-confidence. During the research interview Gerry recalls this incident as one of the highlights of attending the Men's group.

Gerry appears to experience other seemingly facilitative roles in his group.

*Gerry: I was running around trying to rescue people somehow - because I'd had a, such a level of recovery, I thought 'I'm coming in here to save people'. I'd got so much going for me (337-9).*

Gerry notices his wish to 'rescue' others when he competes with his facilitator to lead others. His desire 'to save people' could perhaps suggest a religious inclination, as though Gerry might like to convert other MHSU to his way of thinking, appearing to position himself as superior within his group.

Gerry reflects on his relationship with one group facilitator which he found validating and containing.

*Gerry: That was one of the groups I can remember which, which made me feel, yeah, valued. Just want to feel accepted, just valued and be understood and appreciated. I got finally, because I'd been doing other things, but it really gave me a lot of value, appreciation and acceptance (861-4).*

Gerry also describes a somewhat divergent perspective by explaining he does not feel competitive with every group facilitator. Gerry expresses feeling validated by a particular facilitator and the significance of that relationship.

David also recalls a somewhat divergent perspective when he acknowledges his group facilitator was supportive.

David: *Always made things clearer. He's always helped me explore things. I join most of the groups here (20-1).*

David seems fulfilled by his facilitator's relationship with him, appearing not to experience competitive or confrontational impulses to take over leading his group.

Tania appears to undermine her group facilitator by questioning his competence.

Tania: *I thought because he took the groups he should know all about where to send people but he didn't. And that made me really angry, so I haven't been since (26-7). When you start talking about your voices he doesn't, he always butts in before you've finished (470). I don't feel comfortable enough to go there anymore (19).*

Tania highlights her facilitator's ineffectiveness and inability to listen, which perhaps offers her an opportunity to express rivalry towards her facilitator, signalling his alleged incompetence and enabling her to demonstrate her developing independence and autonomy by leaving the group. Tania appears to focus on her facilitator's apparent deficits by contrasting them against her own seemingly superior position in no longer needing her group.

Galvin appears to challenge his facilitator's competence when he feels he has been ignored.

Galvin: *But it felt like the chair was the one that you had to overtake because they didn't see me and [name] in the same vein, it was as though [name] had more (1112-14).*

Galvin relates to the group facilitator as the '*chair*', seeming to avoid acknowledging her role as group leader, perhaps minimising the perceived hierarchical differences between them. Galvin appears to experience the lack of his facilitator's acknowledgement of him as invalidating. This experience seems to dishearten Galvin and he expresses a sense of injustice that he appeared invisible. Galvin's

stance is to 'overtake', which when reversed becomes 'take-over' and could perhaps suggest competitiveness towards his group facilitator. Being noticed and understood appears important for Tania and Galvin, possibly relating to earlier experiences of unmet needs (according to Bion, 1962). This is explored within the Discussion chapter below.

Florence experiences her facilitator's seeming incompetence.

*Florence: The facilitator just keeps on the same thing all the time. And we, the users, find it's not helpful (422-3). Because it's the same thing every week, the same thing is not good every week (423-4). We're going to change the strategy and do other things towards hearing voices (426). We know that the facilitator won't like it, we know that but that's what we want, to change (433-4). We want it different (435).*

Florence appears to negatively appraise her group facilitator, perhaps increasing her own status and autonomy within the group. Florence appears to engage the whole group in planning to usurp the facilitator's role.

### 3.5.3.1 Summary of Facilitator Rivalry

Some participants appear to closely observe and highlight any perceived deficiencies of their group facilitators. They critique their facilitators, perhaps to undermine the facilitator and raise their own status and autonomy within the group. Some participants experience their emerging independence apart from the group. However, David and Gerry offer contrasting perspectives, seeming to experience containment and validation through their facilitator relationships. This section now turns to consider the superordinate theme *Resoluteness in Life*.

## 3.6 Superordinate Theme: Resoluteness in Life

*Resoluteness in Life* incorporates aspects of the participants' personal development, self-reliance, recovery, fulfilment, hope and finding meaning in life. Resoluteness is defined as a firm belief, determination (Collins English Dictionary,

1980, p.1242). The participants appear to become future orientated, demonstrating how they have overcome difficulties to achieve their goals, with some participants noticing meaning and purpose in their lives. There are two subordinate themes. *Self-reliance* explores the participants' recognition of their strengths and capabilities to set plans in progress, reflecting on how their use of group strategies has helped them to manage intrusive symptoms, building self-confidence and motivation to work towards their goals. *Reaching potential* explores the participants' acknowledgment of their achievements, such as how they have overcome obstacles, and which group strategies have helped them to accomplish their goals. Some participants experience external validation, which appears to boost their sense of recovery. The subordinate theme *Self-reliance* is now explored.

### 3.6.1 Subordinate theme: Self-reliance

*Self-reliance* focuses on the participants' recognition of their emerging potential and self-sufficiency. They reflect on what they have learnt through attending their therapeutic groups, focusing on the symptoms and obstacles which they have moderated, and they make plans which could help them remain well and manage future uncertainty.

Jade expresses her autonomy and her realisation she could determine her own future.

*Jade: I feel I've got to do it. I've got to turn, rely on my own resources (749). I want to learn from the experiences (246). It's so many things isn't it? (251) Having purpose, having a purpose in your life I suppose, family and friends. You know there's no one component really, y'know what I mean. How can you say? I suppose you could say good mental health as well {laughing} that contributes to better quality of life (252-6).*

Jade's awareness of her developing confidence seems to help her notice her capabilities to manage her mental health and begin to consider future plans.



*Jade: The first thing is: let occupation be your, what's the word, your crutch. It's got to be. First thing is some kind of occupation, whether it be working or coming to a day centre or voluntary (270-2). Some people do recover from mental illness, there is, y'know, there is hope (470-1). I have had periods now when I look back and I was quite stable (471-2).*

Jade seems optimistic about her future, noticing that she regards negotiating her mental illness symptoms as secondary to her goal of immersing herself in purposeful activity. Jade appears to be reflecting on her experiences of mental illness over several years, and she expresses optimism that others appear to have recovered and this appears to help her recognise when her own mental illness became less intrusive.

Andre appears to notice his future hopefulness.

*Andre: I feel like a human again, I feel like I've got a purpose, a commitment. I feel like I've got a goal to head for. I feel like I can (480-2). Be all we can be (382). I can speak, I can talk my mind (623).*

Andre seems to express how his self-confidence has emerged from challenging himself and developing skills to speak in his group and that he 'can' communicate his inner thoughts effectively. Andre appears to be taking control and challenging himself to overcome future obstacles to 'be all' he can be, with support from his therapeutic group.

Adam describes his experiences of absorbing feedback from his group.

*Adam: The group is quite often where you find out people having perhaps a different angle on things (335-6). I've tried to see things from their angle (338). I've got to figure this out, making friends (340). There must be people but I haven't really come across them and I would like to meet them (249-50).*

Adam seems aware since attending his group that if he could make friends he might experience less loneliness. Adam seems to regard his future confidently, perhaps suggesting he values the new insights he has gained from his group.

Tania regards her voice hearing as less threatening since attending her group.

*Tania: I understand more about where I'm going now. I understand a little bit more about myself (297). Like who the voices are, because one of them, they could be a family member, or it could be someone in your past that's in your head (302-3). They're saying that I should name them. But I only named one which is [name] the worst one, he's a bully(304-5).*

Tania expresses her growing control over her voices, and she suggests this may have arisen from her changing her perception of them. Tania describes how with the support of other voice hearers in her group that she has named one of her voices, perhaps offering her a sense of control over the intrusions from that voice.

### 3.6.1.1 Summary of Self-reliance

The participants appear to experience managing their mental illness symptoms and future uncertainties by being resourceful and courageous, recognising their abilities to make future plans which could help them remain well. The participants reflect on the strategies they have used with their group peers' support which appear to have helped to moderate the effects of their symptoms. There appears a sense of hopefulness and agency in their outlook: with a focus on plans in-progress. The next subordinate theme, *Reaching potential*, focuses on goals already achieved.

### 3.6.2 Subordinate theme: Reaching Potential

*Reaching potential* could be defined as discovering self-fulfilment and skills (Maslow, 1954). *Reaching potential* focuses on the participants finding meaningful stimulation that gives purpose to their lives. They describe having managed symptom intrusions and recognised triggers which may worsen mental illness and they express agency in choosing activities that they find stimulating and enjoyable.

Adam describes managing his symptoms of severe anxiety and reflects on the differences he notices about himself now when he relates to others.

*Adam: Putting yourself in an uncomfortable situation repetitively, time and time again over an extended period of time, actually that helps (173-4). Trying to identify what thoughts trip off anxiety (179). I've worried about what people think of me really as a person (181-2). I've challenged all that and it's only bit by bit I know, but I'm overcoming my problems now and I've had to go back to work part-time tutoring maths on a one-to-one basis (188-90). I love mathematics yeah. I did maths at university you see. That's where I had my first breakdown but I still managed to get a degree (196-7). Most people have the impression that mathematics is a very cold and logical way of thinking, but actually it's quite creative. And there is a pleasant geometry associated with it. It's intellectually quite satisfying, you know there's a beauty about it that I can't really sort of put into words. But I can appreciate the way it's structured. It has a very beautiful structure (211-6).*

Adam notices that his interest and skills lie within mathematics and he expresses pleasure from his mathematical degree and the external recognition he has earned. Adam's observations of what others perceive about mathematics may have arisen from the feedback of his group peers. Adam notices how he used to feel uncomfortable attending his group and how by challenging himself, that has become easier.

Florence experiences fulfilment through her dramatic achievements.

*Florence: The one voluntary service I do is for older women and it's on ageism. I'm [age] (237-8). I'm out in the public now doing scenarios. We do little plays, comedy plays (because otherwise they'd be boring!) on ageism. And we've had massive results and we won an award (244-6).*

Florence's interest and stimulation seem to emerge from acting in dramatic productions in which she challenges herself to go out into her community, although earlier she described how intrusions from voice hearing used to prevent her from

going out. Florence's account appears to demonstrate that in using the group strategies to manage her voice hearing she now feels confident in going outside and acting in drama productions. Seemingly, in conquering her voice intrusions, Florence's confidence appears to have improved and she now receives positive external acknowledgement, which in turn adds pleasure and meaning to her life.

Gerry reflects on his experiences of becoming involved in public poetry readings.

*Gerry: Kind of excited about sharing my story. I knew the poetry. I was told it was strong by the tutor and the other people. I think people got a lot from it. They said it was very moving and it's a beautiful piece (168-70).*

Gerry notices his ability to express himself through poetry, which has seemingly enabled wisdom and erudition to emerge from his earlier mental health trauma, offering him new insights and meaning in his life. Gerry's skills involving writing and reading poetry appear to have developed into opportunities for public speaking. Gerry used to exhibit anxiety when speaking in public and through self-challenge and encouragement from his group peers he appears to manage speaking in public. Gerry's poetry skills receive external validation which appears to support his recovery and self-worth.

### 3.6.2.1 Summary of Reaching Potential

The participants appear to recognise their achievements, noticing their determination and self-challenge to reach their goals and create meaning and pleasure in their lives. The external validation of such achievements perhaps confirms the competence of the participants in overcoming complex obstacles to fulfil their goals and experience fulfilment and satisfaction. The participants experience engaging with others in their community, perhaps further boosting their self-confidence and self-belief. Mental health recovery, finding meaning, and gaining fulfilment are explored further in the Discussion chapter below.

### **3.7 Summary of Analysis Chapter**

The interpretative phenomenological analysis of the nine participants' utterances in this chapter reflects their initial difficulties in attending their therapeutic groups, however, through attending they appear to increase their self-awareness and gain alternative perceptions of their mental illness symptoms. Acceptance of their mental illness appears to develop within their groups as their focus on future uncertainty is reduced and skills and shared strategies are utilised. Facing-up to things and developing an authentic self-awareness becomes a key focus, with participants describing being supported by other group members' suggestions and encouragement. Stigma and discrimination feature in the participants' experiences and appear overwhelming and undermining. The participants describe their isolation and withdrawal after they experience stigma. It appears that attending therapy groups offers a sanctuary from stigma, perhaps highlighting the value of peer support to overcome obstacles and difficulties.

The participants' experiences of their groups highlight how some participants present themselves as more recovered than their peers, which seems to increase their self-confidence and elevate their status compared to that of their peers. Participants also appear to challenge their group facilitator's leadership role. This could offer an opportunity for participants to enact a different, perhaps more assertive role, demonstrating personal qualities such as independence and autonomy. Participants describe becoming future focused and make plans. Some participants describe their positive experiences of achieving their goals and receiving external validation. The study now turns to the Discussion chapter, where literature, research and psychological theories relating to the participants' experiences of their groups will be explored.

## Discussion Chapter

### 4.1 Introduction

The discussion chapter begins with a review of the themes emerging from the analysis. Each theme is considered within the context of the debates highlighted by existing research, with the aim of contextualising the participants' experiences of their groups. Some of the present study findings appear to differ from existing research and the participants' personal insights into their experiences of attending therapy groups are unique and contribute to enhanced awareness in the field. The present study's implications for practice, the study's limitations, and suggestions for further research follow. In the theme *Recovery Competition* it emerged that in the present study the participants appear to compete with their peers, presenting their own recovery in a more favourable light. This phenomenon does not appear to be the focus of existing therapy group research, suggesting it represents a novel finding arising from the present study. In the theme *Facilitator Rivalry* it emerged that some of the present study participants challenged their group facilitator's leadership role, perhaps vying for superior status within their group. This situation is briefly considered within some therapy group research, which is presented from a facilitator perspective; however, this study differs by offering individual insights into how the participants perceive their facilitators and appear to use the opportunity to their advantage. It appears both *Recovery Competition* and *Facilitator Rivalry* could disrupt therapeutic relationships and the therapy process within the group where such processes remain unacknowledged. I posit that considering the context in which these two phenomena occur could illuminate alternative understanding of the participants' behaviour and is important for the survival of the group as a therapeutic space in which to maintain the engagement of the members in continuing effective group therapy. My stance is to be curious and open about all the issues pertinent to answering the research question: *What is it like to be part of your therapeutic group?*

## **4.2 Research Aims: Contextualising the findings within existing research**

The study set out to explore how MHSU experience being members of their groups; what the opportunity of attending a group offers and what assists MHSU to participate in groups. The section will consider each theme in turn within the context of existing findings and begins with consideration of the first superordinate theme: *Emerging from the Maelstrom*.

### **4.3 Emerging from the Maelstrom**

The superordinate theme *Emerging from the Maelstrom* encapsulates the present study participants' experiences of reflecting on turbulence, trauma and mental distress from which they describe emerging as they become aware of complementary alternative perceptions of themselves and their symptoms. From these descriptions it appears the participants discuss their dynamic connection with the self, perhaps discovering awareness which has only recently become apparent. *Emerging from the Maelstrom* focuses on the participants' experiences of changing self-awareness, emerging confidence, expressions of self-compassion, and valuing their own uniqueness, which appear to emerge from their self-reflection within their therapeutic groups. The participants' descriptions of their body-in-the-world appear to offer individual insights into how physical body sensations could be managed and how apparent limitations could be overcome. The section now turns to consider the subordinate theme *Authenticity*.

#### **4.3.1 Authenticity**

The subordinate theme *Authenticity* explores the present study participants' experiences of their groups as a reflexive space in which to consider aspects of themselves from alternative perspectives, particularly characteristics which had appeared obscured or blocked because of anxiety or fear, or the difficulty of identifying and processing emotions. The participants notice a sense of becoming open to new discoveries of themselves after attending their groups.

Research focusing on individuals who have experienced severe and enduring mental illness suggests that mental distress could involve 'the loss of the sense of the self', and it has been proposed that self-awareness is vital for mental health recovery (Pitt et al., 2007, p.57). Moreover, the researchers do not suggest how self-awareness following mental illness might emerge. Davidson and Strauss' (1992) research with MHSU suggests the effects of mental trauma may include losing touch with one's self, and the researchers suggest 'rediscovering and reconstructing an enduring sense of self' is fundamental to mental well-being (Davidson and Strauss, 1992, p.131); unfortunately they do not describe how this might be achieved. Their methodology involves bi-monthly interviews over two years, which suggests that questions were formulated by the researchers, as opposed to the semi-structured prompts used in the present study where participants have freedom to decide how they interpret a prompt and which aspects to foreground in their responses. The present study also differs as the participants describe how their self-awareness develops and how they notice a sense of connection to the self, and their body, mind and spirit becoming whole after being fragmented, seemingly reflecting on their transformative experiences of self-discovery and authenticity. The present study findings complement Davidson and Strauss's (1992), and Pitt et al.'s, (2007) suggestions, with the additional illumination of some of the processes concerned. The present study participants' authenticity extends to their personal descriptions of parts of themselves becoming integrated and enmeshed together following the trauma of their mental illness. These nuances perhaps contribute to enhanced awareness within the field and are harder to discern from existing research.

Laing's (1960) findings posit that severe and enduring mental illness could result in a 'disruption' to one's sense of self (Laing, 1960, p.17) and his research highlights that without a relationship with oneself, individuals seem unable to experience being with others and struggle with loneliness and isolation. In the present study *Authenticity* includes the participants' reflections about their former distress, and how they used to feel trapped and stuck, perhaps offering support for Laing's (1960) proposals, with the addition of their unique descriptions of how changes within themselves are perceived and how their awareness modifies the way in which they relate to and begin to care for themselves. *Authenticity* includes the participants' descriptions of benefitting from their group peers' acceptance of them, and they acknowledge that through shared experiences, their groups support their self-



awareness and insight into their relationship with themselves. This appears to support Landia et al.'s (2006) and Abba et al.'s (2008) suggestions of group members supporting each other, with the present study adding depth and detail about the qualities and meaning attributed to such peer support. Foulkes' (1948/2005) somewhat generalised suggestions that group members could feel supported by recognising that others experience similar issues omits the meaning of that experience from the group members' perspectives. In contrast, the present study contributes the specificity and uniqueness of the participants' own accounts of what it feels like to experience their relationship with their facilitator, and how they perceive other group members, offering the reader intricate awareness beyond existing research findings.

*Authenticity* focuses on how the present study participants develop tolerance and understanding towards themselves and they reflect on the contributions made by their positive and validating relationships with their facilitators, expressing that they feel understood, or that confusion has become clearer, perhaps suggesting that their therapeutic relationships with their facilitators have become conduits for self-awareness. The existing research regarding the qualities of therapeutic relationships has recognised their inherent complexity. Yalom (1980) suggests that facilitators give unvoiced cues to their group participants, who are observing every movement of their group leader as the facilitator unknowingly conveys parts of themselves. There may be support for this suggestion from Wykes et al.'s (2005) findings that group effectiveness improves where facilitators are experienced, trained and supervised. Wallin (2007) suggests that bodily communication could perhaps increase shared meaning between individuals and therapists and that embodied awareness could foster integration and authenticity between a therapist and client. Shaw (2004) suggests that individuals notice their therapist's voice tone, how their therapist holds their body in the room, and that group members could be affected by the bodily presence and the attunement of the others, which he suggests could develop their awareness of themselves as others perceive them. Thus existing research explores therapist and facilitator relationships from the facilitator's viewpoint. In the current study, participants describe implicit awareness and shared meanings with facilitators, offering supporting for existing findings, *and* contributing the participants' inner perspectives of how they notice their facilitator relating with them. Although Dozier, Stevenson, Lee and Velligan (1991) suggest that a validating attachment relationship with a therapist as an adult could perhaps

help individuals who have experienced severe and enduring mental illness to develop emotional processing, their research includes only participants with a diagnosis of schizophrenia engaged in individual therapy, perhaps suggesting their findings could have limitations.

Several of the present study participants find the group environment helpful and productive, suggesting their group is a catalyst for change and perhaps adding support to Linehan's (1993) suggestion that a supportive environment could promote the well-being of individuals with mental illness. *Authenticity* focuses on the participants' changing insight arising from their group attendance. The participants' perceptions differ in how they describe their self-awareness; some observe and value their uniqueness, others have a sense of opening up to new awareness, perhaps noticing aspects of themselves of which they have only recently become aware. Moreover, they share commonality in their relief and wonder at their re-appraisal of themselves, describing somewhat ethereal perceptions by using metaphor and imagery, expressing their awareness *blossoming*, or being *rooted*. Heidegger's (1927/1962) concept *dasein* (being-in-the-world) incorporates authenticity and he suggests that through self-knowledge one learns to relate to oneself and experience being-in-the-world. Erikson's (1950) theory of identity suggests that adults reach a stage of knowing themselves authentically, a stage he names *integrity*, suggesting 'wholeness' and 'unity' (Collins English Dictionary, 1980, p.759).

Thus *Authenticity* highlights the immediacy of the participants' perceptions of becoming whole and connected from an insider-viewpoint; and how such re-appraisal illuminates their sensations of blossoming and beginning to like themselves, as opposed to many existing group research studies focusing more generally on intervention effectiveness from a facilitator's or researcher's perspective. The section now turns to consider Self-acceptance.

#### 4.3.2 Self-acceptance

The subordinate theme *Self-acceptance* focuses on the present study participants appearing to integrate their mental illness symptoms into their lives and beginning to regard themselves with compassion. The participants describe their individualised

perspectives; this might include noticing changes they could make, or symptom re-appraisal, or changes to how they perceive their own competence, or their recognition that they could negotiate future uncertainty. The participants' perceptions suggest they may be developing confidence in their own judgements. Such awareness from the group members' viewpoint does not appear to be a focus of existing research.

The process that the present study participants describe seems to have some similarities with the acceptance training which is a component of Acceptance and Commitment Therapy (ACT), where individuals adapt to incorporate those aspects of themselves which they previously avoided (Hayes, Luoma, Bond, Masuda and Lillis, 2006; Hayes, 2004). As the present study participants describe less of their mental and physical energy taken up with avoiding, they become aware of areas where they can make a difference to their mental health, perhaps taking medication regularly, or reducing stress to improve mental well-being, or challenging themselves to be with others and join their therapy group. The participants' perspectives illuminate *how* they notice their self-acceptance changing and what it means to them, as opposed to Hayes et al.'s (2006) facilitator-led outlook.

The theme of *Self-Acceptance* has been reflected in Farrell et al.'s (2009) study which suggested participants' self-hatred reduced as a result of the group intervention. The present study participants offer some support for this finding, describing a sense of opening, maturity and tolerance towards themselves, as they notice their increased competence and confidence. The present study participants describe the impact of liking oneself, taking care of one's needs and becoming less self-critical, from their own perspectives, suggesting that they begin to value themselves. These perceptions highlight *how* the participants regard the changes they notice in themselves, and their unique descriptions suggest that their groups enable them to de-centre, in order to accommodate alternative perspectives of their mental illness, and as such their contributions offer awareness to the field. The participants' self-worth appears to enhance their well-being and help them avoid distress. In DBT, Linehan (1993) links acceptance and calmness with *wise mind*, which she suggests allows individuals to reflect, develop and make plans. The present study participants' experiences offer support for Linehan's (1993) suggestion, with the findings contributing insight into *how* the process of self-

acceptance enters awareness and reflexivity. Kabat-Zinn (2009) proposes that self-acceptance and being non-judgmental towards oneself develop one's self-compassion, which appears to be supported by the present study experiences. The present study participants describe their inner dilemmas in facing up to situations that had previously caused them shame and distress, and suggest their groups offer them opportunities for deeper self-reflection. The present study suggests that the participants' group attendance *and* their developing self-acceptance contribute to them taking pride in themselves, seemingly offering support for May et al.'s (2014) findings that group participants appear to become aware of positive aspects of themselves as they experience feeling understood by group peers. The section now explores the subordinate theme Embodiment.

### 4.3.3 Embodiment

The subordinate theme *Embodiment* focuses on how the present study participants regard their body, and how their body feels and reacts in different circumstances. The participants describe how they experience pain, intrusive voices or overwhelming anxiety from their insider view. Langdridge (2007) posits that the body is uniquely situated in time and place, and could become a source of pride and achievement, or frustration and disappointment if it becomes unable to function, mentally or physically, as was the case in the research by Finlay (2006), and Ashworth and Ashworth (2003). The present study participants' reflections suggest that when they perceive their body functioning inadequately, perhaps exhibiting severe anxiety symptoms, they experience emotional turmoil and distress, perhaps recalling similar incidents, and these emotional associations compounded with the distress of their body's seeming inadequacy appears to present the participant with a bigger obstacle to overcome. McDougall (1986) suggests that the body is not only a physical interface but also contains body-memory, where emotional distress could be experienced as physical bodily sensations (somatising). Body-memory could perhaps contextualise the participants' dynamic reactions to their perceived bodily inadequacies and simultaneous distress.

Heidegger (1927/1962) suggests embodiment is a *key* component of an individual's lifeworld, and that one's bodily existence is to have a presence in-the-world, with the mind and body integrated together. In the present study, some of the participants describe their lifeworld dominated by voice intrusions, such that they struggle to go

outside until they utilise one of the strategies learnt in their group which enables them to reduce the omnipotence of their voices. The present study participants' utterances suggest that they re-appraise their voices and interact with them so that they become less frightening; perhaps adding support to Chadwick et al.'s (2000) findings suggesting that symptom re-appraisal could promote assimilation. The participants' perceptions offer the reader access to the inner processes involved in changing their control and cognitions about voice hearing. Summarising *Embodiment*, the participants' detail and depth of their embodied experiences may not have emerged using quantitative research methods.

In summary the superordinate theme *Emerging from the Maelstrom* focuses on the present study participants' self-awareness developing as they emerge from past trauma and distress and become aware of themselves in the present, noticing their attributes as well as bodily restrictions. The subordinate theme *Authenticity* focuses on the participants' experience of their group as a place to reflect on their emerging self-awareness, valuing and appreciating aspects of themselves which were previously unnoticed. The participants reflect on the qualities of their relationship with their facilitators, supporting existing findings, and contributing their own insights into their relationship with their group facilitator which does not appear easily discernible within existing research. In the subordinate theme *Self-Acceptance* the participants describe actively caring for their well-being, noticing their tolerance and openness towards themselves. The participants develop self-compassion and face-up to their difficulties. In the subordinate theme *Embodiment* the participants' reflect on their physical bodily experience of being-in-the-world, describing their embodied pain and anxiety as obstructions to daily life, and their idiosyncratic, creative strategies to moderate or control bodily intrusions, or adapt to reduce their impact. The participants' utterances enhance awareness for the field of their difficulty in ameliorating distress arising from traumatic experiences *and* being among others. Such awareness via the service users' voices appears novel and is harder to discern from existing research. It is perhaps this transferable awareness of participants' inner dilemmas and conflicting demands which could contribute to awareness of living with severe mental illness within the field. In conclusion, the participants' inner perspectives offer the reader access to their lifeworld which appears mainly absent from existing research. The participants illustrate the ways in which their diverse experiences become integrated and valued. The unique detail of the present study offers a perspective of how these participants are able to make

sense of their mental health trauma *and* use their personal qualities to make changes and build on existing well-being, as they reflect on how attending their group has improved their self-acceptance and awareness of their personal attributes. In this section the participants subtly transfer their focus from their past experiences onto the present. The next section explores the superordinate theme *Unveiling*: the participants' experiences of how they appear to others.

#### **4.4 Unveiling – The participants' experiences of how they appear to others**

The superordinate theme *Unveiling* relates to the present study participants' experiences of themselves as they appear to others when they go out in the community. As the supposed veil is lifted, the participants appear to review aspects of themselves in the light of their emerging new awareness. Phenomenologist Heidegger (1927/1962) suggests that as one exists in-the-world, one continually shares one's responses to others, while simultaneously taking-in cues from others; and he suggests the effect could be to synchronously shape the individual as that individual shapes others. James (1890) referred to this aspect of awareness as the social self, meaning how one seems to another person. James' (1890) and Heidegger (1927/1962) appear to be writing from a position where going out into the world is an unremarkable experience; although the participants in the present study sometimes struggle to be with others or when going out into their community. *Unveiling* explores those elements of the participants' lifeworld. I am reminded of Bruner (1990) who suggests we create ourselves by the stories we tell others, proposing that this aspect of the self is fluid, dynamic and constantly under construction. It has been suggested the term *social self* could become interchangeable with other concepts such as the self, ego and identity (Hollway, 2007).

Early group research appears to focus on the merits of receiving feedback from group peers (Yalom, 1975; Foulkes, 1948/2005), suggesting that such responses could offer an opportunity to change aspects of oneself and improve one's social relationships; however, *how* this process occurs remains unclear. The present study differs as participants describe group peers' suggestions in detail and their effects on the participants' own self-appraisal. Participants in the present study describe

intense loneliness and social isolation, including difficulty going out due to intrusive symptoms, with their social withdrawal then further reducing their opportunities for forming social relationships. According to the Social Exclusion Unit (2004), individuals experiencing severe mental illness could be the most socially isolated group. Erikson (1950) and Maslow (1954) suggest that after physical needs have been met the next stage of self-development could be forming social relationships. In the present study it seems that social behaviours develop *within* groups as Landia et al. (2006) suggest, with the present study participants describing their motivation to make friends, or find fulfilment from meaningful occupation, appearing to illustrate that their goals for social contact extend beyond their groups. The section now turns to the subordinate theme *Sanctuary from Stigma*.

#### 4.4.1 Sanctuary from Stigma

The subordinate theme *Sanctuary from Stigma* focuses on the present study participants' views of not fitting in and being discriminated against by others who are not MHSU. The participants reflect on their experiences of feeling safe to discuss stigma within their groups, with peers who have similarly encountered stigma. The participants' experiences include: being invalidated, isolated, marginalised, shamed and distressed.

A body of stigma studies appear to have been constructed from mental health professionals' perspectives which acknowledge the devastating effects of stigma and propose that people who have a severe mental illness could be intimidated and regarded as outsiders (Laing, 1960, 1961; Laing and Esterson, 1990; Byrne, 1997, 2000). Another study highlights that whole families could experience stigma when one of them has a mental illness (Phelan, Bromet and Link, 1998). The present study offers support for these findings, with the participants voicing their stigma experiences directly and describing their groups as a sanctuary from stigma.

Another body of stigma research foregrounds the isolation of those who experience stigma. Fink and Tasman (1992) suggest that stigma and discrimination could arise *between* family members where one of them has a mental illness, and their research suggests that families could lack awareness or be critical, dismissive or intrusive in their interactions towards the individual who is mentally ill. Davidson and

Strauss's (1992) research suggests that critical, humiliating and dismissive interactions by others towards individuals who have a mental illness could 'undermine' their work towards recovery (Davidson and Strauss, 1992, p.137); unfortunately their study does not suggest how stigma experiences might be diminished. In the current study the participants' accounts suggest stigma experiences increase isolation, particularly social withdrawal, preventing individuals from taking part in activities, perhaps diminishing self-confidence and increasing negative mental health symptoms. Ostman and Kjellin's (2002) research suggests that people associating with individuals who have a mental illness could also be stigmatised, as may perhaps have been feared by Florence's friend. The researchers avoid discussion about how stigma by association might be minimised. None of these studies explores MHSU's direct experiences of stigma. The present study participants' experiences of isolation following stigma offer support for existing research, but they also contribute novel awareness through their individualised, specific examples of the indignities they experience *and* how they deal with them. In the present study some participants respond to stigma by expressing fear that their increased stress may lead to their symptoms becoming more intense or overwhelming; while other participants increase their motivation to overcome obstacles in response to stigma. The present participants' utterances suggest that their therapy groups offer them sanctuary from stigma through their non-judgemental shared strategies and insights, and their encouragement and motivation of each other.

The present study participants notice how they experience aspects of themselves emerging and they reflect on their therapeutic groups offering a non-threatening space in which to think and step back from the demands of living with mental illness. This perhaps supports Winnicott's (1990) proposal of *reverie*, that where one is calm and reflexive, one could access inner thoughts about one's authentic being. The sensation of feeling safe to discuss negative self-appraisal within one's group was suggested by Goodliffe et al.'s (2010) study, where participants appeared to exhibit group coherence which the researchers suggest might contribute to the group's effectiveness. The present study offers support for this suggestion, with the participants comparing their groups to a refuge and a sanctuary within which they describe belonging and acceptance by their peers.



Byrne's (2000) research suggests MHSU can feel undermined by staff in public services as well as by others in their communities and suggests that such experiences could have profoundly negative effects and engender feelings of shame. Laing's (1960; 1961) and Laing and Esterson's (1990) research suggests that experiencing stigma and being undermined could magnify mental health symptoms which may then become more difficult to manage. The present study participants' experiences add support to both of these findings with the addition of their individual descriptions. It is this poignancy which the present study contributes to existing stigma awareness.

In accessing the Mind (n.d.) and Rethink initiative: *Time to Change* which challenges stigma in mental illness, there were more posts relating to stigma and discrimination (490), than those involving severe depression (307). Heidegger (1927/1962) proposes that individuals carry the essence of the other within them when relating to themselves perhaps suggesting that when individuals with mental illness are treated with disdain, they may begin to regard themselves with contempt. The present study offers examples of participants who withdraw when they have been stigmatised, however other participants continue to attend their group, go out or speak to neighbours, perhaps highlighting their determination to overcome obstacles using the support they experience within their groups. Harper's (2011) research highlights that MHSU could become undermined by feelings of inferiority as a result of social inequality. In the present study there is support for this suggestion.

McLeod et al.'s (2007, p.295) study suggests attending a group with one's peers appears to help group members feel 'less stigmatised', perhaps suggesting the group offered peer support when painful or shameful experiences were discussed. Within the present study there was support for this suggestion with many participants describing their experiences of voice hearing as stigmatising, negative, undermining and distressing. Moreover, the present study offers support for the benefits of re-appraisal and de-centring from voice intrusions using strategies learnt within their groups as Chadwick et al.'s (2000) and Landia et al.'s (2006) findings propose. In addition, the present study offers support for the specific encouragement offered by group peers which motivates the participants to try out novel strategies in order to diminish the omnipotence of their voice hearing,

complementing the observations made by Chadwick et al.'s (2000) and Landia et al.'s (2006) studies that peer support contributes to the effectiveness of group therapy. Furthermore, the present study participants' utterances highlight *how* they view the process of de-centring from their voices and what it means to them, compared to existing studies where the main focus is the effectiveness of the group intervention.

The present study differs by involving the reader in the participants' cognitions and dilemmas about their voice hearing and their difficulty in challenging dominant voices which have been the source of derogatory and intense personal comments. The present participants' perspectives offer insight into their inner worlds which contribute to awareness of the meaning of their voice hearing experiences within the field. In contrast, Abba et al.'s (2008) and May et al.'s (2014) qualitative studies focus on the effectiveness of their interventions for the group as a whole.

In summarising *Sanctuary from Stigma*; the present study participants describe a range of responses to stigma. Some participants use group members' suggestions or strategies, others respond by taking anti-psychotic medication, or losing contact with a friend, or in becoming motivated to seek out new social relationships within their group. The present study illustrates *how* these participants negotiate and respond idiosyncratically to stigma, making use of their groups which they describe as a refuge and a sanctuary from stigma experiences. The present study complements existing findings by offering specific examples of cognitions and affect processing which appear more difficult to discern from existing studies. The section now turns to consider *Recovery Competition*.

#### 4.4.2 Recovery Competition

The subordinate theme *Recovery Competition* focuses on the present study participants' experiences of presenting their recovery from mental illness as though they may be more recovered than their group peers. Tedeschi and Calhoun's (1995) theory of Downward Social Comparison (DSC) arose from their observations of individuals' recovery from trauma and their theory offers a framework within which this phenomenon might be conceptualised. Tedeschi and Calhoun (1995) suggest that according to DSC, individuals recovering from trauma appear to

position *others* as less recovered than themselves in order to heighten the effects of their own contribution to their recovery, thereby enhancing others positive appraisals of them and simultaneously promoting their own well-being. DSC theory fits well with Heider's (1958) attribution theory which suggests that success could be linked to an internal locus of control, where an individual is biased towards assuming their own actions are causing a positive effect, perhaps perpetuating others' positive appraisals of them. Applied to *Recovery Competition*, Heider's (1958) theory could suggest individuals regard their recovery emerging from their own efforts and perhaps *Recovery Competition* could be conceptualised as the participants' developing their recovery skills. Competition within human relationships could be explained as a challenge for supremacy with *Recovery Competition* being illuminated by the Machiavellian Hypothesis, a theory proposed by Whiten and Byrne (1997) who suggest that humans manipulate others to get the best outcome for themselves, even at the expense of being disingenuous. Davidson and Strauss's (1992) research suggests that their participants' conceptions of themselves were reviewed and compared to their perception of their peers' progress and recovery. Davidson and Strauss (1992) did not name this phenomenon nor discuss potential costs or benefits of such behaviours. In the present study it appears that *Recovery Competition* could depend on the participants' relationships with others as markers of their own recovery and as such *Recovery Competition* may be related to the participants' group attendance *and* their close relationships with each other. In summarising *Recovery Competition*, the participants appear to present themselves as more recovered than their peers, perhaps to convey self-assurance that their own efforts have contributed to their recovery. *Recovery Competition* appears to be a novel finding contributing enhanced awareness of experiences within groups to the field. The discussion now turns to explore trauma.

#### 4.4.3 Trauma

The participants in the present study discuss their experiences of mental health trauma in their groups. Tedeschi and Calhoun (1995) define trauma as experiences of 'physical and psychological pain, anxiety, patience, anger and sadness' (Tedeschi and Calhoun, 1995, p.67). Garety (2014) highlights the 'intense, long-lasting and often unbearable pain' associated with mental health trauma (Garety, 2014, p.3).

Bromberg (2011) offers a framework within which the participants' trauma can be conceptualised, proposing that traumatised individuals tend to focus on their past difficulties, becoming cut-off, avoidant or desensitised to their feelings and he suggests that the brain shuts down after trauma to prevent continuing psychic distress. Such *shutting down*, according to Bromberg (2011), disrupts helpful reflection and post-traumatic learning and development. The present study participants reflect on their past-focused mental distress and instability before joining their therapeutic groups, perhaps offering support for Bromberg's (2011) findings.

Tedeschi and Calhoun (2004) conversely suggest that recovery from mental health trauma could be transformational and beneficial if the individual could assimilate meaning and motivation from the events, and remain optimistic and forward-looking. In the present study Andre views his life as having meaning and a new beginning since being sectioned. This perspective is in line with phenomenologists Deurzen-Smith (1997) and Frankl's (1963) suggestions that individuals choose how to appraise even difficult challenges in their lives and that how one attributes the circumstances of trauma could affect how the event is integrated. Conversely, other participants experience on-going trauma and shame related to their mental health sectioning decades earlier, with some disputing their diagnoses, which does not appear to support Tedeschi and Calhoun's (2004) suggestion, perhaps illustrating how individual differences also impact on how trauma is processed. The present study perhaps illuminates some of the idiosyncratic complexities influencing trauma perception, emotional response and appraisal. The section now turns to explore Facilitator Rivalry.

#### 4.4.4 Rivalry

Most participants in the present study reflect on their relationship with their group facilitator as somewhat rivalrous, highlighting their facilitator's incompetence perhaps to raise their own status in the group, for instance in reflecting on taking a leadership role in the group, or planning to usurp the group facilitator. Freud (1921/1955) suggests group members *plan* to take over their group. Brabender and Fallon (2009) suggest group members *challenge* their facilitator, and propose that group members become less involved with their group facilitator as their other inter-subjective relationships within the group develop. However, neither Freud

(1921/1955) nor Brabender and Fallon (2009) offer clinical examples to highlight *how* such processes emerge within groups, nor do they discuss potential benefits of such behaviour, appearing to retain a focus on group content and process from a top-down facilitator perspective. Conversely, the present study conceptualises *Facilitator Rivalry* from a range of psychological perspectives, considering the potentially positive benefits for the group member.

Within studies of group therapy there appears little about this phenomenon with Spotnitz (1952) proposing that *Facilitator Rivalry*, which he names facilitator challenge, could take various forms such as the whole group demanding their needs are met by the facilitator. There is support for this within the present study, which offers a first-hand, bottom-up experience of *Facilitator Rivalry* as opposed to Spotnitz's (1952) facilitator's perspective. Spotnitz (1952) suggests that rivalry towards one's group facilitator could suggest avoidance of painful or distressing situations by the group members. Spotnitz (1952) suggests that facilitators recognise their own counter-transference, the sensations that they experience in response to the material the group members bring, in order to separate their own reactions from those of the group members. The present study participants offer some support for this and furthermore, their utterances suggest they notice facilitator inauthenticity and unfairness. However, in order for this to be utilised, facilitators may first benefit from training as Wykes et al. (2005) and Woolfe and Tholstrup (2010) suggest.

Another way to conceptualise *Facilitator Rivalry* could be to consider Erikson's (1950) proposal that a stage of development leading to independence occurs when individuals reject and challenge their carers. If this were applied to groups then experiences of conflict and rivalry towards group facilitators could be regarded as part of a developmental process leading towards independence and exploring one's own values and ideologies. The present study offers some support for this as participants reflect on their confrontation and challenge of their facilitators and even leave their group. Using Erikson's (1950) suggestion, *Facilitator Rivalry* could perhaps be seen as preparation for another life phase, perhaps offering the participants a sense of achievement or a foundation on which to build self-confidence and autonomy. Moreover, the present study contributes the participants' own utterances offering the field an opportunity to become aware of their

dissatisfaction with their groups, and *why* one participant chooses to leave. Yalom (1975) proposes therapy groups could resemble family groups, where members assume the roles of rivalrous siblings in competition with the other group members for the attention of their carer or facilitator. The present study does not offer support for Yalom's (1975) somewhat generalised proposal.

*Facilitator Rivalry* could also be conceptualised using Bandura's (1977) Social Learning Theory (SLT) which foregrounds the modelling of skills and strategies through noticing the behaviour of others; thus group members observing their facilitator's role may mirror the facilitator's behaviour to emulate similar leadership qualities. If one adopts Bandura's (1977) suggestions, then role-modelling one's facilitator could appear a desirable outcome, perhaps signifying that the facilitator is regarded positively.

Whichever explanation of *Facilitator Rivalry* is foregrounded depends on whether one takes the facilitator's view of potential group disruption or whether one takes the participant's perspective and considers that *Facilitator Rivalry* could perhaps illustrate role-play of recovery or independence, and therefore a positive group outcome. In the present study denigrating one's facilitator perhaps enables the participants to demonstrate their superiority or autonomy, either by leaving the group or by usurping the facilitator's leadership role and could suggest an aspect of group process leading to recovery.

The present study participants' experiences of *Facilitator Rivalry* seem to suggest that such behaviour may not signal negativity or breakdown of the therapeutic relationship as Spontitz (1952) suggests. Depending how the behaviour is conceptualised, rivalry experiences could suggest that the facilitator is regarded as a positive role-model, presenting group members with an opportunity to demonstrate independence, self-confidence and autonomy; qualities which could be considered helpful in developing future mental well-being. The participants' experiences suggest that such rivalrous behaviours may enable self-reflection and further discussion with facilitators, which may in turn encourage alternative perspectives to emerge for the individual concerned.

In summary, the subordinate theme *Facilitator Rivalry* contributes the participants' first-hand personal experiences of facilitator challenge and rivalry to the field of existing research. The present study's experiential accounts offer insights into group members' potentially modelling themselves on their facilitator, which could enhance awareness of group process, and perhaps reduce disruption to the group's therapeutic process. Moreover, *Facilitator Rivalry* also highlights that the potential for change within groups may have been under-acknowledged in previous studies. The present study's findings highlight that by seeking the group members' perspectives, novel aspects of being in a therapeutic group have emerged.

In conclusion, the superordinate theme *Unveiling* explores the participants' perceptions of themselves as others see them and as they review aspects of themselves in relation to feedback from others in their groups. The participants express their undermining stigma experiences within their groups which they describe offering them sanctuary from stigma. Their discussion of *Recovery Competition* appears to illuminate a projection of their mental health recovery. The participants' experiences of *Facilitator Rivalry* perhaps suggest they role-model their preparation for independence and their development of autonomy. The final section explores the superordinate theme *Resoluteness in life*.

## **4.5 Resoluteness in Life**

The superordinate theme *Resoluteness in life* incorporates the present study participants' recognition of the skills and strategies they have learnt in their groups to help them overcome symptom intrusions and obstacles which diminish their mental well-being. The theme acknowledges the participants' realisation of their abilities and their plans for their future fulfilment, leading to them accomplishing goals. This aspect of future focus is difficult to discern from existing group research where many studies omit measuring the enduring benefits of an intervention. Those studies that highlight continuing benefits fail to convey how such changes may have been transformative for the participants (Wykes et al., 2005; Blum et al., 2008). Post-trauma goal planning has been broadly suggested to be a positive endeavour and Frankl (1963) proposes that continuing to find meaning in life after trauma could instil a sense of purposefulness. Maslow (1954) suggests that a future-focus in life could become a foundation for self-development, planning goals and self-fulfilment;

although he does not suggest how a future-focus might be achieved. Csikszentmihalyi (2002) suggests that finding purpose could involve enjoyment and developing individual control. The section now turns to explore the subordinate theme *Self-reliance*.

#### 4.5.1 Self-reliance

The subordinate theme *Self-reliance* has been defined as achievements requiring motivation and determination (Csikszentmihalyi, 2002) and has been linked to experiences of fulfilment and enrichment by Maslow (1954), who uses the term self-actualisation. Kabat-Zinn (2009) links self-reliance with an increase in self-confidence and a feeling of control. The participants in the present study describe using group suggestions to overcome extreme anxiety, which enables them to build social relationships with group peers, and to develop self-confidence and skills such as teaching, public speaking and acting. *Self-reliance* features the participants' awareness of their capabilities, with some participants reflecting on support from group peers to attend the group or to learn skills which enable the re-attribution of intrusive voices. As each step towards an achievement is completed the participants develop their independence and self-confidence and the reader is invited to share the participants' pride and pleasure. The present study differs in offering the participants perceptions of how their self-reliance develops and grows, perhaps contributing unique awareness to the field, as opposed to Csikszentmihalyi, (2002) and Kabat-Zinn's (2009) somewhat generalised accounts of self-reliance.

Lorentzen and Hoglend (2005) posit that the benefits of longer-term groups could endure for a year post-group, with the present study findings supporting this proposal. The present participants' reflections complement existing findings with their additional details of how they assimilate group learning into their lives and continue to use group strategies after they no longer attend their groups. Some participants comment on the value of their continuing contact with other group peers and this may contribute to the participants' motivation. Wykes et al. (2005, p.208) suggests that 'effects within groups' may contribute to the group's effectiveness and the present study offers examples of how skills learnt within groups could provide a foundation from which motivation and self-confidence may continue to develop after the group.



In summary, the subordinate theme *Self-reliance* highlights *how* the participants' plan future goals, which require their constant adaptation to changing circumstances and demand their flexibility, creativity, motivation, confidence and self-assurance. The present study illustrates the participants' efforts and determination, and contributes the details of such awareness to the field of existing research.

#### 4.5.2 Reaching potential

The subordinate theme *Reaching potential* focuses on the present study participants' descriptions of their completed achievements, exploring learning that has emerged from their group experiences and the positive value of external recognition, which for these participants appears to reduce their tendency for self-deprecation. Csikszentmihalyi (2002) proposes that reaching one's potential is not marked by the achievement alone. Rather, he suggests that the awareness of what one has gained and lost by completing the achievement defines reaching one's potential, and he names this 'reflective individualism' (Csikszentmihalyi, 2002, p.221).

Unlike existing research which describes individual involvement in activities leading to a sense of fulfilment from the author's perspective (Maslow, 1954), the present study participants express their relief and excitement directly, with the reader becoming involved in their respective challenges of managing voice hearing and severe anxiety. In the present study the participants' external validation appears to play a role in their increasing confidence and autonomy. Thus, the participants' experiences appear to support existing research with the present study contributing additional detail and the immediacy of the participants' expressions, cognitions and perspectives, which highlight *how* the participants regard their achievement and their expressions of fulfilment and pleasure which appear harder to discern from existing research.

Thus, the present study enables the reader to develop a more intimate relationship with the participants who share their reflections of overcoming their difficulties and their recognition of their personal qualities which have enabled them to reach their attainments. In summarising *Reaching potential* it appears as though the

participants' experiences have been captured by a narrow focus camera lens zooming into specific details, drawing the reader into the participants' lifeworld and their unique perspectives of their efforts to overcome their problems and reach their potential. The section now turns to focus on the participants' experiences of hope.

#### 4.5.3 Hope

The present study participants' describe hope as a somewhat reflexive quality focusing on what has already been accomplished and on their future-focused motivation for the goals they still wish to achieve. In the present study hope appears future-focused, for example the participants value what they have achieved by daring to attend and speak in their groups, looking back reflexively at how they used to be and realising their potential. In the present study the participants focus on negotiating future intrusive symptoms and look back at how they have coped already by using strategies learnt in their group. Hope, defined as the 'confidence a desire can be fulfilled' (Collins English Dictionary, 1980, p.706) is implied to be future-focused and this is reflected in some research. O'Hara (2010) posits that hope in one's life is central to a forward-looking perspective.

There is a body of research focusing on hope from a mental health professionals' perspective. Dembo (2013) suggests that MHSU sense of purpose could be improved when professionals model authentic hope and focus on strengths and interests, suggesting a future-focus. Dembo's (2013) case study of her clinical work offers an example where her hope for her client helped the client develop self-belief. Hope has been cited as a component of recovery, a marker of *quality of life* in Killaspy, Harden, Holloway and King's (2005) meta-analysis of recovery services; still, the report does not suggest how hopefulness might be increased. Blum et al.'s (2008) study focusing on the effectiveness of a group intervention noticed the group engendered a sense of hope; moreover this was not illuminated by the quantitative measures perhaps suggesting that hope was an additional benefit for the group participants. Davidson and Strauss's (1992) research suggests that hope is a component of mental health recovery, but once again *how* such hope emerges following mental illness is not documented. Cutcliffe and Herth's (2002) research suggests that hope is a life-force which could be increased through the pursuit of personal goals, and they posit that experiencing hopefulness creates a sense of

control over one's future. There appears to be some elements of hope and optimism described interchangeably within existing research (Landrum, 1993).

Another body of research focusing on hope features MHSU contributions. Hope and self-esteem are central to the Recovery Star mental health interventions which encourage a future-focus onto goals, relationships and personal responsibility (MacKeith and Burns, 2008). In addition the Schizophrenia Commission (2012) suggest 'being hopeful', 'treating people as individuals' and enhancing awareness of the lived experiences of people who have 'severe mental illness' (Schizophrenia Commission, 2012, p.68-9), without documenting how this might be achieved. Moreover, perhaps the present study could contribute to raising such awareness in the field by way of the participants' personal perspectives of how they recognise their own hope and inspire each other's motivation.

The research on hope presented from mental health professionals' perspectives appears to focus on the MHSU end-goal, in a somewhat simplified and generalised portrayal of achievement, with a limited focus on the means of arriving at that point and without any description of how individuals make sense of their achievement. The present study differs from existing research as the participants' utterances allow the reader access to their cognitions as they go through different stages, perhaps negotiating obstacles, challenging oneself and facing-up to set-backs leading towards their goal. This intimate background information is less accessible in some existing research. Thus, the present study contributes a more complex perspective of hope, complementing existing research by its depth and detail, but also by presenting hope not only as future-focused but with a thoughtful, reflexive quality in which the present study participants assimilate and value what they have learnt. The section now turns to explore optimism.

#### 4.5.4 Optimism

Practitioner optimism is a focus of the NICE guidelines (2009; 2011; 2014) suggesting MHSU benefit from therapist optimism, however, the guidelines do not specify how therapist optimism might be encouraged. Tillich (1952) defines optimism as 'the courage of confidence' and proposes that optimism and personal freedom enable individuals to know themselves authentically (Tillich, 1952, p.164).

In the present study participants reflect on their experiences of optimism and the reader is offered individual insights into the difference optimism makes within their lives for example, in expressing optimism that they could manage a potential future mental illness relapse. Optimism also enables the participants in the present study to recognise their existing abilities, valuing their progress, and the skills they have developed in negotiating their mental illness and in setting future goals. The participants' experiences synthesise qualities of hope, optimism, self-confidence, competence and self-belief, perhaps suggesting optimism and hope may be multi-faceted.

Existing MHSU research which focuses on optimism is dominated by mental health professionals' perspectives which appear to link optimism with recovery. Davidson and Strauss's (1992) research suggests that practitioner optimism promotes mental health recovery without documenting how such optimism could be conveyed. Wolfson, Holloway and Killaspy (2009) suggest that MHSU benefit from the optimism of their recovered peers, and there is support for this within the present study.

Summarising hope and optimism: the participants' experiences in the present study offer support to existing research, and contribute their awareness of the complexity of these experiences, as they reveal *how* they notice their hope and optimism developing and the ways they find pleasure in life. The participants appear to draw on their hope and optimism, which appears motivational and purposeful in their lives. The section now turns to consider recovery.

#### 4.5.5 Recovery

There is a wealth of existing research regarding mental health recovery (Davidson, Rakfeldt and Strauss, 2010). Many existing studies are from mental health professionals' perspectives (Davidson and Strauss, 1992; Davidson, Schmutte, Dinzeo and Andres-Hyman, 2008). Davidson et al., 2008 propose that research could focus less on recovery and curing mental illness, and more on embracing individuals with an enduring mental illness living meaningful lives. A common theme of recovery research appears to be offering generalised suggestions, as if sweeping a wide angle lens over individual experiences, perhaps merging and blurring them

to capture trends and universality with a seeming loss of focus on individuality. Killaspy et al. (2005) asked *service providers* what *service users* would like from mental health rehabilitation services and they suggest that recovery encompasses quality of life, social inclusion, community living, hope, independence and autonomy. Conversely, the present study offers detailed and particular experiences of fulfilment, future-oriented well-being and perceptions of recovery, what it feels like and how it becomes assimilated into life experiences, with some participants finding purpose in community activities. The present participants' utterances illustrate their unique responses, which appear absent from the somewhat generalised and detached recovery suggestions of Killaspy et al., (2005) which were seemingly obtained without consulting MHSU.

Traditionally, mental health recovery seems to have been measured by a reduction in mental health symptoms (Drury, Birchwood, Cochrane and Macmillan, 1996). However, participants in the present study experience recovery simultaneously with voice hearing, over which they assert a sense of control, which does not appear to support Drury et al.'s (1996) suggestion. Rapp and Goscha's (2006) recovery suggestions link confidence with increased control and this is supported by the present study findings, which in addition, illustrate the participants' strengths and agency, illuminating *how* they develop self-confidence and achieve control, which is omitted from Rapp and Goscha's (2006) findings.

Conversely, Harper and Speed (2012) propose that recovery is not dependent on the absence or control of symptoms, but marked by a fulfilling life, community re-engagement and loving relationships. Harper and Speed (2012) posit that purpose in life is a component of mental health recovery, which is supported by the participants in the present study who find purpose via their occupation and making friends, perhaps suggesting there may be some overlap between the concepts of recovery and purpose. Davidson and Strauss (1992) suggest that recovery includes living one's life undefined by mental illness or diagnosis. The present study participants' experiences of pleasure and fulfilment support this proposal and their experiences of external validation appear to confirm their sense of meaning in life.

There are suggestions from quantitative group studies supporting both the reduction of symptoms (Soler et al., 2009; Tschuschke et al., 2007) and the re-appraisal of

symptoms (Landia et al., 2006; Wykes et al., 2005; McLeod et al., 2007) which are both considered components of mental health recovery from the perspectives of the researchers. What is absent from the existing research is the corroboration of these quantitative measures of symptom improvements with the bottom-up perspectives of the group members themselves. The present study differs in offering the group members' perceptions of recovery and suggests symptom re-appraisal and a sense of control over symptom intrusion is important to the participants.

The NICE (2007) guidelines relating to *behavioural change* groups suggest that recovery consists of support, social skills training, community involvement and resilience. However, their research does not foreground MHSU voices and is led by researcher and service-provider perspectives. Furthermore, the concept of resilience meaning 'recovering easily from illness' (Collins English Dictionary, 1980, p.1241) has been dismissed by Rutter (2008), suggesting resilience is typically the focus of service providers but is generally absent from MHSU perspectives of recovery. The present study participants do not describe resilience, appearing to support Rutter's (2008) perspective and the present study offers examples of the participants' agency, dynamism, determination and interaction which seems to contrast with the focus on *support*, the term used by NICE (2007), which could perhaps appear passive by comparison.

Wolfson, Holloway and Killaspy's (2009) recovery survey of MHSU, carers and service providers seemingly complements Killaspy et al.'s (2005) findings, proposing that recovery consists of good physical and mental health, respect, and integrating the effects of past trauma. This is supported by the present study participants' descriptions linking good health with quality of life. The negative effects of physical ill-health on mental health recovery have been posited (Yasamy, Cross, McDaniell, Saxena, 2014) and are supported by the experience of long-term pain affecting mental well-being within the present study.

Alternative perspectives of recovery are offered by MHSU recovery case studies. Coleman's (2014) experience of recovery from severe mental illness focuses on the development of self-confidence, taking control of decisions and interacting with others recovering from severe mental illness. Participants in the present study mirror these changes, as they experience empowerment after giving up alcohol and

recognise their self-reliance and growing independence is emerging following their group attendance. Coleman (2014) discusses how he developed awareness of learned behaviours in order to improve his social interactions and the present study participants' experiences offer support for this suggestion as they develop self-awareness and self-confidence, they assert control over their intrusive symptoms and become more involved in the community. Chadwick's (2007) experience of recovery also suggests managing learned behaviours, such as sensitivity to noise, to help social re-integration and recovery from severe mental illness. The present study offers support for this, offering an individualised, detailed description of managing voice intrusions on a noisy bus that perhaps raises awareness for the field.

In summary, existing *Recovery* research appears split between symptom reduction and symptom re-appraisal, with the present study participants offering support for the latter. Resilience may be the focus of service providers but is not usually the focus of service users and is not reflected by the present study participants. NICE guidelines (2007) refer to MHSU *support* seemingly positioning service users as passive, as opposed to the present study's examples of their active motivation and dynamism. Consulting service providers appears to produce suggestions that recovery is linked to quality of life. Conversely, consulting MHSU appears to suggest that recovery from severe mental illness is linked to good physical and mental health, and integrating the effects of trauma, and there is support for these suggestions within the present study. Nonetheless, recovered MHSU experiences suggest that taking control of decisions, social interaction and managing learned behaviours could increase opportunities for mental well-being and these suggestions are complemented by the personal accounts within the present study.

Overall, the subordinate theme *Reaching potential* focused on the present study participants' descriptions of what they achieved and their future aspirations, complementing existing research with their intimate perspectives on finding meaning, building confidence, having a purpose, negotiating mental health symptoms, making friends, having an occupation and establishing future goals. The present study participants' accounts differ from existing research in offering individual descriptions of reaching one's potential. Existing research can omit MHSU perspectives and may follow a service provider agenda, with some

researchers focussing on resilience, which has not been foregrounded by service users in the present study, perhaps offering support for Rutter's (2008) proposal that resilience is a service provider agenda. The suggestions of two recovered MHSU, Coleman (2014) and Chadwick (2007) appear to be supported by the study participants' experiences; perhaps suggesting they share transferable insights and awareness because of their first-hand experiences of severe and enduring mental illness.

Consequently, the superordinate theme *Resoluteness in Life* incorporates the present study participants' experiences of planning for their future, which they appear motivated and determined to achieve, perhaps creatively managing symptoms and negotiating future uncertainty. Their accomplishments suggest they experience fulfilment, excitement and satisfaction. Some participants develop self-confidence and self-belief, learning new skills which attract external validation. The section now turns to focus on ethical considerations.

## **4.6 Ethical Considerations**

In reflecting on my engagement with the study participants I am aware that many of them are from cultures and ethnicity outside of my own white British experiences. This may have impacted on how the participants thought about their mental illness; whether they were seen as mad or bad, whether they were assumed to have done wrong and mental illness was a punishment, or whether mental illness could be seen as a family curse or an indicator of weakness (Moodley and Palmer, 2006). Squire (2000) suggests ethnicity and culture could influence the participants' meanings and practices regarding their mental illness. I am aware that the participants' perspectives from a range of ethnicities and cultures could have influenced how they regarded my involvement in their research interviews, as an outsider, perhaps influencing how they chose to respond to the open-ended prompts or the ways in which meanings may have been co-constructed between us within the research interviews.

As a counselling psychologist I could appreciate other differences between me and the participants, such as their language, race, religion and family backgrounds within which their cultural experiences are situated and which Fernando (2002)



suggests are as important as ethnicity and culture. I am aware my view of mental illness is Eurocentric, with mental health treatment guided by legislation, situated in a time when there are anti-psychotic medications whose use is directed by national guidelines and which subtly influence the ways in which mental illness is conceptualised. I am also aware that my own personal goal as a counselling psychologist is to be congruent and model unconditional positive regard towards the individuals I work with (Rogers, 1974), and to follow the ethical guidelines of the British Psychological Society (2009) and the Health and Care Professions Council (2008). The section now explores my reflexivity as a researcher.

## **4.7 Reflexivity Statement**

Stainton Rogers (2007) suggests that researcher reflexivity is an exploration of one's actions and judgements which may have had a role in what research is produced. The iterative process of IPA demands returning to the data at different times to allow new awareness to emerge and the process of researcher reflexivity bears some similarities, since by engaging in reflexivity at different points during the research process, previously dismissed or overlooked perspectives can be re-evaluated regarding their impact on the study.

In terms of developing as a counselling psychology practitioner, one's reflexivity is a primary focus for learning and self-appraisal (Woolfe, et al., 2010). Within the scientist-practitioner paradigm, my practitioner focus on therapeutic work with individuals who have experienced severe and enduring mental illness has left an indelible mark on me and similarly as I met with the study participants, their descriptions and responses to harrowing events will forever be etched on my memory. Undoubtedly my previous work with such individuals has influenced my desire to foreground the views of the present study participants and the ways in which my awareness has been constructed. The open-ended prompts were based on my experiences of running NHS groups, which subtly shaped how the prompts were asked and the nature of the prompts. The motivation to use prompts was to enable the participants to respond idiosyncratically and use their own judgements about issues they wished to discuss (Smith, 2003), and to resist influencing the data by asking pre-prepared questions from my own outsider perspective. I was genuinely interested in the subject of group experience and the participants were

enthusiastic. Kirmayer (2003) suggests group members and clients can spot clinician authenticity and my interest in the participants' group experiences was probably apparent and elicited the intimacy and depth of the research interviews. Weedon (1987) suggests that meanings can evolve as they are co-constructed and I was influenced by the ways in which language was used and how the utterances made sense to me. Another researcher may have considered the same utterances from a different perspective and made differing associations.

My aim was to present the participants' inner lifeworld experiences as they were revealed to me and it is possible that I may have made assumptions which the participant did not intend. For this reason I referred to my research journal throughout and noted where I had experienced particular reactions during the research process so that I could be aware of any personal bias in order to counteract the effects. My critical-realist epistemological position remains that there may be more than one perspective and that by rooting all of my interpretative and analytical work within the data, such meanings can be transparent to the reader.

In terms of the scientist paradigm I found the participants' lifeworld experiences drew me in and I had to process, step back and return to the data much later in order to make objective evaluations. The desire to produce unique, novel awareness of the participants' experiences of attending their groups for the field of mental health practitioners was my constant motivation which directed and shaped the study. Smith (2008) and Smith, Flowers and Larkin (2009) suggest flexibility in adapting their methodology to suit the task and the research question. I also attended carefully to Yardley's (2008) suggestions to demonstrate my researcher integrity by improving the rigour and validity of the study, to create robust, transferable awareness within the field. The validity markers are discussed below. As I became immersed within the data and completed the differing research processes I discovered the need to exercise patience and compassion towards myself. There seemed some parallels with the individuals with whom I worked therapeutically, some of whom were struggling to exercise patience and self-compassion, and this study provided me with an opportunity for insight into how difficult this can be when applied to oneself. Through the study, during my personal learning and development, I found first-hand the value of changing one's pace and demonstrating acceptance towards oneself. I feel these are valuable life skills which

will be helpful in my future clinical and personal development. The section now summarises the study's contribution to the field.

## **4.8 Summary of the Study's Contribution to the Field**

As has already been discussed, participants' experiences of therapeutic groups do not seem to be fully accessible within existing research and therefore many of the perspectives described in the present study offer greater depth and detail of how situations arise, the participants' reactions to them and how the participants negotiate difficulties. The finding *Recovery Competition* appears to be novel and previously unrepresented within the field. *Recovery Competition* could indicate the participants' preparation for recovery as they demonstrate self-confidence and autonomy, or it could perhaps emerge from the participants' group attendance or their on-going relationships with each other. The finding of *Facilitator Rivalry* has been briefly discussed within existing research suggesting it could imply a negative facilitator relationship or a breakdown in group therapy; depending how one conceptualises this phenomenon, it could indicate a positive therapeutic relationship where group members model a leadership role as they move towards independence.

The present study uniquely presents the participants' precise, detailed, distinctive experiences, with sharp focus on the essence of their lifeworld. Their stigma experiences offer insight into their reactions, the impact of stigma and the participants' relief when they experience their group as a sanctuary where they feel safe to discuss stigma and other debilitating situations. In the present study it appears that the reader is invited to stand beside the participants to momentarily share their perspective of their lifeworld, including their humiliation and their struggle to remain motivated. The present study illuminates how the participants' personal characteristics appear to impact on the different ways in which obstacles are approached and negotiated. There seems to be a depth to the participants' sensations which they access through the use of metaphor, such as a description of having something stuck inside oneself and the relief and lightness of letting it go within a group. The participants' accounts endorse their creative dynamism in re-appraising and modifying obstacles or symptom intrusions to achieve their goals and participate in fulfilling activities. Some participants manage intrusive voice

hearing using different suggestions from their group and the reader is momentarily invited into the participants' lifeworld to witness the disruption the voice hearing experiences can cause. Individual experiences are described rather like inner thoughts coming into awareness as 'inner mental' associations, cognitions and processes (Laing, 1961, p.24).

Participant experiences touch on awareness difficult to express in language, and participants create imagery to share insight, such as their descriptions of having a load on one's back or walking on water. The reader is invited into the participants' experience of negotiating their environment, such that the reader becomes aware of the participants' inner cognitions about dominant voices, their deliberations and perhaps their decision to challenge an omnipotent voice, offering particular examples of living with severe and enduring mental illness for the field. The participants' descriptions focus on different ways in which intrusive symptoms could be re-appraised and did not include symptom reduction which was proposed as a component of *Recovery* by older research. The participants' accounts do not include resilience which appears to have been foregrounded by service provider agendas. Existing *Recovery* research which has not consulted MHSU suggests recovery is linked to quality of life; but when MHSU are consulted by researchers, MHSU relate *Recovery* to good physical and mental health and integrating the effects of trauma. The participants' views of recovery were shared by recovered MHSU suggesting that recovery can include taking control of decisions; social interaction and managing learned behaviours. Finlay and Evans (2009) suggest that participant experiences could be transformative and could impact on others' awareness of a situation, offering an opportunity to see another individual's experience as if through their eyes. The present study could contribute such an opportunity, perhaps raising awareness of group processes and offering transferable insight of individuals living with severe and enduring mental illness for the field.

A further contribution to the field was made by disseminating the present study findings at the BPS Division of Counselling Psychology conference (Barley, 2015). The presentation's focus of the participants' apparent *Facilitator Rivalry* raised a discussion about group process and the conceptualisation of such a phenomenon. This section now turns to examine the implications for practice.

## **4.9 Implications for Practice**

### **4.9.1 Endurance of benefits**

The present study participants' utterances complement existing findings in offering support for the benefits to well-being of the re-appraisal of symptoms. Moreover, the groups appear to offer somewhat unrecognised potential in equipping the participants to negotiate intrusions and obstacles even after they no longer attend their group, with the positive effects from groups becoming enmeshed within everyday life activities.

The present study foregrounds the MHSU participants' enduring experiences of their groups, which appears to encourage their future-focussed plans in asserting their recovery, perhaps suggesting that the impact of therapy groups may have been under-estimated and that their potential for on-going benefits to the participants' lives may not have been adequately reflected by existing group studies.

### **4.9.2 Reviewing research methods**

In order to capture the essence of the group members' experiences adequately, the use of less structured qualitative methods could be promoted by counselling psychologists with the aim of producing diverse perspectives of group process and foregrounding the participants' individuality, resourcefulness and strengths, in contrast to the portrayal of service users in some existing research.

### **4.9.3 Group member mentoring**

The study highlights that the participants responded positively to group psychological therapy after their mental health trauma, and that their experiences of joining groups was often difficult without the encouragement of other MHSU. This could be an area in which mental health professionals become involved so as to manage how spaces in groups are used and to avoid resources being wasted.

#### 4.9.4 Stigma awareness

It appears from this study that mental health stigma still occurs and that because of it individuals negotiating mental health symptoms may still experience their motivation and resources diminished. The existing research suggests that reducing stigma could promote continuing recovery and reduce the human and financial costs of mental illness (Laing 1960, 1961; and Byrne 1997, 2000). The present study participants' utterances offer support for this suggestion and express how their group offers them a sense of relief from stigma and that the support of their group peers who may also have experienced stigma seems to moderate its impact.

#### 4.9.5 Goal setting

It appears from the study that a specific task for counselling psychologists and facilitators appears to be helping individuals define which achievable goals they could work towards, in order to build on existing strengths and accomplish an achievement, which could itself offer future fulfilment, purpose, enjoyment and meaning in life.

#### 4.9.6 Facilitator supervision

The present study suggests support for existing research proposing that facilitators receive appropriate training and supervision in order to enhance the effectiveness of a group intervention, and additionally to conceptualise group processes including *Facilitator Rivalry* and *Recovery Competition* (Wykes et al., 2005; Woolfe and Tholstrup, 2010). The present study's insight into *Facilitator Rivalry* and the potential for such behaviours to divert and disrupt the group process and the therapeutic relationship appears to be reported infrequently within existing research. The present study's consideration of such behaviour resembling the participants modelling themselves on their facilitators' leadership qualities could be further explored within facilitator training. Furthermore, the participants' somewhat competitive displays of their own recovery compared to that of their peers in *Recovery Competition* appears to offer novel awareness to the field. The present study offers clinical examples which could be modified into specific facilitator training to raise awareness of both of these phenomena, with the potential effects of raising awareness of the complexities of group process and the potentially under-

recognised opportunities for change within groups being acknowledged within the field.

One of the implications for practice arising from this study was my line manager's invitation to devise and offer just such training to a team of psychologists at a National Health Service (NHS) sexual health service in 2015.

#### 4.9.7 Group therapy assessment

From my perspective as a counselling psychologist I facilitated a large number of group therapy sessions in nearly all the NHS services in which I worked. My course required the submission of three clinical process reports to assess my use of psychological interventions and process via a short transcription of an individual therapy session, with the group therapy I facilitated not being part of this clinical assessment. Instead, a group therapy transcription could be assessed using the same client safeguards for confidentiality, to include group therapy interventions within clinical coursework, since it is noticeable how many current NHS positions require group therapy facilitator competence.

#### 4.9.8 Authenticity

The participants' experiences in the present study support the suggestion by Jung (1966) that psychological interventions are most effective when facilitators practice and believe in them. Jung (1966) suggests that facilitators are not just representing their therapy model, but *are* the model for their group members.

### **4.10 Research Limitations**

#### 4.10.1 Methodological limitations

IPA is not constructed to create generalisable nomothetic data, so this could be considered a limitation, as the study findings are not universally applicable (Smith, 2004). However, they may perhaps be transferrable in terms of informing practitioners about other group therapy situations. This study could appear limited in that the issues discussed by the participants have in a sense been frozen in time

and place, since it is unlikely that a participant might discuss the same things in another study (Willig, 2013).

A further methodological limitation in IPA is that although IPA values individual perspectives, the researcher is required to cluster individual utterances together into themes. The clustering into themes suggests some element of homogeneity or sameness, with the individual accounts suggesting difference, which presents a dilemma for IPA researchers. As a researcher wishing to transcend this possible limitation, I have illustrated the themes by drawing on individual participants' utterances; in addition, examples of convergence *and* divergence have been identified within the themes and I have included my personal reflexivity of my epistemological position and my interpretative stance, which are rooted within the data.

#### 4.10.2 Sample limitations

With nine participants the present study could be considered limited by its size. However, Smith (2004) suggests that there could be advantages of greater attention to detail and depth, which may not be achieved using a larger sample.

While it remains unclear what motivated these participants to join the study, it appears that this self-selecting opportunistic sample appear to be experiencing recovery at the time of their research interviews. It was clear that not all of the present participants were enjoying their groups, with instances of therapeutic rupture and participants leaving their groups. The study could perhaps have covered a range of different issues if participants at earlier stages of their mental illness or soon after diagnosis had agreed to participate.

The participants in the present study could be considered to be a purposeful sample (Smith, 2003), as they were able to reflect deeply on their experiences of attending longer-term therapy groups. They could also be considered somewhat homogenous having all attended longer-term group therapy, and having all received diagnoses of severe mental illness some time before the research began, and in having had time to reflect on its meaning for them. However, the present study participants' discuss their experience of attending several different longer-term therapy groups (Appendix



8) which could be considered to perhaps lack some elements of homogeneity which may have been present if the participants had all experienced the same group. Therefore this could suggest the findings from the present study may have limited transferability to other situations, being specific to these participants, the groups they attended and their being situated in time and place. In order to counteract this possible limitation, I have been transparent in my data collection and analysis, to enable the reader to assess the likely transferability of the present findings with regard to other situations (Smith et al., 2009).

The participants are not intended to represent other MHSU. The participants in the present study live independently, some have experienced living with partners, some have had children and all have experience of working. One could easily surmise that the participants' experiences might differ if they were situated elsewhere, younger, or recently diagnosed.

It could appear limiting that the participants in this study have had or are having individual therapy; that some participants attend more than one therapy group and have contact with different mental health professionals and their mentor at the centre. In this way, the impact of their therapy group is not occurring separately or distinctly from all the other elements influencing the participants' mental well-being and self-awareness.

The study participants discuss their experiences of attending a number of longer-term therapy groups run locally for several months, and contacting their mentor at the centre about practical issues, thereby reducing stress through accessing support. In other areas those resources may be different or absent. More particularly, in the current financial climate, brief, solution-focused, agenda-led group interventions may be offered, which could limit the transferability of the findings to other situations.

The fact that data was collected in one location could be seen as a limitation. One could surmise that therapy groups in another area with different mental health services may have elicited the discussion of different experiences by the participants. The section now turns to discuss study validity.

## **4.11 Study Validity**

Validity within this study has been thoroughly scrutinised to ensure the integrity and quality of the findings (Smith, 2011). Yardley (2000; 2008) suggests validity should be thorough and comprehensive, including Sensitivity to context; Commitment and rigour; Transparency and coherence; and Impact and importance. Sensitivity to context includes the study's contextualisation within theory and sociocultural research, situating the participants' lives and perspectives, and using ethical procedures. Commitment and rigour includes methodological skills in data gathering, analysis and demonstrating engagement with the subject matter. Transparency and coherence includes outlining procedures carefully with a clear rationale and synthesis between the method and the theory. Impact and importance highlights clinical implications and how awareness can be enhanced. Table four highlights the location of validity markers throughout the study. The section then explores considerations for further research.

<b>Validity</b>	<b>Study sections</b>	<b>Description of Reflexivity</b>
<b>Sensitivity to context</b>	1.1.1, 4.6 1.5 2.2.2 2.15.4, 2.15.2 2.10, 2.14, 2.15 2.17 2.15.3	Researchers sensitivity to involvement in study Sensitivity to conceptualisation of mental illness Critical-realism with post-modernism Researcher impact on participants Sensitivity to ethics and data gathering Transcription reflexivity Sensitivity to power in language use
<b>Commitment and rigour</b>	1.4 1.4.12 2.14 2.7, 1.5.1 2.21 2.15 2.11 2.6	Engagement within Literature review Engagement with MHSU as researchers Rigour in data gathering Social construction impact on language Reflexivity on the Analysis process Reflexivity on data gathering Sample considerations Research question design, method and analysis coherence
<b>Transparency and coherence</b>	2.18 2.2, 2.6, 2.4 2.15, 2.17, 2.21 Appendix 10 2.18, 2.21 2.20	Interpretive transparency Coherence between epistemology, rationale, and IPA Reflexivity Transparent Analytic procedure Transparency in Analysis Member checks versus Audit of themes
<b>Impact and importance</b>	4.8 4.9 2.19	Summary of contributions to the field Implications for practice Validity

**Table Four: Highlighting validity throughout the study**

## 4.12 Further Research

Creating an additional data point as Yardley (2008) suggests with either a second research interview with the same participants, or another source of data, such as diary writing (Smith, 1999), could offer additional awareness of the participants' therapeutic group experiences. Writing could be a therapeutic tool in recovery from mental illness (Baikie and Wilhelm, 2005; Sartori, 1977) and some of the participants in the current study were finding that writing helped them to recognise their growing insight and self-awareness.

I would be interested in conducting a further qualitative analysis of MHSU participants' experiences of attending *shorter* therapy groups, perhaps including brief therapy, agenda-led and solution-focused groups. Current qualitative brief therapy group research (May et al., 2014; Abba et al., 2008) tends to focus on the intervention as opposed to the experience of attending the group. A further study of MHSU participants' experiences of therapy groups could focus on NHS groups or groups situated within several different locations.

It would be interesting to further research *Recovery Competition* and *Facilitator Rivalry* to explore whether these phenomena occur in other group situations and how other group members negotiate their mental health status and recovery.

Furthermore, it would be interesting to conduct a study of MHSU participant experiences of choosing not to attend therapy groups, in order to consider potential barriers to participation and any possible resolution. The chapter now ends with the conclusions of the study.

## 4.13 Conclusions

The present study contains the participants' unique experiences of their therapeutic groups. The participants all have first-hand experiences of living with a severe and enduring mental illness defined by the Department of Health (1996). Many of their experiences of therapeutic groups do not feature within existing research. Some existing group research focusing on group content and outcomes appears to

obscure the group participants' views. Other group research focusing on process can be presented from the facilitator's top-down perspective which can appear to detract from the group participants' experiences. In the present study the participants' utterances illustrate their experiences with a level of detail which invites the reader into their lifeworld. The participants describe their stigma experiences, their reactions, and how they respond, and their perceptions of their groups offering *Sanctuary from Stigma*. After some participants are ostracised or stared at by their neighbours they demonstrate motivation to continue going out and trying to make friends with others, despite their setbacks. Through the directness of the participants' voices, the reader is invited to momentarily share their perspective of their lifeworld including their humiliation from stigma experiences. The study illuminates how the participants' individual characteristics appear to impact on the different ways in which stigma experiences are approached and negotiated.

The finding of *Recovery Competition* appears novel and previously unrepresented within existing research. Depending how one conceptualises *Recovery Competition*, it could perhaps convey a heightened sense of self-assurance, perhaps highlighting the individual's contribution to their recovery; or the participants' preparation for recovery, or it could perhaps be related to the participants' group attendance or their on-going relationships with each other. The finding of *Facilitator Rivalry* has received limited discussion within existing group studies which suggest it could imply a negative facilitator relationship or a breakdown in group therapy. Depending how one conceptualises *Facilitator Rivalry*, the present study findings conversely suggest it conveys a *strong* therapeutic relationship with one's facilitator, which perhaps encourages the group member to model their facilitator's leadership skills or begin to demonstrate their independence. These two phenomena, if unacknowledged, could have a negative impact on the therapeutic alliance or even disturb the survival of the group as a therapeutic space. These findings together highlight that the potential for change in therapeutic groups may have been previously under-estimated by group research.

Some situations seem harder to describe using language and the participants' use metaphor and dynamic imagery to convey intense feelings and sensations. Participants describe *Hope* including a reflexive element of assimilating and valuing how skills have been acquired, as well as future-focused motivation.

The participants' accounts foreground their creative dynamism in negotiating obstacles and their intrusive mental health symptoms to achieve their goals and participate in fulfilling activities. A participant describes her distress as she negotiates her environment on a noisy bus as she struggles with voice hearing intrusions, describing her internal cognitions about her dominant voice and her deliberations and decision to challenge that voice. Thus the study offers examples which could enhance the awareness of living with severe and enduring mental illness for mental health professionals within the field.

Throughout the study the participants' experiences of their therapy groups are contextualised within existing research. It was apparent that older research suggesting symptom reduction may be linked to *Recovery* was not supported by the participants' experiences, nor did the participants' describe resilience, which could originate from a service provider's research agenda. It was apparent that *Recovery* research produced differing findings, depending on whether MHSU were consulted. When MHSU were consulted, findings suggested good physical and mental health and integrating the effects of trauma were linked to recovery. Furthermore, the participants' views of recovery were shared by recovered MHSU suggesting that recovery includes taking control of decisions, social interaction and managing learned behaviours, perhaps suggesting that the MHSU case studies and the participants share insights and awareness of living with severe and enduring mental illness. The study findings aim to offer transferable awareness with the potential to enhance clinical practice. The findings have been adapted by the researcher into training material with the aim of enhancing group facilitation.

The costs of mental illness to psychological health appear to have long-term consequences for these participants and their coping strategies, self-challenge and courage to try new things are valuable assets. Asking the participants about their experiences of their therapeutic groups has been a novel and interesting way to raise awareness about how the participants negotiate obstacles and intrusions with a level of detail that may not otherwise have been revealed. The present study highlights that the life situations being faced by these participants demand their creativity, motivation and determination, with their therapy groups offering on-going opportunities for self-challenge and adaptive strategies which can offer the participants choices and a sense of control over their future; particularly as the

participants appear to continue to use the strategies learnt in their groups after they no longer attend. As David summarises: *I live by counselling and I live by group therapy* (24).

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## **Section C Journal Article**

**'I was walking on private water'.**

**Mental health service users' experiences of their  
therapeutic group: An Interpretative Phenomenological  
Analysis.**



**Qualitative Paper for submission to Psychology and  
Psychotherapy: Theory, Research and Practice**

'I was walking on private water'. Mental health service users'  
experiences of their therapeutic group: An Interpretative  
Phenomenological Analysis

Christine Barley

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Word count (exc. figures/tables): 6000 words

Please refer to Appendix 11 for Author Guidelines

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## Abstract

**Objectives.** Much research into groups has examined the effectiveness of an intervention from a top-down researcher perspective, leaving a void in what is known about the experiences of attending a therapeutic group from the group members' perspectives. The present study explores Secondary Care mental health service users' (MHSU) experiences of therapeutic groups using Interpretative Phenomenological Analysis (IPA), with the research question: *What is it like to be part of your therapeutic group?*

**Design.** This research utilised a bottom-up, qualitative, phenomenological and ideographic design using semi-structured individual interviews.

**Method.** Nine MHSU who had experienced severe and enduring mental illness and had attended a therapeutic group were recruited to participate. The interviews were transcribed and analysed using Smith, Flowers and Larkin's (2009) IPA methodology.

**Results:** Eight themes emerged. The focus of this paper will be the following three themes: *Sanctuary from Stigma*, *Recovery Competition* and *Facilitator Rivalry*. *Sanctuary from Stigma* explores the participants' creative strategies used to overcome social hostility. *Recovery Competition* highlights the novel finding of participants' competitively promoting their own recovery against that of their peers. *Facilitator Rivalry* explores the participants' challenge of their facilitator's leadership.

**Conclusions:** The findings illuminate the impact of the group experiences from the participants' perspectives, enhancing the awareness of the group processes. The themes suggest that group participants use their groups in novel ways to promote and expedite their recovery. Such awareness could benefit facilitators and reduce situations contributing to therapeutic rupture.

### Practitioner Points

- exploring group process and implicit communication within groups
- exploring the therapeutic relationship and engagement within therapeutic groups
- ameliorating obstacles to effective group psychological interventions with people who have a severe and enduring mental illness.



## Appendices

**Appendix 1: Table One - Therapy group research reviewed  
highlighting limitations, findings and method**

Author, brief title	Key Method Details	Key Findings	Key Limitations
<b><i>Art, music and activity group research</i></b>			
<p><b>1. Teglbaerg (2011)</b></p> <p>Art therapy may reduce psycho---pathology in schizophrenia by strengthening patients' sense of self</p>	<p>Qualitative analysis</p> <p>Year---long weekly art group for individuals who have received a diagnosis of schizophrenia</p> <p>Pre-group, mid-group and post-group interviews</p> <p>'Modified grounded theory' with phenomenology</p>	<p>Stronger sense of self emerged</p>	<p>No direct quotes from the participants' interviews supporting findings</p> <p>'Modified grounded theory' lacks cited theoretical basis</p> <p>Top-down facilitator perspective denies the reader the participants' unique insights into their group</p>
<p><b>2. Crawford et al. (2012)</b></p> <p>Group art therapy as an adjunct treatment for people with schizophrenia.</p>	<p>Quantitative analysis</p> <p>A multi---centre pragmatic randomised controlled trial (RCT) of weekly art and activity groups lasting a year</p> <p>3 conditions – treatment as usual (Tau),</p> <p>Tau and art therapy,</p> <p>Tau and activity therapy (consisting of board games, watching DVDs, visiting cafes)</p> <p>Measures at 12 and 24 months</p> <p>Global Assessment of Functioning (GAF)</p> <p>Positive and negative syndrome scale (PANSS)</p>	<p>No improvement to global function or symptoms assessed by positive and negative syndrome scale across three conditions</p> <p>Findings conflict with NICE guideline 82 (2009)</p> <p>Schizophrenia treatment interventions: to consider art therapy referral</p>	<p>32% attrition unaddressed</p> <p>Unclear what obstacles there were to attending art therapy group</p> <p>Potential interim benefits were not measured</p> <p>Group attendance averaged 3 members so effects of attending group therapy might be lost</p> <p>Benefits at 12 months not sustained</p> <p>GAF completed by researchers</p> <p>Unaddressed confound: facilitators asked not to explore participants thoughts and feelings</p>
<p><b>3. Eyre (2011)</b></p> <p>Therapeutic chorale for persons with chronic mental illness</p>	<p>Mixed methods analysis of weekly choir for individuals with severe mental illness</p>	<p>Self-esteem, mood and self--care improved</p>	<p>Likert scale responses (critiqued by Spermon, 2010; Parkinson, 2007) as unrepresentative of nuances and specificity.</p>

Author, brief title	Key Method Details	Key Findings	Key Limitations
	<p>Choir participants attended between 4 and 24 weekly sessions</p> <p>Researcher's own self-report questionnaire consisting of 42 Likert rated questions and 5 'qualitative questions'.</p>		<p>No suicidality or self-harm measures</p> <p>Endurance of choir benefits post group unmeasured</p> <p>Session content unspecified</p> <p>Researcher's questionnaire lacks construct validation; reliability established by paired t-tests of 2 questions</p> <p>'Qualitative questions' lack a cited theoretical basis and their method of analysis not cited</p> <p>Potential confound from dual role of researcher and group facilitator unaddressed</p>
<p><b>4. Gajic (2013).</b></p> <p>Group art therapy as an adjunct for the treatment of schizophrenic patients in a day hospital</p>	<p>Case study researcher observations and quantitative measures of 2 service users' attending a weekly on-going art therapy group.</p> <p>Service users had been given a diagnosis of schizophrenia</p> <p>GAF</p> <p>Clinical Global Impression (CGI)</p>	<p>No improvement to symptoms or function</p> <p>Researcher suggests introduction of human figures into art work could indicate improved mood and self-confidence.</p>	<p>Unclear how many sessions were attended</p> <p>Group content theoretical basis uncited</p> <p>Methodology theoretical basis uncited</p> <p>GAF completed by researchers</p> <p>No suicidality or self-harm measures. No measures of mood.</p> <p>Suggestions that mood and self-confidence improved lack corroboration from either quantitative measures or service users' comments.</p>
<p><b>5. Gahnstrom-Strandqvist et al. (2004).</b></p> <p>Stories of clients with mental illness: The structure of occupational therapists' interactions</p>	<p>Qualitative narrative analysis</p> <p>Occupational therapists as participants reflecting on their role in motivating service users who have severe mental illness to</p>	<p>Findings suggest occupational therapists engage and support service users in taking risks and in offering opportunities to develop</p>	<p>Lacks the involvement or voices of service users. Appears to foreground professionals' observations perhaps at the expense of positioning the service users as lacking in autonomy</p>

Author, brief title	Key Method Details	Key Findings	Key Limitations
	attend activity groups Interviews		Occupational therapists reflections offer a top-down, third party perspective of service users.
<p><b>6. Etoile (2002).</b></p> <p>The effectiveness of music therapy in group psychotherapy for adults with mental illness</p>	<p>Quantitative analysis</p> <p>6 session music therapy groups involving listening, creating and improvising music</p> <p>Researcher's own self-report questionnaire consisting of 42 Likert rated questions</p>	<p>Decreased anxiety</p> <p>Improved social relationships</p>	<p>Theoretical basis for methodology not cited</p> <p>Researcher's own questionnaire construct validity and reliability not cited</p> <p>No suicidality or self-harm measures</p> <p>Endurance of benefits unmeasured</p> <p>Likert scale responses (critiqued by Spermon, 2010; Parkinson, 2007) as unrepresentative of nuances and specificity</p> <p>Potential confound from dual role of researcher and group facilitator unaddressed</p>
<b><i>Quantitative longer-term therapy group research</i></b>			
<p><b>7. Tschuschke et al. (2007).</b></p> <p>Evaluation of long-term analytic outpatient group therapies</p>	<p>Quantitative meta-analysis</p> <p>40 Longer-term psychodynamic therapy groups lasting 80-100 sessions containing individuals who have been given a range of differing severe mental illness diagnoses.</p> <p>GAF</p> <p>Symptom Checklist (SCL)</p> <p>Inventory of Interpersonal Problems (IIP)</p> <p>Reliable Change Index (RCI)</p> <p>Facilitators all have at least 2 years' experience.</p>	<p>No difference in rate of improvement between those who have received a diagnosis of personality disorder and those who have received a diagnosis of another severe mental illness</p> <p>60% recovered indicating no residual mental illness symptoms (measured according to the Reliable Change Index -- RCI), 30% recovered indicating statistically significant</p>	<p>Previous individual therapy of around 67 sessions may have influenced group benefits.</p> <p>No enduring measure of benefits</p> <p>No inter-rater reliability of measures as therapists spread throughout Germany, Switzerland and Austria.</p> <p>Sessions not manualised -- content varies depending on issues raised by group members. This may limit the transferability of findings.</p> <p>No information about how group members found experience of attending group or how the improvements were</p>

Author, brief title	Key Method Details	Key Findings	Key Limitations
	Data collected 1997---2003	improvement	integrated into their lives.  GAF completed by researchers  Unclear whether the 60% 'recovered' group members experienced the group benefits the same way as the measures suggest.
<p><b>8. Lorentzen et al. (2005).</b></p> <p>Predictors of change after long---term analytic group psychotherapy.</p>	<p>Quantitative analysis</p> <p>3 Longer---term psychodynamic group (Foulkes' 1986 model) containing individuals who have been given a range of differing severe mental illness diagnoses.</p> <p>All groups facilitated by same 2 therapists</p> <p>Symptom Checklist (SCL)</p> <p>Global Severity Index (GSI) Likert scale</p> <p>Inventory of Interpersonal Problems (IIP)</p> <p>GAF</p> <p>Likert group evaluation by participants</p>	<p>Equal improvement to symptoms and function for individuals who have received a diagnosis of personality disorder and those who have received other severe mental illness diagnoses.</p> <p>Endurance of benefits 1 year post---group.</p> <p>3% attrition rate.</p>	<p>Sessions not manualised ---content varies depending on issues raised by group members. This may limit the transferability of findings.</p> <p>Likert scale responses (critiqued by Spermon, 2010; Parkinson, 2007) as unrepresentative of nuances and specificity</p> <p>GAF completed by researchers</p>
<p><b>9. Wilberg et al. (2003).</b></p> <p>Outpatient group therapy following day treatment for patients with Personality Disorders</p>	<p>Quantitative meta-analysis</p> <p>21 longer---term psychodynamic groups (Foulkes and Anthony's 1957 model) averaging 120 sessions, containing individuals who have been given a range of differing personality disorder diagnoses</p> <p>Likert self---report group evaluation by participants</p> <p>GAF</p>	<p>Reduction in symptoms and distress.</p> <p>Improved functioning.</p>	<p>43% attrition rate unaddressed by researchers.</p> <p>Sessions not manualised ---content varies depending on issues raised by group members.</p> <p>Lack of session specificity may limit transferability of findings in other situations.</p> <p>Likert type responses (critiqued by Spermon, 2010 and Parkinson, 2007) as</p>

Author, brief title	Key Method Details	Key Findings	Key Limitations
	Global Severity Index (GSI)  Circumplex of Interpersonal Problems (CIP)		unrepresentative of nuances and specificity.  Concurrent individual therapy unaddressed by researchers.  GAF completed by researchers  Endurance of group benefits unmeasured
<b><i>Quantitative and qualitative bipolar therapy group research</i></b>			
<b>10. Weber et al. (2010)</b>  Mindfulness based cognitive therapy for bipolar disorder: A feasibility trial	Quantitative analysis  8 session mindfulness based cognitive therapy group for bipolar disorder  Beck Depression Inventory---II (BDI---II)  Kentucky Inventory of Mindfulness Skills (KIMS)  Montgomery Depression Scale (MDRS)  Young Mania Rating Scale (YMRS).	No symptom reduction. Improved mood and anxiety  No evidence of bipolar relapse prevention  Improvements to quality of life during intervention	Researchers selected participants exhibiting depressive symptoms, which could mean study results could be unrepresentative due to the mood fluctuations within bipolar disorder  65% attrition unaddressed  Unclear whether effects due to attending the group or practising mindfulness  Mindfulness practice decreased over time  Beck Depression Inventory –II (BDI-II) may not differentiate persistent, complex, severe depressive symptoms  YMRS and MDRS completed by researchers  No evidence of reduction in suicidality or self-harm
<b>11. Williams et al. (2008).</b>  Mindfulness---based cognitive therapy (MBCT) in bipolar disorder: Preliminary evaluation of immediate effects	Quantitative analysis  8 session mindfulness based cognitive therapy groups for bipolar disorder   BDI-II	Reduction in anxiety and depression  No reduction in bipolar symptoms	Researchers selected participants exhibiting depressive symptoms, which could mean study results could be unrepresentative due to the mood fluctuations within bipolar disorder  BDI-II may not

Author, brief title	Key Method Details	Key Findings	Key Limitations
on between-episode functioning			<p>differentiate persistent, complex, severe depressive symptoms</p> <p>No suicidality or self-harm outcome measures</p> <p>Unclear whether changes due to attending group or practising mindfulness</p> <p>No data on the endurance of benefits post-group</p>
<p><b>12. Dijk et al. (2013).</b></p> <p>A randomised controlled pilot study of Dialectal Behaviour Therapy skills in a psychoeducational group for individuals with bipolar disorder</p>	<p>Quantitative analysis</p> <p>12 session Dialectal Behaviour Therapy (DBT) skills training group consisting of mindfulness and psychoeducation</p> <p>Compared to an unspecified waiting--list control</p> <p>BDI-II</p>	<p>Improved mood and increased use of mindfulness</p>	<p>Researchers selected participants exhibiting depressive symptoms, which could mean study results could be unrepresentative due to the mood fluctuations within bipolar disorder</p> <p>BDI--II may not differentiate persistent, complex, severe depressive symptoms</p> <p>No suicidality or self-harm outcome measures</p> <p>Unclear whether changes due to attending group or practising mindfulness</p> <p>No data on the endurance of benefits post-group</p>
<p><b>13. Chadwick et al. (2011).</b></p> <p>Experience of mindfulness in people with bipolar disorder.</p>	<p>Qualitative analysis</p> <p>An 8 session Mindfulness based cognitive therapy (MBCT) group for bipolar disorder (based on Williams et al. 2008) with Tau (consisting of medication, keyworker, routine appointments), followed by a 6 session MBCT booster group. Compared with Tau.</p> <p>Semi-structured</p>	<p>Participants describe meanings of learning mindfulness skills; learning to adapt mindfulness practice to balance mood; beginning to appreciate their own unique situation.</p> <p>Participants integrate mindfulness practice into their everyday lives.</p>	<p>Participants recruited to study all had moderate mood fluctuations – unclear how intervention could be adapted for use by individuals with severe mood swings or whether the demands of using the intervention would be greater for those with severe mood swings.</p> <p>No indication of the endurance of benefits post-group.</p> <p>Unclear whether</p>

Author, brief title	Key Method Details	Key Findings	Key Limitations
	interviews (based on Smith, 1995). Thematic analysis of data (based on Joffe and Yardley, 2004)	<p>Participants reflect on choosing how to respond to their fluctuating mood.</p> <p>Mindfulness practice experienced as more challenging when mood depressed.</p> <p>Increased self-acceptance.</p>	<p>intervention has beneficial effects on symptoms or function.</p> <p>Unclear whether changes due to attending group or practising mindfulness</p>
<b><i>Quantitative borderline personality disorder therapy group research</i></b>			
<p><b>14. Soler et al. (2009)</b></p> <p>DBT therapy skills training compared to standard group therapy in borderline personality disorder: A 3 month RCT</p>	<p>Quantitative analysis RCT comparing 13 session DBT skills training groups compared to standard group therapy (defined as exploration, clarification and confrontation).</p> <p>Clinical Global Impression for Borderline Personality Disorder (CGI-BPD).</p> <p>Hamilton Rating Scale Depression (HRSD).</p> <p>Brief Psychiatric Rating Scale (BPRS).</p> <p>Symptom Checklist (SCL).</p> <p>Buss-Durkee irritability inventory (BDI).</p> <p>Barratt Inventory of impulsivity (BI).</p> <p>BDI-II</p>	<p>Reduction in depression, anxiety and symptoms.</p> <p>Reduced irritability.</p> <p>Researchers suggest active intervention by participants in their groups is difficult to assess.</p>	<p>Participants who stopped attending the group were not followed up: researchers suggest it may be due to medication changes.</p> <p>34% attrition not fully addressed. Enduring benefits not measured</p> <p>Limitations poorly addressed – only methodology issues considered.</p> <p>Unclear whether benefits relate to group attendance with peers or the intervention or a combination of both.</p> <p>BDI-II may not differentiate persistent, complex, severe depressive symptoms</p>
<p><b>15. Farrell et al. (2009).</b></p> <p>A schema-focused approach to group psychotherapy for outpatients with</p>	<p>A RCT comparing a 30 session schema-focused therapy (SFT) group with individual treatment as usual (tau) consisting of</p>	<p>Reduction in symptoms. Improvements in function.</p> <p>Researchers suggest group</p>	<p>Tau condition consists of individual therapy as opposed to the SFT condition consisting of the group and the individual therapy</p>

Author, brief title	Key Method Details	Key Findings	Key Limitations
borderline personality disorder: RCT.	<p>individual therapy.</p> <p>SFT group condition also receive tau</p> <p>Participants are women who have received a diagnosis of borderline personality disorder</p> <p>SFT group is manualised (based on Farrell and Shaw's, 1990 model) and facilitated by experienced therapists</p> <p>SFT consists of emotional awareness training, borderline personality disorder psychoeducation and distress management training.</p> <p>Borderline Syndrome Index (BSI)</p> <p>Symptom Checklist (SCL-90) GAF</p> <p>Diagnostic Interview for Personality Disorder (DIB-R)</p>	<p>members experienced reduced self-hatred and reduced self-harm after the SFT group</p> <p>SFT group no attrition</p> <p>94% SFT group participants no longer met borderline personality disorder criteria as assessed by measures</p>	<p>Women participants could perhaps limit transferability of findings</p> <p>Reduced self-hatred and reduced self-harm after the SFT group was not corroborated by measures</p> <p>GAF completed by researchers</p> <p>Tau condition 25% attrition unaddressed by researchers</p> <p>Unclear whether SFT group members experienced similar level of recovery as measures indicated</p>
<p><b>16. Linehan et al. (2006).</b></p> <p>One year RCT and one year follow-up of DBT v therapy by experts for suicidal behaviours and borderline personality disorder</p>	<p>Quantitative analysis</p> <p>One year RCT with one year follow-up in both conditions.</p> <p>Dialectal Behaviour Therapy (DBT) groups and concurrent individual therapy compared with community treatment for borderline personality disorder.</p> <p>Group element consists of skill training</p> <p>Suicide attempt self-injury interview</p> <p>Suicidal behaviours questionnaire</p> <p>Reasons for living</p>	<p>Researchers attribute 50% reduction in suicidality, and reduced use of crisis services to the DBT intervention.</p> <p>Lower attrition for DBT participants</p> <p>No difference in self-harm for either condition</p>	<p>Community treatment component (undefined) consisted of one hour weekly individual therapy without groups.</p> <p>DBT participants received 3.5 hours therapy weekly.</p> <p>Lower DBT attrition could arise from being more engaged by longer therapy hours</p> <p>Eight DBT participants' (15.4%) suicidality measures were incomplete due to participant distress, lack of memory or refusal to answer, perhaps suggesting the participants found the</p>



Author, brief title	Key Method Details	Key Findings	Key Limitations
	<p>inventory</p> <p>Treatment history interview</p> <p>Hamilton Rating Scale Depression (HRSD)</p>		<p>measures onerous.</p> <p>No endurance of benefits measured</p> <p>Researchers do not consider whether the effects of attending a group with peers for a year could have an impact on the outcome</p>
<p><b>17. Blum et al. (2008).</b></p> <p>Systems training for emotional predictability and problem solving (STEPPS) for outpatients with borderline personality disorder: A RCT and 1 year follow up</p>	<p>Quantitative analysis</p> <p>RCT comparing 20 session STEPPS groups comprising skills training (from standard DBT) and cognitive therapy with twice weekly individual therapy, with Tau (weekly individual therapy)</p> <p>BDI-II</p>	<p>Improvements in symptoms, function and mood</p> <p>Benefits endured for a year post-group</p> <p>Researchers suggest attending the group with peers may improve 'social support, hope and therapeutic alliance'</p>	<p>BDI-II may not differentiate persistent, complex, severe depressive symptoms</p> <p>'Social support, hope and therapeutic alliance', are uncorroborated by the quantitative measures</p>
<p><b>18. Bateman and Fonagy (2009).</b></p> <p>RCT of outpatient Mentalisation-based treatment versus structured clinical management for borderline personality disorder</p>	<p>Quantitative analysis</p> <p>Comparison of Mentalisation-based therapy (MBT) groups for borderline personality disorder and an undefined control group.</p> <p>18 sessions</p> <p>BDI-II</p> <p>GAF</p>	<p>Suicidality and self-harm reduced by 50%</p> <p>Improved symptoms, mood (measured by BDI-II) and functioning (measured by GAF) post-group.</p> <p>Researchers suggest MBT group benefits endure for 5 years</p>	<p>MBT intervention includes weekly follow-up group lasting 2 years therefore endurance of group benefits could be considered to last a further 3 years</p> <p>BDI-II may not differentiate persistent, complex, severe depressive symptoms</p> <p>GAF completed by researchers</p> <p>Researchers do not consider whether attending a group with peers for 5 years could impact on the outcome</p>
<p><b>19. Hubbard et al. (2007).</b></p> <p>Social problem-solving plus psychoeducation for adults with personality disorder</p>	<p>Quantitative analysis</p> <p>Comparison of 16 session problem solving and psychoeducation groups with an unspecified control group.</p>	<p>Problem solving and social functioning increased, and anger was decreased following the group intervention.</p>	<p>Measures regarding suicidality and self-harm omitted.</p> <p>High level of participant attrition 48% remains unaddressed by researchers.</p> <p>Control group content</p>

Author, brief title	Key Method Details	Key Findings	Key Limitations
			unspecified
<p><b>20. Gratz et al. (2006).</b></p> <p>Preliminary data on an acceptance-based emotion regulation group intervention for deliberate self-harm among women with borderline personality disorder</p>	<p>Quantitative analysis</p> <p>14 session acceptance-based emotion regulation group for women with borderline personality disorder, compared to a waiting list control group receiving 'treatment as usual'.</p> <p>Deliberate Self-Harm Inventory (DSHI)</p> <p>Difficulties in Emotional Regulation Scale (DERS)</p> <p>Acceptance and Action Questionnaire (AAQ)</p> <p>Borderline Evaluation of Severity over Time (BEST)</p> <p>Depression Anxiety Scales (DASS)</p>	<p>Mood improvement.</p> <p>42% reduction in self-harm attributed to intervention.</p>	<p>Concurrent individual therapy of 8% participants unaddressed by researchers.</p> <p>Researchers omit baseline self-harm scores raising questions about integrity of findings.</p> <p>Unclear about the nature of the self-harm reduction: could relate to intensity, frequency or the level of intervention required.</p> <p>Endurance of benefits unassessed.</p> <p>'Treatment as usual' unspecified</p> <p>Suicidality unmeasured.</p>
<b><i>Quantitative psychosis and hearing voices therapy group research</i></b>			
<p><b>21. Landia et al. (2006).</b></p> <p>Group Cognitive Behaviour Therapy for Delusions: Helping patients improve reality testing</p>	<p>Quantitative analysis</p> <p>13 session Cognitive Behaviour Therapy (CBT) group for delusions</p> <p>Characteristics of Delusions Rating Scale (CDRS)</p> <p>Cognitive Assessment of Voices Interview Schedule</p> <p>Topography of Voices Scale</p> <p>Psychotic Symptom Rating Scale (PSYRATS)</p>	<p>Reduced delusions and reduced delusional distress attributed to cognitive strategy to dismiss delusional thoughts</p> <p>Researchers observed group members supporting each other in challenging their delusional beliefs</p> <p>Re-attribution of the meanings assigned to voices.</p>	<p>Quantitative measures did not account for key finding that group members supported each other in challenging their delusional beliefs.</p> <p>Group effectiveness may be under-represented by quantitative measures</p> <p>Unclear whether benefits are the result of the intervention or attending group with peers or a combination of both factors.</p>
<p><b>22. Wykes et al. (2005)</b></p> <p>What are the effects of group CBT for voices? A</p>	<p>Quantitative analysis</p> <p>7 session group CBT for voices</p> <p>Social Behaviour Scale</p>	<p>Improved self-esteem and social behaviour</p> <p>Group benefits endured for 6</p>	<p>Unclear whether social behaviour increased with group peers or outside of group.</p> <p>Unclear what self-</p>

Author, brief title	Key Method Details	Key Findings	Key Limitations
Randomised Control Trial	Psychotic Symptom Rating Scale (PSYRATS) Rosenberg Self-esteem measure Mental Health Research Unusual Perceptions Schedule (MUPS)	months post-group. Changing voice attributions was rated as effective by participants No reduction in symptoms 'effects within groups' (undefined) Facilitator CBT training, experience and supervision increased effectiveness of therapy.	esteem improvements mean to group members. Unclear whether benefits are the result of the intervention or attending group with peers or a combination of both factors.
<b>23. McLeod et al. (2007; 2007a).</b> Cognitive behavioural therapy group work with voice hearers	Quantitative analysis 8 session CBT group for voice hearers BDI-II	Researchers attribute less frequent, less powerful voice hearing to the group intervention. Distress remained unchanged Researchers suggest participants felt 'less stigmatised' by their voices from meeting as a group	Researchers omit some quantitative data and their research limitations BDI-II may not differentiate persistent, complex, severe depressive symptoms Endurance of group benefits unmeasured The participants' reduced stigmatisation was uncorroborated by the participants or quantitative measures
<b>24. Ruddle et al. (2011).</b> Review of hearing voices groups.	Quantitative analysis Comparison study of hearing voices groups consisting of CBT, skills--training, mindfulness and unstructured support groups.	Participants' distress reduced where groups were perceived as safe; hearing voices strategies were shared and alternative beliefs about voices were considered. Paucity of evidence for effectiveness of skills--training, mindfulness and unstructured support groups Quantitative CBT hearing voices groups appear most effective but	Comparative study omitting differences or idiosyncrasies of individual groups Includes study findings of individual therapy for hearing voices Unclear whether benefits due to attending a group with peers or from the intervention Unable to illuminate mechanisms of change in hearing voices groups

Author, brief title	Key Method Details	Key Findings	Key Limitations
		<p>many studies lack control groups</p> <p>Qualitative studies suggest non-threatening space and reduced social isolation are considered most effective by participants</p>	
<p><b>25. Barrowclough et al. (2006).</b></p> <p>Group cognitive behavioural therapy for schizophrenia</p>	<p>Quantitative analysis RCT</p> <p>18 session CBT group for schizophrenia compared to Tau (consisting of case management, medication, day centre and drop-in centre contact)</p> <p>Positive and negative syndrome scale (PANNS), GAF</p> <p>Social Functioning Scale</p> <p>Hospital Anxiety and Depression Scale (HADS)</p> <p>Beck Hopelessness Scale (BHS)</p> <p>Rosenberg Self-Esteem Scale (RSE)</p>	<p>Improved self-esteem and mood (reduction in depression) in group CBT condition</p> <p>Distress remained unchanged</p> <p>Researchers suggest facilitators adhered to manualised session content</p> <p>Endurance of benefits measured at 12 months post-group</p>	<p>GAF completed by researchers</p> <p>40% attrition unaddressed</p> <p>Suicidality and self-harm unchanged</p> <p>Group benefits measured at 12 months post-group were not sustained</p>
<p><b>26. Chadwick et al., (2000).</b></p> <p>Challenging the omnipotence of voices: Group cognitive behaviour therapy for voices</p>	<p>Quantitative analysis</p> <p>8 session CBT group for voice hearers</p> <p>Post-group structured interview</p> <p>Hospital anxiety and depression scale (HADS)</p> <p>Belief conviction rated by a 10cm line</p> <p>Topography of voices rating scale (Hustig and Hafner, 1990)</p> <p>Likert Therapy rating (Yalom, 1995)</p>	<p>Reduced voice omnipotence</p> <p>Increased control of voices attributed to the intervention <i>and</i> being in the group with peers</p> <p>Researchers acknowledge <i>shared insight</i> and <i>peer support</i> in challenging voices (from structured post-group interview data) may have contributed to group intervention</p>	<p>14% of participants declined to complete the measures, perhaps suggesting they found them onerous</p> <p>Post-group structured interview analysis method unspecified</p> <p>Shared insight and peer support in challenging voices were unmeasured by the quantitative ratings</p> <p>Likert type responses (critiqued by Spermon, 2010 and Parkinson,</p>

Author, brief title	Key Method Details	Key Findings	Key Limitations
		efficacy	2007). No improvement in depression or anxiety post--group (HADS scale)
<b><i>Qualitative psychosis and hearing voices therapy group research</i></b>			
<p><b>27. May et al. (2014).</b></p> <p>Person--based cognitive therapy groups for distressing voices: a thematic analysis of participant experiences of the therapy</p>	<p>Qualitative Thematic analysis (based on Braun and Clarke, 2006)</p> <p>12 session person--based cognitive therapy group for participants who have received a diagnosis of psychosis and personality disorder, consisting of mindfulness and ACT (based on Chadwick, 2006)</p> <p>Semi--structured individual interview schedule</p>	<p>Self-esteem and social relationships improved – participants reflect on <i>what</i> it means and <i>how</i> it has occurred.</p> <p>Participants distinguished positive aspects of themselves and described relief from their dominant voices</p> <p>Researchers consider the effects of being in a group and socialising with group members ‘non-specific group factors’ as contributors to the group’s effects</p>	<p>No enduring measure of therapy group benefits</p> <p>Unable to distinguish the benefits of attending the group from the benefits of the intervention</p>
<p><b>28. Abba et al. (2008).</b></p> <p>Responding mindfully to distressing psychosis. A grounded theory analysis</p>	<p>Qualitative analysis.</p> <p>8 session Mindfulness group for voice hearers who have been given a diagnosis of psychosis (based on Chadwick et al, 2000).</p> <p>Grounded theory analysis (based on Glaser and Strauss, 1967). Individual and group semi--structured interviews</p> <p>Participants encouraged to attend missed sessions as groups on a rolling programme.</p> <p>Avoids researcher bias by incorporating multiple data analysts</p>	<p>Participants learned decentering to consider significance of their voices from a differing perspective</p> <p>Participants able to change their attributions about their voices</p> <p>Challenges previous research suggesting meditation unhelpful with psychosis (Yorston, 2001).</p> <p>Group members supported each other learning the</p>	<p>Participants could be repeating the intervention rather than using their own insight</p> <p>Participants’ responses focus on the intervention instead of the experience of attending the group</p> <p>Unable to distinguish the benefits of attending the group from the benefits of the Mindfulness intervention</p>

Author, brief title	Key Method Details	Key Findings	Key Limitations
		<p>Mindfulness skills</p> <p>Participants' utterances involve reader</p>	
<p><b>29. Goodliffe et al. (2010).</b></p> <p>Group person--based cognitive therapy for distressing voices.</p>	<p>Qualitative analysis</p> <p>5 focus group discussions (based on McGowan, Lavender and Garety, 2005) were analysed using grounded theory analysis (Charmaz, 2003).</p> <p>8 session person---based cognitive therapy group for voice hearers consisting of mindfulness and ACT (based on Chadwick et al., 2000).</p>	<p>Emotional demands from voice hearing intrusions were alleviated following the group.</p> <p>Group experienced as safe space. Participants describe negotiating their negative emotional reactions to voices.</p> <p>Participants experienced stress and social isolation as a result of voice intrusions.</p> <p>Participants describe challenging and accommodating their voices.</p> <p>Participants appeared to separate themselves from their voices and become reflective.</p> <p>Authors suggest some benefits may have arisen from being part of a group <i>and</i> sharing experiences with peers and not just from the mindfulness intervention.</p>	<p>Authors suggest how the mindfulness intervention is used by each participant remains 'idiosyncratic', perhaps suggesting the findings could have limited transferability to other situations.</p> <p>Unclear whether benefits due to attending the group with peers or from practising mindfulness</p>
<p><b>30. Martin (2000).</b></p> <p>Hearing voices and listening to those that hear them</p>	<p>Case study facilitator observations (modelled on Parse's, 1991 theory of nursing) of weekly on---going unstructured hearing voices group (following</p>	<p>Facilitator observes the group members reflecting on their experiences of their voices as real/not real</p> <p>Facilitator suggests</p>	<p>Service user view of their voices as real/not real is not corroborated by direct quotation.</p> <p>Study contains four direct quotes from group members, perhaps</p>

Author, brief title	Key Method Details	Key Findings	Key Limitations
	<p>Romme and Escher's 1993 model).</p> <p>Group encourages peer support</p> <p>Facilitator offers a non-judgmental space for the exploration of voice hearing. Group sessions have fluid content depending on the group members' discussion.</p> <p>Every 12 weeks the group members verbally review their perspectives and experiences of the group.</p>	<p>group members express improved self-esteem and benefit from being with non-judgmental group peers who share their experience as voice hearers.</p> <p>Facilitator suggests group members reflect on their idiosyncratic auditory hallucinations</p>	<p>marginalising their unique experiences and expertise in living with voices</p> <p>Unclear how many sessions were attended</p> <p>Methodology theoretical basis uncited. Analysis method of service user utterances uncited raising questions about validity.</p> <p>Session variability could suggest findings may have limited transferability.</p>





## Appendix 2: Semi-structured research discussion prompts

- Please have a look at this consent form and sign it if you agree.
- Can I check what you understand being a participant involves?
- What questions have come up for you?
- We're here to talk about what it feels like to come to a group, the group you have been attending. Can I check you agree to this?
  
- I'm wondering which group have you been coming to?  
How long ago was that? How many times did you go to the group?  
What was it like to come to the group the first time?
  
- What was it like to come to the group after that? What had changed?  
What was it like for you to be there in the group?  
What sort of experiences did you have in the group?  
What was that like? (being part of the group?) Can you give an example of that?
  
- What kind of things have come out of being in this group?  
Has there been any changes you've noticed in yourself because of coming to the group? What difference has that made to you?  
If the group had not been set up, what difference would that have made to you?
  
- What was your best time in the group? Can you tell me a bit more about the bits of the group you enjoyed? Can you give me an example of that?  
And what was your worst time in the group? (if you want to talk about that)  
What do you think it would be like if the group had to stop running?  
What other things do you want to tell me about the group?  
How has coming to the group changed you? (how was that?) Can you put your finger on what it was that you got out of the group? Can you give me an example of that?  
When you look back how do you feel about the group?
  
- What other things have I not asked you about the group?
- Would that affect how you feel about joining another group?



## Appendix 3: Independent Audit of Themes

### by Dr Georgina Tory

**Key:** The yellow highlighted lines have been inserted into Table two within the Methodology chapter above which highlights where the Independent Auditor's theme suggestions appear to overlap with the Analysis of all the transcripts in the present study.

Email from Dr Georgina Tory:

Here is a list of themes I noticed:

I haven't listed all the examples of these themes in the brackets below, but I hope they are apparent/easy to find within the annotations I have made throughout the sample transcript you provided.

- Feelings and experiences around seeking help in the first place and process of finding the group (e.g. possible difficulty in owning the help seeking emotionally and also difficulty and frustration practically speaking)
- Life before the group (e.g. loneliness etc) – (the following highlighted section has been included in the research text)
- Initial feelings as he attends the centre for the first time (e.g. feeling anxious about being questioned, not knowing who's who, feeling staff might be on another level to him etc)
- Initial feelings within the group as he begins to attend (e.g. anxiety about talking etc)
- The good qualities and experiences he has gained from the group experience (e.g. being able to help others; being heard; shared experience; not feeling so alone existentially; self--transformation and personal strength; a real experience of connection etc) and the way he views it as a whole (e.g. like a family/ a secure attachment etc)
- The difficulties he has experienced with the group (including how his gender beliefs affected his experience of the group at times; possible difficulty in being the one who is helped by others; lack of time at points; watching others struggle e.g. with talking etc)
- Life after the group (e.g. strength, but also vulnerability to external forces/systems etc)
- Experience of the groups versus other groups in outside world (e.g. housing and benefit groups, neighbours, recreational groups) – (e.g. the greater sense of depth and quality of connection etc)

Dr Georgina Tory

HPCP Registered Counselling Psychologist

[www.drgeorginatory.co.uk](http://www.drgeorginatory.co.uk)



## Appendix 4: Ethics Release Form from City University London

### Ethics Release Form for Student Research Projects

All students planning to undertake any research activity in the School of Arts and Social Sciences are required to complete this Ethics Release Form and to submit it to their Research Supervisor, **together with their research proposal clearly stating aims and methodology**, prior to commencing their research work. If you are proposing multiple studies within your research project, you are required to submit a separate ethical release form for each study.

This form should be completed in the context of the following information:

- An understanding of ethical considerations is central to planning and conducting research.
- Approval to carry out research by the Department or the Schools does not exempt you from Ethics Committee approval from institutions within which you may be planning to conduct the research, e.g.: Hospitals, NHS Trusts, HM Prisons Service, etc.
- The published ethical guidelines of the British Psychological Society (2009) Guidelines for minimum standards of ethical approval in psychological research (BPS: Leicester) should be referred to when planning your research.
- Students are **not permitted to begin their research work until approval has been received and this form has been signed by Research Supervisor and the Department's Ethics Representative.**

#### Section A: To be completed by the student

Please indicate the degree that the proposed research project pertains to:

BSc      M.Phil      M.Sc      ✓D.Psych      n/a

Please answer all of the following questions, circling yes or no where appropriate:

1. Title of project

Giving a voice to mental health service users. A study using IPA. What it is like to participate in a group for mental health service users. Unique knowledge for mental health professionals and counselling psychologists.

2. Name of student researcher (please include contact address and telephone number)

Christine Barley, Trainee Counselling Psychologist, City University,  
Northampton Square, London, EC1V 0HB m: 07799 084535 e:  
Christine.barley.1@city.ac.uk

3. Name of research supervisor

Dr Jacqui Farrants e: j.farrants@city.ac.uk

4. Is a research proposal appended to this ethics release form?

Yes  No

5. Does the research involve the use of human subjects/participants?

Yes  No

If yes,

a. Approximately how many are planned to be involved? A maximum of 14

b. How will you recruit them?

- i. By visiting the groups and talking to the service users about my research.
- ii. By offering service users flyers about the research containing details about the methodology and the importance of informed consent. The flyers, the

2

research methodology and ethics have been discussed with group staff and keyworkers.

iii. The group staff will facilitate service users joining the research as participants by talking about my research during their groups. The group staff and keyworkers will mediate between the researcher and the potential participants so that anyone experiencing a mental health crisis or other difficulties such as distressing symptoms, or side-effects from anti-psychotic medication will not be approached about this research.

c. What are your recruitment criteria?

*(Please append your recruitment material/advertisement/flyer)*

- i. Prospective participants must understand English and have attended a therapeutic group run for mental health service users on two occasions.
- ii. Prospective participants must be mental health service users. A mental health service user is defined as an individual who has accepted a service offered by primary, secondary, tertiary or inpatient care either within the NHS, third sector, voluntary or private sector.
- iii. Prospective participants are not involved in any other research.
- iv. Participants are free to choose whether or not to participate without inducements, payment and without affecting their treatment or access to services.

d. Will the research involve the participation of minors (under 18 years of age) or vulnerable adults or those unable to give informed consent?

Yes      No

Vulnerable adults

d1. If yes, will signed parental/carer consent be obtained?

Yes       No

The prospective participants are over 18 and live independently from their parents and are considered competent to provide informed consent by the staff facilitating the group.

d2. If yes, has a CRB check been obtained?  Yes

No

*(Please append a copy of your CRB check)*

6. What will be required of each subject/participant (e.g. time commitment, task/activity)? *(If psychometric instruments are to be employed, please state who will be supervising their use and their relevant qualification).*

---

i. Participants will be asked to sign an informed consent form and will be advised they can drop out of the research later if they wish without affecting their involvement in the group and the mental health service.

ii. Participation involves an audio recorded discussion with me lasting from 30 minutes to an hour about the group they attend. In the discussion I will use prompts to encourage participants to talk freely about their own attendance at the group. The prompts focus the discussion on the individual themselves and not on anyone else who attends the group.

iii. The participants will be de-briefed and given an information sheet suggesting potential support from service staff, my research supervisor, myself, the Samaritans, Sane and where to make a complaint about the research. The aim is to provide an opportunity for participants to be able to discuss any feelings that have arisen from their discussion either independently or within the service, or to change their mind about participating. The Samaritans number is available 24/7 and can be accessed if any of the other suggestions are unavailable

7. Is there any risk of physical or psychological harm to the subjects/participants?

Yes       No

If yes,

a. Please detail the possible harm?

---

i. The discussion about the group itself is not intended to be distressing. Participants are not anticipated to experience psychological harm from the research since discussing their group is something they may engage in with the service staff in daily life, however, some participants may experience a negative or positive emotional reaction to their discussion about the groups they attend. Sometimes old memories are accessed when an individual tells their story and if any of the memories are traumatic or distressing, the participants could experience distress.

ii. For this reason, the de-briefing sheet contains suggestions for support to enable the participant to discuss any distress they may have experienced either with a person who is part of the service they attend or someone outside of the service.



b. How can this be justified?

i. The opportunity for the participants to discuss their experiences of attending their group may be a positive, transformative experience. Re-telling an experience can enable the participant to have a new perspective on their situation. For instance, an individual who has not felt validated and heard can use the experience of discussing their thoughts and feelings about their group to express their individual perspective about their situation and this experience may be helpful and the individual may feel that expressing their story helps them to clarify their thoughts and feelings.

ii. The participants may find the experience of being listened to by a supportive independent individual from outside of their service a therapeutic experience. I am clear I am not offering a therapy session in place of the research discussion, however, my counselling psychology training has enabled me to work effectively with people who are mental health service users.

iii. The participants are encouraged to ask questions before the research starts. If a participant becomes distressed during the discussion I can suggest pausing or stopping the discussion. Likewise, if a participant begins to discuss something personal they have not intended to speak about I can suggest erasing that specific material from their data.

iv. The participants are aware they can drop out of the research at any time. The option to drop out is written on their informed consent form and they will be told about it during the preliminary discussion before the research starts.

v. The participants are self-selecting and they choose whether to participate voluntarily, without coercion and without affecting any service or treatment they may be receiving.

vi. I am mindful of participants who exhibit distress and I aim to minimise this. I have worked with individuals before and collected data in this way. As a trainee counselling psychologist I will place respect for and protection of the participant uppermost.

vii. The participant's research discussion is intended to produce only a similar level of distress as a conversation about their group attendance with a member of staff at the service would produce.

viii. The participants are all known to the staff of the services where the groups are run.

ix. The findings produced from the final research will be disseminated to inform and improve the practice of counselling psychologists and mental health professionals.

c. What precautions are you taking to address the risks posed?

---

i. The participants will be given my research mobile phone number and email address so that they can ask questions, gain support, change their mind about participating, and discuss their feelings with me before or after the research session.

ii. Each mental health service user has access to staff at the services where their group is run whom they can contact if they are distressed.

iii. Participants will also be given my supervisor's contact details, the Samaritans number, and the Sana number so they can get support independently, outside of the service where their group is run and separately from me, if they wish.

iv. I have a professional relationship with the staff at the service where the group is run and we have agreed to openly raise any concerns, such as participant distress with each other.

v. I have discussed the design and methodology of my research with mental health service users and staff at the services where the groups are run and have listened to feedback and made adjustments, where necessary. The service staff and mental health service users have reviewed my research flyers and information sheets and have given feedback which has led to any changes that were necessary.

vi. No direct questions will be asked. The participants are encouraged to talk freely using prompts.

vii. Participants are given details of the complaints procedure to enable them to make an independent complaint about the research.

8. Will all subjects/participants and/or their parents/carers receive an information sheet describing the aims, procedure and possible risks of the research, as well as providing researcher and supervisor contact details?

Yes

No

*(Please append the information sheet which should be written in terms which are accessible to your subjects/participants and/or their parents/carers)*

9. Will any person's treatment/care be in any way be compromised if they choose not to participate in the research?

No

Yes

The participants can choose freely whether or not to participate in the research separately from their attendance at their group.

10. Will all subjects/participants be required to sign a consent form, stating that they fully understand the purpose, procedure and possible risks of the research?

Yes

No

If no, please justify

If yes please append the informed consent form which should be written in terms which are accessible to your subjects/participants and/or their parents/carers)

---

Yes – each participant is required to sign an informed consent and information form before they can participate in the research. The details in the consent form will be discussed again with the mental health service user before the research discussion begins and there will be chance for questions and clarification. The group staff have assessed each prospective participant as competent to give their informed consent. The information and consent form has been attached.

11. What records will you be keeping of your subjects/participants? (e.g. research notes, computer records, tape/video recordings)?

---

i. The consent forms, the audio recordings, anonymised research notes and anonymised transcripts will be generated during the research. There will be a sheet linking participant research numbers with their consent forms which will be kept separately and securely. All these items will all be kept securely locked in a filing cabinet according to City University London regulations.

ii. Transcription will remove any personal details such as names, location, or particular identifying references. This is to protect the anonymity of the mental health service user from anyone reading the analysis in the finished research.

12. What provision will there be for the safe-keeping of these records?

i. The consent forms, the audio recordings, anonymised research notes, anonymised transcripts will be kept securely in a locked filing cabinet according to City University London regulations. The sheet linking participant research numbers with their consent forms will be kept separately also in a securely locked filing cabinet according to City University London regulations.

ii. The audio recording device will be transported after data collection using a zipped pouch worn by the researcher. The audio recording device will be securely stored in a locked filing cabinet until an anonymised transcription of the data has been completed and the research has been marked.

iii. The computer records will consist of anonymised typed transcripts which will be stored securely.

13. What will happen to the records at the end of the project?

i. Current City University London regulations will be followed. The consent forms, and the sheets linking the participant with their consent form will all be shredded securely when the research has been marked. The audio recordings will be deleted from the audio device. The anonymised research notes, and anonymised transcripts will be retained securely.

ii. The finalised research will not contain any identifiable material and it will be shared and disseminated and a copy will be stored in City University London library.

14. How will you protect the anonymity of the subjects/participants?

i. Consent forms bearing the participant's names will be stored securely in a locked filing cabinet according to City University London regulations. Sheets bearing participant's names and unique research reference numbers will be stored separately in a locked filing cabinet.

ii. Research notes and transcriptions will be anonymised. Research notes will be anonymised by using a unique research number for each participant. The

transcriptions are anonymised when they are transcribed as all personal details such as names, locations, or particular identifying references will be erased. The audio recordings will be stored securely in a locked filing cabinet until the research has been marked as City University London regulations require.

iii. Participants will also be given a de-briefing sheet containing my supervisor's contact details, the Samaritans and Sane numbers so they can make obtain independent support, outside of the service where their group is run and separately from me, if they wish.

iv. The de-briefing sheet also contains details of how participants can complain about the research. The de-briefing sheet has been attached.

15. What provision for post research de-brief or psychological support will be available should subjects/participants require?

---

i. The participants will be given a de-briefing sheet containing my research mobile phone number and email address so that they can ask questions, gain support, change their mind about participating, and have a discussion with me after their research discussion.

ii. Each mental health service user has access to group staff at the services where their group is run whom they can contact if they are distressed

*(Please append any de-brief information sheets or resource lists detailing possible support options)*

If you have circled an item in underlined bold print or wish to provide additional details of the research please provide further explanation here:

**6.d.** The participants are considered *vulnerable adults* because they have been receivers of a service provided for mental health service users. All the participants are over 18 and live independently in the community and the staff of the services where the groups are run have assessed the participants and found:

---

i the participants are competent to understand the research and make their informed consent to participate in the research

ii. the participants are not experiencing distressing situations, symptoms or side-effects at the time of the research.

Signature of student researcher: Christine Barley Date January 2013

**CHECKLIST:** the following forms should be appended unless justified otherwise

Research Proposal  
Recruitment Material  
Information Sheet  
Consent Form  
De-brief Information

### **Section B: Risks to the Researcher**

1. Is there any risk of physical or psychological harm to yourself?

Yes       No

If yes,

a. Please detail possible harm?

---

Participants may discuss distressing events during the research discussion. I will be able to seek support from my therapist if I feel overwhelmed by their distress.

b. How can this be justified?

---

i. The subject is not intended to be distressing. I can get support from the staff who run the groups.

ii. The discussions take place within a room near the group area where staff are nearby.

c. What precautions are to be taken to address the risks posed?

---

I can gain support from the group staff at the service, or from my university tutor or from my therapist if I feel overwhelmed by the participants' feelings.

---

**Section C: To be completed by the research supervisor**

*(Please pay particular attention to any suggested research activity involving minors or vulnerable adults. Approval requires a currently valid CRB check to be appended to this form. If in any doubt, please refer to the Research Committee.)*

Please mark the appropriate line below:

Ethical approval granted  -----

Refer to the Department's Research and Ethics Committee-----

Refer to the School's Research and Ethics Committee-----

Signature

[Redacted Signature]

Date

[Redacted Date]

**Section D: To be completed by the 2<sup>nd</sup> Departmental staff member**

*(Please read this ethics release form fully and pay particular attention to any answers on the form where underlined bold items have been circled and any relevant appendices.)*

I agree with the decision of the research supervisor as indicated above

Signature

[Redacted Signature]

Date

[Redacted Date]





## Appendix 5: Centre Approval for Research Study

[REDACTED]

Date: Thursday 7<sup>th</sup> March 2013

Name of Investigator: Christine Barley - Counselling Psychology  
Trainee,  
City University London, Northampton Square,  
London EC1V 0BB.

'What It Feels Like To Be Part of A Group'

Dear Christine,

This letter is to confirm we have reviewed the proposed research study being conducted by you Christine Barley - Counselling Psychology Trainee to conduct research project at the [REDACTED] IR7E Mind entitled "What It Feels Like To Be Part of A Group". We hereby grant you permission to conduct your research project at this site.

The permission to conduct the research at this site shall commence on March 18<sup>th</sup> 2013 and end on May 31<sup>st</sup> 2013 unless terminated earlier by either party.

You are required to ensure that all information regarding clients or staff remains secure and strictly confidential at all times. You must ensure that you understand and comply with the requirements of the [REDACTED] Confidentiality policies and procedures, which are available to you upon request and the Data Protection Act 1998. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution

You must act in accordance with [REDACTED] Health & Safety policy and procedures, which are available to you upon request and to take reasonable care for the health and safety of yourself and others while on the above premises.

You must observe the same standards of care and propriety in dealing with clients, staff, equipment and premises and you must act appropriately, responsibly and professionally at all times.

If your current role or involvement in research changes, or any of the information provided in your research proposal changes, you must inform us forthwith.

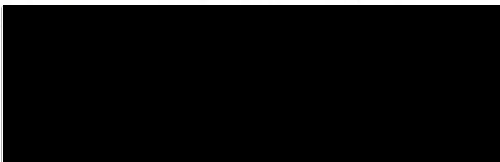
Mind relies on donations to continue its work  
Please help if you can  
Contact 020 8985 4239 to make a donation

[REDACTED]



If you have any questions regarding the content of this letter of permission, please do not hesitate to contact me on the numbers below.

Signed:  
Print:



Signed:  
Print:



Christine Barley  
Counselling Psychology Trainee



Need raises on donations to continue its work  
Please help if you can  
Contact 020 8903 4239 to make a donation



## Appendix 6: Research Participant Informed Consent Sheet

### 'What it feels like to be part of a group'

Christine Barley, Counselling Psychology Trainee,  
City University London, Northampton Square,  
London EC1V 0HB. mobile: .....

email: ..... [REDACTED]

Dear Participant

#### **What is the purpose of this study?**

This research is based on individual discussions with group members about what it feels like to be part of a group. The study aims to inform mental health professionals and counselling psychologists who facilitate groups about what the group members have found.

#### **Do I have to take part?**

No, whatever you choose will not affect your contact with this service. If you choose to take part, our discussion will be recorded so it can be typed up and then your name and other personal details will be removed as it is typed. You can also change your mind about participating up to a month afterwards.

#### **Why have I been invited to take part?**

Because you have taken part twice in a group for mental health service users and you speak English.

#### **What will happen if I choose to take part?**

You will be asked to sign this consent form and keep a copy. We will have a discussion lasting from 30 minutes to an hour about the group. Our discussion will be recorded and typed up without your name or details in it.

#### **Are there any benefits to taking part?**

Yes, some people find telling their story is helpful and they enjoy being part of the bigger picture and having their voice heard.

#### **Are there any disadvantages to taking part?**

Not usually as I use prompts to get our discussion about your group started and then you decide what you say to me. If our discussion did bring up some difficult memories and you felt unsettled afterwards you can discuss it with me. At the end I will give you a sheet containing details of some organisations where you can get support, or you could talk to the staff here.

#### **Is it confidential?**

Yes, unless you tell me about harming yourself or others.

#### **What happens to the research?**

The research is being undertaken at City University London in line with ethical guidelines published by the British Psychological Society (2009), the Health and Care Professions Council (2008) and City University London and is supervised by Dr Jacqui Farrants:



The anonymised research findings will be published and shared. A copy of the research will be kept in City University London library.

Please ask me any questions you may have.

I agree to take part in this City University London research. I have read this information sheet. I am willing to: have a discussion with the researcher and I agree the discussion can be recorded.

Participant Name(PRINT)\_\_\_\_\_Date\_\_\_\_\_

Participant Signature\_\_\_\_\_

Researcher Name\_\_\_\_\_

Signature\_\_\_\_\_Date\_\_\_\_\_

## Appendix 7: Research De-Briefing and Information

Thank you for taking part in this research.

It's important to do research to inform people who are not connected with your group about your experiences of being a part of the group.

Has anything come up for you since you took part in the research discussion?

There are several ways you can get support.

You can: Speak to your group facilitator about your feelings.  
Contact me to ask questions, give feedback or to talk about your feelings. I can respond to emails and texts.  
Email ..... or text .....

Contact my research supervisor Dr Jacqui Farrants by email.  
Email [REDACTED]

You can speak to someone 24/7 at the Samaritans on 08457 909090

You can speak to Sane from 6pm – 11pm daily on 08457 678 000

If you want to complain about the research you can contact Anna Ramberg by email, letter or phone.

Email [REDACTED] or phone [REDACTED] or write to

Anna Ramberg, Secretary to the Senate, CRIDO, City University  
London, Northampton Square, London EC1V 0HB  
quoting the brief title of the research  
'What it feels like to be part of a group'.



## Appendix 8: Participant Demographics

### Adam, Georgina and Florence

	<b>Adam</b>	<b>Georgina</b>	<b>Florence</b>
Age	Early 30s	Late 30s	Early 70s
Ethnicity	Caribbean	British	British Caribbean
Diagnosis	Schizophrenia, Major Depressive Disorder	Major Depressive Disorder, Personality Disorder	Bipolar Affective Disorder, Personality Disorder
Therapeutic Groups	Men's, Mixed, Time to Talk	Women's, Mixed, Time to Talk	Women's, Mixed, Time to Talk Voice hearing
Length of Group Participation	Several months	A month	Several years
Length of Research Interview	31 minutes	44 minutes	51 minutes
Life Experiences	Early trauma, Isolation, Severe depression	Early Trauma Separation from carer, Severe depression, Physical ill health	Early trauma, Severe depression, Self-harm, Physical ill health
Mental Health Experiences	Psychosis, In-patient treatment	Suicidality, In-patient treatment,	Mania, Voice intrusion, In-patient treatment,
Occupation	Part Time work	Creative courses	Part time work

## Appendix 8: Participant Demographics

### David, Tania and Gerry

	<b>David</b>	<b>Tania</b>	<b>Gerry</b>
Age	Mid 40s	Mid 30s	Mid 40
Ethnicity	Persian	British	British/Irish
Diagnosis	Schizophrenia	Schizophrenia	Bipolar Affective Disorder
Therapeutic Groups	Men's, Mixed, Hearing Voices Time to Talk	Women's, Mixed, Hearing Voices, Time to Talk	Men's, Mixed, Time to Talk
Length of Group Participation	Several years	Four years	Nine years
Length of Research Interview	38 minutes	42 minutes	76 minutes
Life Experiences	Early trauma, Voice hearer, Severe panic and anxiety.	Child sexual abuse, Trauma flashbacks, Ex-heroin user, Voice hearer	Early trauma.
Mental Health Experiences	Voice intrusion, Psychosis, In-patient treatment	Voice intrusion, Psychosis, In-patient treatment, Severe anxiety	Mania, In-patient treatment, Severe anxiety
Occupation	Creative Courses	Part-time work	Part-time work



## Appendix 8: Participant Demographics

### Andre, Galvin and Jade

	<b>Andre</b>	<b>Galvin</b>	<b>Jade</b>
Age	Mid 40s	Late 50s	Mid 40s
Ethnicity	European	Mixed-Race	British
Diagnosis	Schizophrenia, Major Depressive Disorder	Bipolar Affective Disorder, Personality Disorder	Bipolar Affective Disorder, Major Depressive Disorder
Therapeutic Groups	Men's, Mixed, Time to Talk	Men's, Mixed, Time to Talk	Women's, Mixed, Time to Talk
Length of Group Participation	About a month	A month after a gap of several months	Two years
Length of Research Interview	56 minutes	83 minutes	61 minutes
Life Experiences	Early trauma, Severe Anxiety, Severe panic	Child sexual abuse, Trauma flashbacks, Anger management	Early trauma, Severe depression, Attempted Suicide, Fatigue, pain
Mental Health Experiences	Psychosis, In-patient treatment	Psychosis, In-patient treatment,	Mania, In-patient treatment,
Occupation	Creative Courses	Retired	Volunteering Carer



## Appendix 9: Research Flyer and Sign-up Sheet

### Research Flyer

**Have you ever been part of a therapeutic group?**

**What was that like? What did you get from it?**

**Would you like to talk to a researcher about being in your group?**

- **Talk about your experience of being in your group**
- **Allow the researcher to record the session**
- **Recognise the session is for research not counselling**

#### **Why become involved?**

Use this opportunity to have your voice heard – Make an impact

Tell your own unique story – Be part of the bigger picture

Bring about change - Talk about your experience in your group

Together we can influence professionals with new knowledge

You'll be asked to **sign** a consent form

The session will be **recorded** so it can be typed

When it has been **typed up** there will be no identifying features. Your name will not be there.

**Contact:** Christine Barley  
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email:

.....

mobile: .....

## Appendix 9: Research Flyer and Sign-up Sheet

### Sign-up Sheet

Would you like to join this research?

Have you ever been part of a therapeutic group?

What was that like? What did you get from it?

Would you like to talk to a researcher about being in your group?

- Talk to Christine Barley about your experience of being in your group
- Allow the researcher to record the session
- Recognise the session is for research not counselling

#### Why become involved?

Use this opportunity to have your voice heard

Tell your unique story

Talk about your experience in your group

You'll be asked to **sign** a consent form

The session will be **recorded** so it can be typed.

Your name will not be there.

Christine is here on Mondays from 10 – 4pm

Name	Best time

## Appendix 10: Gerry's initial analytic notes

Gerry Thomas	
Line 255	Psychological centre as an attachment <sup>Gerry</sup> 215 'was getting into encouragement/feedback' Staff act as containers for emotions 'groups taught me how' safe place, my things out (Lobby/carer) Winnicott
	group as attachment - Gerry
line 86-7	'I attached from 2000 to 2011' 'real meeting point' focus / focal point - draws attention to it meeting point - how central to life it being - metaphor can keep on meeting 'for some people' himself included, all together layers of meaning
Gerry Thomas	Need for attachment outside of family life - a normal opportunity power of attachment organisation / staff / service users group / facilitator
	Gerry line 98 'similar group of people would be in the group' Someone like me, normalising, not judged comfortableness (not challenged)
	Meaning of group
Gerry	'Finding hope things disappear'
line 23	'So really there was a real group' being oneself making sense of experience
line 105	'Issued down on paper' - skill of post to access psychological awareness
line 134	'Connected to it then writing it down' emotions, feelings, things that have frustrated him reminded him of another part of self, other experiences
269	discussed relationships with families 'I even talked to one of the members here about it'
278-273	sharing their relationships' 'my relationship with my Dad never been kind of good'

## Appendix 10: Gerry's later analytic notes

Gerry	
<p>Theme of</p> <p>87</p> <p>149-150</p> <p>230</p> <p>273-276</p> <p>303-5</p> <p>311-314</p> <p>334-337 <del>341-342</del></p> <p>411-415 <del>417-423</del></p> <p>529</p>	<p>Not being alone - normalising</p> <p>'good point for some people' Use of metaphor</p> <p>felt more comfortable, everyone got MH probs</p> <p>'its life-long journey'</p> <p>'never been easy, difficult thing to do - having other people's stories -'</p> <p>'kno it as would go fund well being - sharing innermost feelings reflecting'</p> <p>'hardly face, easier way of sharing, felt guided in the shore that appear'</p> <p>'learning is people going thir own journeys - I was running around trying to rescue <del>some</del> people'</p> <p>Wishing I can live with other people who need it at all 'not in emergency provisionally'</p> <p>'these came back with me'</p>
<p>Theme of</p> <p>88-91</p> <p>167</p> <p>1812</p> <p>198-200 <del>418-419</del></p> <p>421-423 <del>424-425</del></p> <p>503</p>	<p>Future purpose / Temporality - Direction</p> <p>'I got idea how powerful group could be - joining lots groups together'</p> <p>'I was excited abt sharing my story'</p> <p>'I felt good in myself - it was compared' 'my topic, my area, speciality'</p> <p>'sharing recovery stuff, positive things, perseverance'</p> <p>'if I go somewhere to do talk, I feel valued - strong place in MH system'</p> <p>'I feel purposeful, group had no aims, energy'</p> <p>'Forgiving yourself, yourself'</p>
<p>Theme of</p> <p>155-156</p> <p>164</p> <p>214-218</p> <p>219-221</p> <p>348-9</p> <p>444-446</p>	<p>Keeping Going - Motivation / Determination:</p> <p>'physicality of shyman - I'd share but I'd be shy sharing'</p> <p>'I sat with it, still presented, being myself in it'</p> <p>'Struck with classed' 'struck to classes'</p> <p>'my strength building up, perseverance thing happens, could not let go'</p> <p>'I'm less affected <del>about</del> someone says and did this'</p> <p>'A start of group, family, I cried within that group'</p>
<p>Theme of</p> <p>80</p> <p>77-99</p> <p>151-117</p> <p>190</p> <p>239</p> <p>252</p> <p>271</p>	<p>Acceptance - Finding oneself:</p> <p>'need to be open, share stuff' 'share harrowing experiences'</p> <p>'similar group of people in group'</p> <p>'connection to myself, understanding condition, putting into words'</p> <p>'When I feel anxiety, I sit with it, experiencing it more'</p> <p>'I have to be aware of that fragility'</p> <p>'unhappiness eating, not drinking'</p> <p>'Sharing relationships with Gods, mine never good' (CONT-4)</p>

## Appendix 10: Page six of Gerry's marked transcript

274 was sharing that. And that was a kind of difficult thing to do. Tough to share that in, in that  
275 setting. And, and hearing other people's stories of their fathers and things brought things into  
276 perspective a bit more as well, which was good within the group.

277  
278 CP: So it feels like you were able to challenge yourself even in that group. Because I guess  
279 talking about this personal stuff, that could have been quite unsettling, couldn't it?

280  
281 Gerry: Yeah it was quite upsetting stuff but sometimes needing, needing to come out. I think  
282 it's unsettling when it's left in here, in there. When it's left within, so I think when it comes out  
283 there's a little bit of ease, a little bit of a release, maybe, so it can be a bit of unsettling story  
284 or a bit of a release with it as well. It was kind of like I was hanging, holding onto all this. Now  
285 I've kind of shared it, it just makes it a little bit, it feels a bit lighter. So a bit like, less of a  
286 burden. Not a real conscious kind of thing, just kind, kind of lighter, kind of less of a load on  
287 the back. Just by sharing the, the. I think that's really kind of, but I know it's within that men's  
288 group there was many opportunities. But I only did it for about six months, but it was good. It  
289 was once every Friday it was that group. It was good for you to do that. Just men! Having  
290 women would be a bit, a bit, a bit. The poetry group at [name of place] was mixed. The  
291 group I'm in at the moment is mixed. Don't know why at [name] the men's group was just  
292 men so that was just a bit of a different. Maybe I could share stuff with a man? Where there  
293 wasn't women there to judge. That I'd feel I'd be judged or something

294  
295 CP: Yeah so maybe it just felt comfortable at that point. Was that a fixed group? You had  
296 more or less the same members?

297  
298 Gerry: Yeah, same members, fixed groups. Sometimes there was only 3 or 4 of us in there,  
299 sometimes there's be 3 of us in there, me, just 2 members and the manager a few of the  
300 times, which was a. We'd always go in and say, me and this other member here would go in,  
301 and we'd share a laugh, and we had similarities we shared within the group, me and the  
302 member I'm talking about. We kind of gone really far down the roots to recovery in relation to  
303 other members mainly. Two of us would go and found well-being and stuff, so there was no  
304 surprise that would be discussed, that we were sharing our innermost feelings or reflecting  
305 on our recovery level mainly.

306  
307 CP: And that might have helped, mightn't it? You having a friend in the group that you felt  
308 compatible with and were at a similar stage of their journey maybe?

309  
310 Gerry: Yeah, it did make it a bit easier to have a friendly face in the group that I felt yeah, an  
311 easier way of sharing that maybe. Yeah I wasn't really connected to him as a very good  
312 friend or anything, just very close to, as someone I can. I just had a, you know, just felt good  
313 with, that I could share that aspect easily, yeah.

314  
315 CP: That's been important

316  
317 Gerry: Yeah incredibly important

318  
319 CP: What about tough times in that men's group where things were more difficult or didn't go  
320 the way you'd hoped, or maybe left you feeling

321  
322 Gerry: Less for me really, less than in that respect, less of those kind of really, tough things.  
323 Maybe half of the work has been done, maybe? Maybe a lot of the work has been done,  
324 maybe? I don't get thankfully, you know within my group in [place] I have sometimes, some  
325 of the members, men my age, sharing stuff that they cry, they kind of get really emotional.  
326 You know I do less of that now I'm understanding more, the, you know, the experience we're  
327 experiencing. I learn from maybe lessons within them, I'm less deeply affected by them as  
328 much, so.

