

Mental Health and Recovery: Experiences of Peer Support Workers Employed in Mental Health Services

Thesis submitted in fulfilment of the Professional Doctorate in Counselling Psychology at London Metropolitan University (“Top-up” Route)

Michelle Mackin

Supervised by
Dr Angela Ioanna Loulopoulou

School of Psychology
Faculty of Life Sciences and Computing
London Metropolitan University
2019

Declaration

I hereby declare that the work submitted in this dissertation is fully the result of my own investigation, except where otherwise stated.

Name: Michelle Mackin
Date: March 2019

Contents

Acknowledgements	page 6
Abstract	page 7
Abbreviations	page 8
Chapter 1. Introduction	page 9
1.1. Reflexive statement	page 9
Chapter 2. Literature Review	page 14
2.1. Recovery	page 14
2.1.1. Differing perspectives of recovery	page 14
2.1.2. Personal recovery	page 15
2.1.3. Stages of personal recovery	page 17
2.1.4. Recovery within the NHS	page 19
2.2. Peer support	page 22
2.2.1. Peer support and recovery	page 23
2.2.2. Benefits of peer support to service users	page 23
2.2.3. Benefits of the role for PSWs	page 25
2.2.4. Challenges of the role for PSWs	page 29
2.2.5. UK studies exploring PSW role and recovery	page 30
2.3. The need for this research	page 32
2.4. Relevance to counselling psychology	page 33
2.5. Research aims and questions	page 34
Chapter 3. Methodology	page 35
3.1. Choice of methodology	page 35
3.2. Epistemological and ontological perspectives	page 36
3.3. Interpretative phenomenological analysis (IPA)	page 37
3.3.1. Philosophical foundations of IPA	page 38
3.3.1.1. Hermeneutics	page 38
3.3.1.2. Phenomenology	page 38
3.3.1.3. Symbolic interactionism	page 38
3.3.1.4. Idiography	page 39
3.3.2. Limitations of IPA	page 39
3.4. Other approaches considered	page 40
3.4.1. Grounded theory	page 40
3.4.2. Discourse analysis	page 41
3.4.3. Narrative analysis	page 42
3.4.4. Mixed methods	page 42
3.5. Procedure	page 43
3.5.1. Participants	page 43
3.5.2. Recruitment	page 44

3.5.3. Data collection	page 45
3.5.3.1. Interviews	page 45
3.5.3.2. Pilot interview	page 46
3.5.4. Data analysis	page 46
3.6. Ethical considerations	page 47
3.6.1. Informed consent	page 48
3.6.2. Confidentiality and data protection	page 48
3.6.3. Potential risks	page 48
3.7. Quality assurance	page 49
3.7.1. Reflexivity	page 50
3.7.2. Member checks	page 51
Chapter 4. Analysis	page 52
4.1. Summary of superordinate and subordinate themes	page 52
4.2. Superordinate theme 1: Early recovery pre-PSW role	page 54
4.2.1. Subordinate theme: Written-off and on the “scrapheap”	page 54
4.2.2. Subordinate theme: Turning points and eye-opening experiences	page 58
4.3. Superordinate theme 2: Adjusting to the role	page 63
4.3.1. Subordinate theme: Not getting stuck into each other’s lives	page 63
4.3.2. Subordinate theme: They need to give us more credit	page 67
4.3.3. Subordinate theme: Tensions between PSW values and service aims	page 71
4.4. Superordinate theme 3: PSW role and recovery	page 73
4.4.1. Subordinate theme: I actually now believe that recovery is possible	page 74
4.4.2. Subordinate theme: I feel that I can contribute again	page 75
4.4.3. Subordinate theme: Being a beacon of hope	page 78
Chapter 5. Discussion	page 81
5.1. Early recovery of the PSW	page 81
5.2. Adjusting to the PSW role	page 83
5.3. How the PSW role influences recovery	page 87
5.4. Implications for counselling psychology and service delivery	page 90
5.4.1. Counselling psychology’s role in improving the recovery focus	page 90
5.4.1.1. Psychological formulation	page 94
5.4.1.2. Staff support and training	page 95
5.4.1.3. Reflective practice	page 95
5.5. Strengths and limitations of this research	page 96
5.6. Suggestions for further research	page 98
5.7. Conclusion	page 99
Chapter 6. Final Reflexive Statement	page 101
6.1. Starting the doctoral course	page 101

6.2. Finding participants		page 101
6.3. Interviews		page 101
6.4. Influence of the research on my clinical practice		page 103
6.5. Heightened awareness of my own biases		page 105
6.6. Roles and identities of the participants		page 105
6.7. Carrying out the analysis		page 106
6.8. Final reflections		page 108
References		page 110
Appendices		page 141
Appendix A	Research flyer	page 142
Appendix B	Letter to participants	page 143
Appendix C	Consent form	page 146
Appendix D	Demographic form	page 147
Appendix E	Interview guide	page 148
Appendix F	GAD-7 and PHQ-9	page 150
Appendix G	Distress protocol	page 153
Appendix H	Ethics	page 154
	Email from Health Research Committee	page 155
Appendix I	Quality assurance	page 157
Appendix J	Example of transcripts with themes	page 158
	Themes identified for one participant	page 164
Appendix K	Advice from participants	page 171

List of tables

Table 1.	Characteristics of the recovery journey	page 16
Table 2.	Stages of psychological recovery	page 18
Table 3.	Details of participants	page 44
Table 4.	Superordinate themes and subordinate themes with key quotes	page 53

List of figures

Figure 1.	Diagrammatic summary of superordinate and subordinate themes	page 52
-----------	--	---------

Acknowledgements

First of all, I would like to thank Jim, my husband; he has been supportive and patient over the many years that I have worked towards becoming a counselling psychologist and completing this research. Without his support, this research would certainly not have been possible.

I would like to thank my supervisor Dr Angela Loulopoulou who has helped me feel grounded when I have been in a desperate panic and overwhelmed. She believed that this research would be possible to complete, even when I didn't.

Thank you to my lovely sister, Natasha, who encouraged me along the way and provided valuable feedback.

I have also had a number of other people who have helped me by offering support, guidance, and much appreciated feedback. I could not have completed this research without any of them. I have been amazed at the level of belief people have had in me. Thank you so much.

Thank you also to Alan Frankland. I would not have become a counselling psychologist had I not met him. He has been an inspiration to me throughout my career.

Finally, I would like to thank all of the participants in this study. I feel privileged that they have been willing to share their stories with me. The interviews and conversations I had with them helped to inspire me and improve my own practice as a counselling psychologist.

Dedication

This research is dedicated to the memory of my parents. My Mum sadly died at the very beginning of my journey to become a counselling psychologist, and my Dad died just before I submitted this thesis. Dad, hopefully you have updated Mum on what has happened over the years, and at least I was able to tell you that "I've just about finished my research" when I last saw you, so you knew I was nearly there.

Abstract

Rationale: The employment of peer support workers (PSWs) is intended to encourage a greater recovery orientation within mental health services. However, it is important that this does not occur to the detriment of the workers themselves. If the role of the PSW is to change the culture of services and demonstrate recovery, it is important that the role itself is beneficial to recovery. Finding out from the workers themselves how their own recovery is influenced is necessary.

Aim: Within the UK there is a paucity of research into the recovery experiences of PSWs. This study intends to add to the UK research base and to develop an in-depth understanding of how the role influences the PSWs' own recovery.

Method: Six PSWs participated in this study. Semi-structured interviews were carried out which asked participants about their experiences of their role and how it had influenced their own recovery and their views about recovery. Interviews were then transcribed and analysed using interpretative phenomenological analysis.

Findings: Three superordinate themes emerged from the study: 1) Early recovery pre PSW role, 2) Adjusting to the PSW role and 3) PSW role and recovery. It was identified that the peer support role helps to facilitate PSWs' recovery. However, potential difficulties were highlighted within the role which may be detrimental to the PSWs' recovery. These included other staff being uncertain and worried about the role and the workers within them, boundary dilemmas, tensions between the peer support and service values, and the potential for PSWs to become over-involved with service users. These findings are discussed in relation to existing literature and recommendations are offered.

Abbreviations

BAME: Black, Asian and minority ethnic

BPS: British Psychological Society

IPA: Interpretative phenomenological analysis

LMU: London Metropolitan University

NHS: National Health Service

PSW: Peer support worker

RCT: Randomised controlled trial

UK: United Kingdom

US: United States

1. Introduction

Within this study, I aimed to gain an understanding of peer support workers' (PSWs') experiences of how their role has contributed to their own recovery, and whether it has influenced their views about recovery. This section of the thesis offers the background to the study and a reflexive account of the reasons why I became interested in this topic.

1.1. Reflexive statement

Reflexivity is an important element of qualitative research. Within qualitative research the researcher is the "investigative tool" (McLeod, 2003, p. 94). Therefore, in order for the research to be credible, the researcher needs to be open as to how they position themselves in relation to the research topic (Finlay, 2003). This reflexive statement aims to give some indication to the reader of where I positioned myself in relation to the topic of this study. Hopefully, this offers some transparency as to my assumptions and beliefs which were likely to have influenced the research.

I grew up among people who were very anxious. I did not know this at the time, as it was normal and part of everyday life. I would often get told off. I realise now that it was because my family were worried; perhaps about being criticised by others, or that I may be harmed in some way. It did not really help. It just meant that I grew up not feeling good enough.

I developed social anxiety, perhaps as a result of being bullied at school, as well as being vulnerable due to anxiety resulting from environmental and genetic factors. I did not know I had social anxiety. I only noticed that I was different somehow, and that things which looked easy when other people did them, were not so easy for me. It just reinforced my feelings of not being good enough. This personal background led me to study psychology. As I developed into adulthood, I began to realise that things could be different, that I did not have to be afraid of things; that fear and anxiety were getting in the way of living, rather than being helpful. I decided to study psychology in order to understand myself and others better.

I began to learn, and I became excited about the knowledge I was developing. I began to apply the knowledge I was gaining in my own personal development. I learnt that

some of the assumptions that I was jumping to in social situations were just assumptions based on my previous experiences and not necessarily “the truth”. I learnt that the discomfort I felt in social situations was not “just me” but was something called “social anxiety” and that it can be addressed. I began to challenge myself and gained in confidence as a result. I found that my anxiety, although not going away completely, lessened.

After completing my degree and having gained some confidence, I decided I wanted to help others. I had benefitted from what I had learned, and I wanted to spread the word! I began counselling training and worked in voluntary organisations for a while. Then, I managed to obtain a post working in mental health services. I had a very rosy image of what to expect. I expected all the staff to be exceptionally caring and understanding (all the time). I also thought that they would have a great deal of expertise and knowledge. I thought that everyone who wanted help would be offered it. I thought that those receiving the help would be asking for help in order to change and make their life better.

Although the staff in the team were very knowledgeable and had a great deal of experience on the whole, I was unprepared for the reality of working in mental health services. One particular occasion that stands out for me as I look back is hearing a nurse on the phone to someone who was suicidal, and then after finishing the call laughing and stating how it was absurd that the person wanted to die as a way of getting away from the panic attacks (in which they feared they were going to die).

This comment and reaction to it (laughter from others) triggered a strong emotional response within me. I felt shocked that someone would make light of someone’s distress. I think that now I would have a different experience of that event and would be curious as to what was going on for the nurse and why they would respond in this way. However, in some way, it was that difficult experience that inspired me even more to want to make a difference. I wanted to be able to support service users to have a voice and to challenge misunderstandings. This is what led me to decide once and for all to do my counselling psychology training. I felt that in the role I had at the time, I did not have the power to influence in quite the same way that a psychologist would.

I have now worked within the NHS for nineteen years and have specifically worked within mental health services for sixteen years. I qualified as a counselling psychologist in 2007, and it was in this year that the document “Putting People First” was published. This document stated that “effective peer support is essential in the transformation of adult social care and in enabling people using services to have greater choice and control” (Department of Health, 2007, p. 2) and emphasised the need for service users to be given more control in making choices for their care.

In 2011, the document “No Health Without Mental Health” was published (Department of Health, 2011), and this encouraged service user involvement in order to promote a recovery focus. By this time, I was working within a community mental health team (CMHT) and began to see changes in the way services were set up, with a greater focus on the involvement of service users within the development of services. I left working within the CMHT in 2015, and towards the end of my time there, the service began to encourage “co-production” where educational and therapeutic groups were set up which would be co-facilitated (or sometimes fully facilitated) by service users. In addition, they had developed a number of PSW roles, and service users known to the team were being encouraged to apply for these posts. However, this also occurred at a time of austerity within the NHS, and when clinical posts were being reduced. As staff members retired or left, their posts were not being replaced, and a large number of posts were being regraded to lower pay bands.

This left me feeling cynical about the reasons for the promotion of co-production and the development of PSW posts. I wondered whether co-produced groups were really being set up to benefit service users’ recovery, or were they more for the benefit of the service? I also felt concerned about the impact on service users when they were talking of applying for PSW roles. They spoke of wanting to “make a difference” and “give something back”, and I wondered whether they were holding an idealised view (in much the way I did at the start), and how they would experience the realities. I was reminded of my own experiences of beginning work within mental health services and felt concerned that PSWs new to working in the NHS may experience similar difficulties and that this may be unhelpful to their recovery.

I decided to explore this area further and began to search for literature which explored the experiences of PSWs. I read more about the recovery model and the development of PSW roles. I discovered that very little research into the recovery experiences of PSWs had been carried out in the UK.

Around this time, I was also beginning to feel a little disillusioned with my role within the CMHT and I wanted a new challenge. My route to qualifying as a counselling psychologist was via the BPS Qualification in Counselling Psychology, and I had previously considered doing a top up doctorate. I therefore decided that it would be worthwhile to develop my interest in recovery and peer support into a piece of research.

This is what led me to decide to research the experience of PSWs. I wanted to find out whether PSWs' experiences of working within mental health services in the NHS reflected what I was being told by service managers: that the role is beneficial to both service users and the PSWs. I therefore decided to bring together my interest in the topic of recovery and peer support, and my doctoral qualification, and then applied to do the doctorate at London Metropolitan University.

I now work in an inpatient unit. Besides some direct clinical work, a large part of the role is to ensure that the ward functions as a psychologically informed environment (Johnson & Haigh, 2011). As part of this I make sure that staff are receiving adequate support and supervision in their role. I provide training sessions on psychological concepts and therapeutic strategies. I also facilitate reflective practice groups and take part in developing psychologically informed treatment pathways for clients admitted to the ward.

As I am the sole psychologist on the ward, it can feel very challenging. However, I have the opportunity to support staff who may find it hard to understand a service user's perspective. I am also alert to situations when staff may come across as dismissive. I recognise that staff work in these settings because they do want to help and so this is a sign that the staff member may be feeling stressed, out of their depth or de-skilled. A key part of supporting staff is to provide opportunities for reflection and to enable staff to talk through some of their experiences of the work they do. Staff can

be either directly or vicariously traumatised by the work they do (Nolte, Downing, Temane & Hastings-Tolsma, 2017; Sodeke-Gregson, Holttum & Billings, 2013). I feel that my role as psychologist on the inpatient ward helps to address situations such as that mentioned previously, where staff who are stressed can react dismissively to the distress of service users.

So, this provides some background, and gives an indication of how I am positioned in relation to the data (with an amount of cynicism for mental health services and a projection of my own experience of feeling misunderstood and hurt in the initial phases of adjusting to working within mental health services). I wanted to carry out this research in order to hear actual experiences of those who have been in the position of receiving care, and who have gone on to work in mental health services. Also, I thought it would be useful in helping me to perhaps question some of my assumptions and untangle my own experiences from that of others (perhaps not everyone has the same level of cynicism as me).

2. Literature Review

2.1. Recovery

Recovery is a simple word, and most people will know what it means. The Encarta world English dictionary (Rooney, 1999, p. 1571) defines recovery as follows:

Return to Health: the return to normal health of somebody who has been ill or injured.

However, recovery in the sense of the “recovery model” or the “recovery approach” within mental health services refers to a philosophical approach and a complex set of ideas that are more difficult to define and which have been in development for the last 100 years (Smith-Merry, Sturdy & Freeman, 2010). Generally, mental health recovery refers to people who have experienced mental illness being able to live a fulfilling and meaningful life despite symptoms being present (Anthony, 1993). This contrasts to the medical model perspective which suggests that recovery is the reduction of symptoms (Andresen, Oades & Caputi, 2011).

2.1.1. Differing perspectives of recovery

Due to the complexity of the concept, there is no one accepted way of conceptualising recovery from mental illness. However, a number of perspectives have been proposed and developed. Traditionally within mental health services recovery has been considered from a biomedical perspective. This particular approach focuses on the reduction of symptoms and aims towards “cure”. This has been termed “clinical recovery” and is the approach that has mainly been used by mental health professionals (Slade et al., 2014; Whitwell, 1999).

The difficulty with a clinical recovery perspective is that it pathologises what it views as symptoms of illness (which may be the consequence of trauma), and it is rated and decided upon by the clinician rather than the client (Slade & Longden, 2015). More contemporary ways of understanding recovery focus on a consumer/service user perspective which holds that people can recover a meaningful life despite having experienced (or be experiencing) mental health difficulties (Roberts & Boardman, 2013).

2.1.2. Personal recovery

The recovery movement has encouraged a broader consideration of recovery, one which takes into account the lived experience of mental illness and which acknowledges that a person may feel that they will never be the same again after developing mental illness (Whitwell, 1999). This broader concept of recovery is known as “personal recovery” and is understood as “a way of living a satisfying, hopeful, and contributing life even within the limitations caused by illness. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of mental illness” (Anthony, 1993, p. 12).

Personal recovery is not about “cure” but is about “recovering a life” (Slade et al., 2014, p. 14). The idea that people with mental health problems need to be offered treatment so that they can be changed to “fit in” and become “normal” is not consistent with the values of personal recovery. According to a personal recovery approach, it is society that we need to change, not the people (Slade et al., 2014).

Despite the appeal of personal recovery with its focus on personal meaning, it is not without its difficulties. One criticism of personal recovery is that it is difficult to identify a shared definition because it may mean different things to different people (Slade & Wallace, 2017), and this makes the concept of recovery vague (Beresford, 2015). The vagueness of the term personal recovery also makes researching the concept difficult and complicates its practical application within services (Slade, 2009).

In view of these difficulties with the concept of personal recovery, research has been carried out which aims to develop a greater understanding of the characteristics and processes of personal recovery. Leamy, Bird, Le Boutillier, Williams and Slade (2011) carried out a systematic review of the qualitative literature. They identified thirteen characteristics of recovery, and these are listed in Table 1. The authors suggest that these characteristics help to provide a deeper understanding of the subjective accounts of the recovery journey as well as clarifying the philosophical stance of personal recovery.

Table 1. Characteristics of the recovery journey (Leamy et al., 2011 p. 448)

Characteristics of the Recovery Journey (listed in descending order of frequency)
<ul style="list-style-type: none">• Recovery is an active process• Individual and unique process• Non-linear process• Recovery as a journey• Recovery as stages or phases• Recovery as a struggle• Multidimensional process• Recovery is a gradual process• Recovery as a life-changing experience• Recovery without cure• Recovery is aided by a supportive and healing environment• Recovery can occur without professional intervention• Trial and error process

As well as the characteristics of recovery, Leamy et al. (2011) identified five main processes of personal recovery: Connectedness; Hope and optimism; Identity; Meaning and purpose; and Empowerment (CHIME). According to Leamy et al. (2011), these identified recovery processes provide a useful way of measuring the changes which occur during recovery. The researchers also carried out a subgroup analysis focusing on the perspective of individuals of Black, Asian and minority ethnic (BAME) origin. This analysis supported the overall findings; however, there was a greater emphasis on spirituality and stigma for the BAME group. In addition, two further categories were identified for this group: culture-specific factors and collectivist notions of recovery (Leamy et al., 2011, p. 449).

Despite the usefulness of frameworks such as that proposed by Leamy et al. (2011), it needs to be considered that the categories identified in their research are just one way of grouping the findings, and the nature of recovery means that it is highly individual and therefore difficult to establish a definitive view of personal recovery (Leamy et al., 2011). Although there is a high level of consensus between studies (e.g. Bird et al., 2014; Leamy et al., 2011; Onken, Craig, Ridgway, Ralph & Cook, 2007; Roberts & Boardman, 2013), it has been highlighted that the CHIME processes which are widely cited within the literature do not include or reflect upon the difficulties inherent in the recovery journey (Stuart, Tansey & Quayle, 2017). In this way CHIME provides a positive stance which is not reflected in all personal recovery stories and which may inadvertently lead individuals to feel that they have failed in their recovery and increase feelings of isolation (Hancock, Smith-Merry, Jessup, Wayland & Kokany, 2018; Stuart et al., 2017). Leamy et al. (2011) acknowledge this dilemma within their research and caution against using their framework as a fixed way of viewing recovery; rather, they hope that it is used to generate further research and discussion.

2.1.3. Stages of personal recovery

It is argued that in order to further define and understand recovery it is necessary to consider ways of measuring the process of personal recovery and to explore whether there are particular stages within the recovery journey which can give an indication of an individual's progress (Andresen, Caputi & Oades, 2006). Andresen, Oades and Caputi (2003) reviewed the existing literature and synthesised the results of five qualitative studies in order to develop their "psychological model" of recovery. They used the term psychological recovery to acknowledge the inclusion of medical perspectives within the individual's personal recovery journey. They proposed five stages, which were based on service user accounts, and included moratorium, awareness, preparation, rebuilding and growth. These stages are further described in Table 2.

Table 2. Stages of psychological recovery (Andresen et al., 2003, p. 591)

Stage	Features
Moratorium	The individual does not identify with the “illness identity”. This stage is characterised by feelings of powerlessness, confusion and hopelessness. The person withdraws and it is as though their life is on hold.
Awareness	The person becomes aware that life beyond illness is possible and they see themselves as being capable of recovery. This stage may be triggered by external events such as others conveying hope, or it may be that it derives from an internal drive or emotional state.
Preparation	The person begins to recognise the possibility of a better life; they start to reconnect with their values and to make a decision to work towards their own recovery.
Rebuilding	The person is fully committed to their own recovery and begins the actual work of recovery. They begin to set goals related to their values. They may reassess their previous life goals and values. There may be a realisation that old goals were counterproductive. In this stage they take full responsibility of their illness and of their life. It involves a willingness to take risks and experience setbacks.
Growth	The person has a greater awareness of how to manage symptoms. The person is hopeful about the future and lives a meaningful life. Their sense of self is not bound up in “illness” and they have a life narrative which ascribes meaning to their illness.

Further studies have also aimed to identify stages which occur during recovery. In their systematic review, Leamy et al. (2011) used the transtheoretical model of change (Prochaska & DiClemente, 1983; Prochaska, DiClemente & Norcross, 1992) in order to synthesise the various stages proposed in the studies they reviewed. The transtheoretical model includes five stages: (1) precontemplation, (2) contemplation, (3) preparation, (4) action, and (5) maintenance and growth. This model is commonly used within the field of substance misuse. The stages developed by Andresen et al. (2003) can be transposed onto the transtheoretical model, and the use of the transtheoretical model has been validated by more recent studies, including a review by Slade, Williams, Bird, Leamy and Le Boutillier (2012).

Despite these findings, recovery is generally accepted as being non-linear and so the usefulness of a stage model of recovery has been questioned (Ellison, Belanger, Niles, Evans & Bauer, 2018; Jose, Lalitha, Gandhi & Desai, 2015; Slade et al., 2015). In addition, there is a lack of consensus regarding the number of stages (Andresen et al., 2006) and whether people necessarily go through any stages at all. Indeed, it is possible for someone to recover without ever acknowledging that they have a mental illness (Davidson, Roe, Andres-Hyman & Ridgway, 2010).

In response to these criticisms, Andresen, Oades and Caputi (2011) acknowledge the argument against a stage model, but suggest that recovery can be compared to healthy human development. They argue that recovery is a process of personal development with individuals moving back and forth between the various stages as new learning and increased awareness develops. However, the authors also consider that there has to be a point where someone moves from being “in recovery” to being “recovered” – otherwise this is counter to the recovery approach, which suggests that recovery is possible. Leamy et al. (2011) suggest that rather than developing new models to illustrate recovery it will be more beneficial to accept the differing perspectives of this concept and to focus efforts on developing recovery-oriented services.

2.1.4. Recovery within the NHS

Despite this driver in the NHS to promote recovery and encourage service user involvement, concerns have been raised about some aspects of mental health provision not being compatible with a recovery focus (Bonney & Stickley, 2008).

It is argued that the legal frameworks and policy of the NHS encourage a risk-averse approach, and mental health professionals can often feel fearful of positive risk taking for fear of legal consequences. This defensive practice undermines the recovery approach as it encourages coercive methods of managing risk (Hauser, Commons, Bursztajn & Gutheil, 1991; Mann, Matias & Allen, 2014; Passmore & Leung, 2002; Perkins & Repper, 2016). Interventions such as community treatment orders (CTOs) and the use of seclusion in inpatient settings are contradictory to a recovery approach, (Boardman & Roberts, 2014; Vassilev & Pilgrim, 2007), and this view has been

supported in the qualitative research literature (Lawn, Delany, Pulvirenti, Smith & McMillan, 2015; Meehan, Vermeer & Windsor, 2000).

In order to increase the recovery orientation, services work to engage the service users in shared decision making and collaborative care planning. However, it is argued that even then the power is ultimately handed back to professionals and the full involvement of the service user often falls short of true collaboration (Matthias, Salyers, Rollins & Frankel, 2012; Slade, 2017).

There is also concern that the concept of recovery can be misused within mental health services and that organisations may try to implement a recovery focus without being fully committed to the values of this approach (Slade et al., 2014). This can lead to recovery being taken over by professionals and becoming just another intervention, thereby undermining the ethos of recovery (Aston & Coffey, 2012; Rose, 2014). One difficulty is that clinical recovery is so ingrained within services and the concept of personal recovery is so vague that there are inevitably misunderstandings about what the recovery approach actually means for service users within an NHS context (Tickle, Brown & Hayward, 2014).

Even services which are considered to be recovery focused may not be viewed in this way by service users. A recent study by Waldemar, Esbensen, Korsbek, Petersen and Arnfred (2018) investigated the experiences of service users receiving inpatient care from a service which had been implementing recovery-focused care since 2011. The findings revealed that the participants did feel accepted and understood by clinical staff. However, the participants also disclosed how they sometimes felt neglected by staff who were too busy completing paperwork in the office, and they also voiced feeling burdened by the continual observation and assessment on the ward; they felt that the treatment focused on medication with little choice over alternative interventions. Therefore, although the service was deemed to be recovery focused, the experiences of the participants did not reflect this. Waldemar et al. (2018) concluded that simply educating staff about recovery was not sufficient in itself.

It can be particularly difficult to remain true to a recovery approach within inpatient settings, but it is not impossible. Inpatient settings which offer a range of therapeutic interventions such as art therapy, occupational therapy and psychology are likely to increase the service user's perception of choice (Wykes et al., 2018). In addition, engaging the whole team in providing a psychologically informed environment has been found to be beneficial in reducing distress of service users and improving their confidence in managing emotions. It is therefore suggested that this is a way forward in enhancing a recovery focus (Araci & Clarke, 2017; Durrant, Clarke, Tolland & Wilson, 2007).

A study by Chang, Grant, Luther and Beck (2014) found that teaching ward staff CBT techniques and strategies in the form of an eight-hour workshop enabled staff to feel more confident in providing therapeutic interventions and reduced their concern with managing aggression on the ward. It also increased the staff's perception of the time available to engage in individual sessions with the service users and there was a decrease in the frequency of restraints and a reduction in the use of seclusion. This study echoes the findings of a more recent study by Wykes et al. (2018) which found that training staff in psychologically informed interventions improved the service user's experience of the inpatient setting. These findings are interesting when compared to the study by Waldemar et al. (2018) in that they appear to address the areas that participants said were lacking. They suggest that despite there being difficulties in implementing recovery in mental health settings supporting staff to understand and utilise psychological concepts may go some way towards improving the recovery focus of services.

Although developing recovery-oriented services may be difficult, the solution is not to let go of the recovery approach in mental health services but to support roles and professions which offer a different perspective to the medical model, including counselling psychologists, clinical psychologists, and occupational therapists and for services to continue to strive towards providing a recovery focus (Nugent, Hancock & Honey, 2017; Slade et al., 2014). It is also suggested that having PSWs in the workforce will help to mitigate restrictive and coercive practice (Brophy, Roper, Hamilton, Tellez & McSherry, 2016; Skills for Health, 2011) and will help to support a

recovery focus, even within inpatient and secure settings (Basset, Faulkner, Repper & Stamou, 2010; Lloyd, Williams, Vilic & Tse, 2017; Perkins & Repper, 2016). The next section of the review considers peer support and explores the role of the PSW within the context of current research and literature.

2.2. Peer support

Peer support has developed out of the consumer movement, which aims to challenge the stigma and marginalisation of those experiencing mental health problems (Mead, Hilton & Curtis, 2001). The intention of peer support is to encourage the focus on wellness and recovery rather than pathology (Curtis, 1999), and one of the key ideas in the development of PSW roles is that those who have experienced mental illness themselves will find it easier to empathise with and understand the perspectives of service users (Mead & MacNeil, 2006). It has been suggested that this will help to improve the satisfaction of service users and will improve outcomes (Bradstreet, 2006; Sabin & Daniels, 2003; Solomon, 2004). In addition, because the PSWs have recovered from their own mental health problems and are demonstrating that they are living full and worthwhile lives, this will then help to instil hope in the clients they are working with (Bradstreet, 2006; Bradstreet & Pratt, 2010; Mead & MacNeil, 2006; Rooney, Miles & Barker, 2016).

As per Skills for Health (2011, p. 4), a PSW is defined as:

... an individual who has experience of having lived with their own mental health condition and who has undertaken their own recovery journey. They are someone who is employed in a paid capacity to draw upon and use their own lived experiences of mental health distress, to deliver services to others as an integral part of the mental health workforce. They are usually employed either directly by mental health trusts or via a third sector organization.

The role of a PSW can be considered to be on a continuum with other helping relationships (Davidson, Chinman, Sells & Rowe, 2006). However, the intrinsic difference with the peer support relationship is that the PSW is using their experience in an intentional way to help others. The experience of “having been there” and then

progressing to recovery is a key aspect of the relationship (Davidson & Rowe, 2008, para. 2).

2.2.1. Peer support and recovery

Peer support is suggested as one of the elements of a recovery-oriented NHS (Department of Health, 2011). It is considered to be crucial in ensuring that the philosophy of recovery is embedded into services (Ashcraft & Anthony, 2005), and it aims to offer hope to service users that recovery is possible (Gidugu et al., 2015; Solomon, 2004). Consultations with service users have revealed that peer support is viewed favourably, with positive benefits for both service users and peer support providers (Faulkner & Bassett, 2010).

In order to understand how the PSW role may influence recovery, the next section of this chapter discusses the benefits of the role to both service users and PSWs, as well as the challenges.

2.2.2. Benefits of peer support to service users

Salyers and Macy (2005) found that involving service users in the provision of services can powerfully model recovery and can offer hope and increase the engagement of other service users. It has also been suggested that the involvement of service users acts as a reminder to staff that recovery is possible (Clifton, Repper, Banks & Remnant, 2013).

In considering the benefits to the service user, a number of studies have identified positive results for personal recovery focused outcomes, such as self-rated feelings of hope and empowerment, increased feelings of acceptance and self-efficacy (Chinman, Young, Hassell & Davidson, 2006; Cook et al., 2012; van Gestel-Timmermans, Brouwers, van Assen & van Nieuwenhuizen, 2012; Lloyd-Evans et al., 2014; Mahlke et al., 2017). A recent study by Vayshenker et al. (2016) found that moderate and high attenders of a peer support service demonstrated statistically significant improvement on some subjective aspects of recovery, such as reduced self-stigma, increased self-esteem, improved self-efficacy and increased community-activism. Studies have also

identified benefits such as, improved symptoms, improved social functioning and reduced use of psychiatric services (Chinman et al., 2014; Davidson, Bellamy, Guy & Miller, 2012; Nelson, Ochocka, Janzen & Trainor, 2006).

When comparing peer services with more traditional mental health services (e.g. community mental health teams and inpatient services), studies have found the outcomes to be similar (Bellamy, Schmutte & Davidson, 2017; Wroblewski, Walker, Jarus-Hakak & Suto, 2015). A review by Doughty and Tse (2011) found that overall, consumer-led services demonstrated outcomes which were as positive as those of traditional services, and a Cochrane review by Pitt et al. (2013) concluded that the outcomes for consumer-providers were no better or worse than that of professionals, with low-quality evidence that consumer-providers within mental health services may reduce the use of emergency services. A later review by Chinman et al. (2014) found that peer support interventions led to reduced inpatient admissions and better recovery outcomes when compared to the outcomes of traditional services. However, they stated that a limitation of their review was the poor quality of available studies.

A review by Lloyd-Evans et al. (2014) was less favourable. They carried out a systematic review and meta-analysis of eighteen randomised control trials (RCTs) investigating the effectiveness of peer support for people with severe mental illness. Studies that focused on peer support for people with depression or personality disorders were excluded. The authors reported that the outcome of the analysis of these articles suggested that the evidence for positive effects on hospitalisation or symptoms of mental illness was negligible. However, they did find some positive results for outcomes related to the recovery process, such as self-rated feelings of hope and empowerment, but stated that these results could be a result of reporting bias (Lloyd-Evans et al., 2014).

As can be seen from the brief summary of the literature, despite the drive to involve service users in the delivery of services, and the recent development of PSW roles within the NHS, the actual research evidence has been mixed. Reviews of the literature have been limited by the poor quality of available studies (Chinman et al., 2014). In their review, Lloyd-Evans et al. (2014) highlighted methodological problems which

meant that there was a risk of bias in the studies reviewed, and they reported that the confidence levels for the outcome studies were low. There is also a lack of consistency with the terminology and methodological approaches used, and there has been a lack of consensus as to what constitutes effectiveness across studies, thus making it difficult to synthesise the results. In addition, PSWs are employed in a number of different settings and the role varies widely, and this makes it difficult to compare outcomes (Vayshenker et al., 2016).

Another difficulty with the evidence base is that there seems to be an epistemological discrepancy between the ethos and philosophical underpinning of peer support and that of the organisations which strive for evidence-based interventions. As indicated in a report from the National Mental Health Commission (2014), much of the effectiveness research focuses on medical outcomes and ignores the recovery-focused outcomes. This demonstrates the difficulties with introducing a personal recovery-oriented intervention into a medical-model-informed service.

Qualitative evidence suggests more positive views of peer support, and this is likely to be a result of qualitative studies being less focused on symptoms and more focused on service user accounts of their own experience, which, as highlighted in research by Andresen, Caputi and Oades (2010), can be very different from medical perspectives of recovery. However, because descriptive or qualitative studies are not designed to quantify the effectiveness of services, they are not included in reviews that focus on outcomes. Despite this, qualitative research is useful in providing a rich description of how consumer-led services are delivered, and the unique experiences and perceptions of PSWs (Davidson, Sells, Sangster & O'Connell, 2005; Loveland, Weaver Randall & Corrigan, 2005). In addition, developing measures which are more consistent with a recovery focus may be beneficial in understanding the contribution of PSWs within a service (Andresen et al., 2006).

2.2.3. Benefits of the role for PSWs

It has long been considered that helping others can be beneficial (Nelson, Layous, Cole & Lyubomirsky, 2016; Reissman, 1965) and can improve confidence, increase self-awareness and self-esteem and improve functioning (Heidemann, Cederbaum, Martinez

& LeBel, 2016; Krause, 2016; Schwartz & Sendor, 1999). In addition, there is considerable research which suggests that employment is beneficial to mental health (Modini et al., 2016; Secker & Membrey, 2003), and research has also linked employment and recovery from mental illness (Lysaker & France, 1999; Saavedra, López, Gonzáles & Cubero, 2016; Walsh & Tickle, 2013). Therefore, it could be inferred that the PSW role could be beneficial in promoting recovery in the PSW, as well as promoting recovery in others.

Findings from research into peer support have offered some backing for this view (Repper & Carter, 2011), and many studies have found that PSWs have high levels of job satisfaction (Chang, Mueller, Resnick, Osatuke & Eisen, 2016; Cronise, Teixeira, Rogers & Harrington, 2016; White, Whelan, Barnes & Baskerville, 2003). Furthermore, MacLellan, Surey, Abubakar and Stagg (2015) found that PSWs gained a sense of responsibility and achievement through their work, and this helped them to be hopeful about further employment in the future.

Qualitative studies in particular have found that those offering peer support often experience an increased level of self-esteem and a sense of personal competence (Bracke, Christiaens & Verhaeghe, 2008; Gerry, Berry & Hayward, 2011; Johnson et al., 2014; Mowbray, Moxley & Collins, 1998; Proudfoot et al., 2012). Walker and Bryant (2013) carried out a review of qualitative studies and found that there were a number of positive experiences of being a PSW, including improved “wellness” and increased self-esteem.

Most available studies which consider the recovery of PSWs have tended to explore broad concepts such as “benefits” and have not focused specifically on the recovery journey of PSWs. However, in recent years, a number of studies have focused more exclusively on the recovery of the PSW (Bailie & Tickle, 2015; Kido & Kayama, 2017). For example, a grounded theory study conducted by Austin, Ramakrishnan and Hopper (2014) found that despite different backgrounds, peer workers shared a general path consisting of “disruptive crisis, diagnosis of illness, stabilization, empowerment and recovery” (p. 4). The authors argue that the peer support role facilitates continued recovery by encouraging the PSWs to reflect on their own experiences, suggesting that

contributing to the mental health system rather than being dependent on it encouraged the PSWs to feel more empowered and develop a “helper identity” (Austin et al., 2014, p. 8).

The study by Austin et al. (2014) is particularly relevant to my own study due to its unambiguous focus on recovery and peer support. However, it does have some limitations. As explained by Austin et al. (2014), the study focused on peer advocates in a specific setting, and this role may not be typical of peer support in other settings; therefore, their results cannot be generalised. Considering the role of the peer worker more specifically, the service in the study by Austin et al. (2014) is a consumer-run organisation that provides social support including housing, benefits advice and recovery-focused workshops. This is very different from the role of the PSW within the UK, particularly those within an NHS setting. In addition, the mental health system in the US is different to that of the UK, and so the recovery experiences, as well as the experience of the role, may be quite different for PSWs in the UK.

Other studies have also found that providing peer support is beneficial to the recovery of the PSW. For instance, Proudfoot et al. (2012) found that PSWs can facilitate their own recovery by increasing their knowledge of mental health and coping strategies. In addition, MacLellan et al. (2015) found that the role increased the PSWs’ self-awareness and self-acceptance, and this helped them to evaluate their own recovery in comparison to others’ recovery. The authors argued that this enabled the PSWs to take greater ownership of their own recovery and to integrate their mental illness experiences into their life.

In order to clarify the benefits to the PSWs’ recovery of providing peer support, Bailie and Tickle (2015) carried out a review of qualitative literature which focused on the topic of recovery for PSWs. They found that when in this role, the PSWs’ knowledge about mental illness and recovery increased, and this facilitated their recovery, as well as increasing their confidence and self-esteem (Bailie & Tickle, 2015). In addition, Bailie and Tickle (2015) highlighted how telling their personal stories helped PSWs to change the perspective of their recovery journey from an “illness story to a recovery

story” (p. 56). The authors determined that being a role model and helping others had a positive influence on PSWs’ identity (Bailie & Tickle, 2015).

Other themes identified by Bailie and Tickle (2015) in the studies they reviewed included “position within a professional team” (p. 57), and this related to some of the caveats of the role, such as there sometimes being a lack of clarity as to the expectations of the role, as well as the ethos of peer support not always fitting the ethos of the teams they were based in and not always feeling valued. The final theme was “impact of employment” (Bailie & Tickle, 2015, p. 58), and this related to some of the benefits of being in employment, including the development of skills, some challenges, such as finding the work stressful and this affecting their mental health, and also seeing the role as a stepping stone to further employment.

Bailie and Tickle (2015) suggest that their findings demonstrate that the PSW role is beneficial in facilitating recovery by providing the individual with a clear role and thus a sense of identity, as well as increasing self-worth. However, they caution that the role may not be beneficial for all PSWs. A limitation of this study is that it focused solely on qualitative studies and did not make reference to or comparison with quantitative data. In addition, consideration was not given to the inclusion of service user involvement in the studies reviewed. Bailie and Tickle (2015) also highlight that they did not involve service users in the development of their review and so the interpretation of the literature is based on the perspectives of clinician-researchers rather than service-user-researchers.

A recent qualitative study carried out by Kido and Kayama (2017), which focused on PSWs’ experiences of recovery and concerns, found that participants gained a sense of achievement from the PSW role and gained confidence in their abilities. The authors state that the participants seemed to find the role beneficial and that it helped to facilitate their recovery. Kido and Kayama (2017) did identify some concerns with the role: the participants were troubled by having to manage the dual roles of service user and service provider; in addition, the participants voiced some doubts and uncertainties about their abilities within the role. Kido and Kayama (2017) argue that this may adversely affect the recovery of PSWs.

There are some limitations within the study by Kido and Kayama (2017), particularly in relation to considering the result in relation to PSWs in the UK. First of all, the study was carried out in Japan, and services are likely to be different in terms of resources and structure. In addition, some of the difficulties may have been a consequence of the lack of training prior to starting the role, whereas in the UK PSWs receive extensive training before starting their role (Watson, 2014). Also, in the Kido and Kayama (2017) study, all PSWs were based within the team in which they had received (and were still receiving) support, and this may have influenced their experiences, for instance feeling more connected with their source of support even though this created more boundary dilemmas.

2.2.4. Challenges of the role for PSWs

Despite the benefits of peer support, as discussed in the previous section, the role is not without its challenges, and many of the studies have also found difficulties which may impact adversely on the PSW. Some qualitative studies have found that PSWs can experience discrimination by other staff who may not understand the role or who have outdated attitudes regarding mental illness (Cronise, 2016; Cronise et al., 2016; Mancini, 2018).

In addition, the PSW role can vary greatly, and some studies have found that PSWs have experienced a lack of role clarity (Cronise et al., 2016; Miyamoto & Sono, 2012; Moran, Russinova, Gidugu, Yim & Sprague, 2012). In their review, Walker and Bryant (2013) considered the findings of qualitative studies and found that there were a number which found that PSWs were dissatisfied with their pay and that they were offered insufficient hours. In addition, the PSWs frequently felt excluded by other workers and were often treated as service users rather than colleagues. Walker and Bryant (2013) suggest that the culture of the workplace can either facilitate or impede the role of the PSW depending on whether the culture promotes or discourages key peer support activities; for instance, carrying out the PSW role in a setting where self-disclosure is frowned upon would be extremely difficult.

There have also been concerns in the literature that PSWs have not been given adequate support to carry out the role and there has been some confusion regarding confidentiality and difficulties maintaining role-related boundaries (Gates & Akabas, 2007; Kemp & Henderson, 2012; Kilpatrick, Keeney & McCauley, 2017). These difficulties are perhaps a result of this being a new area of knowledge, as although people with a lived experience of mental illness have been encouraged into posts within services, direct client contact has generally been carried out by professionals in roles in which self-disclosure about personal experiences is discouraged. However, peer support encourages a move away from the established medical model and encourages an empathic stance “through the shared experience of emotional and psychological pain” (Mead et al., 2001, p. 6), and this is not always understood by other clinical staff.

2.2.5. UK studies exploring PSW role and recovery

One of the difficulties with the current available research is that most of the available studies have been carried out in locations other than the UK. For instance, of the thirty-four studies included in a metasynthesis by MacLellan et al. (2015), ten were from the UK, and only four of these were related to peer support in mental health services (the remainder were related to breastfeeding support and physical healthcare), and of the ten studies included in Bailie and Tickle’s (2015) metasynthesis, just two were UK based.

Notable UK studies focusing on participants in a peer support role include that of Doherty, Craig, Attafua, Boocock and Jamieson-Craig (2004), who carried out a qualitative study exploring the experiences of two healthcare assistants who had previously used services (“consumer-employees”) and who were employed within an assertive outreach team. The consumer-employees were encouraged to bring their lived experience to the role, alongside the tasks of a healthcare assistant. Doherty et al. (2004) carried out semi-structured interviews with the participants after six months of being in post, and then after eighteen months.

The benefits for the participants identified by Doherty et al. (2004) included the role providing opportunities to get back into work, and the development of new skills. However, it was also reported within the study that the consumer-employees felt under pressure to ensure they did not become unwell, and it was found that they did have

more time off sick than non-consumer-employees in the same setting. A further negative finding was that the consumer-employees did not feel as if they were treated as equals with other staff even after working in the service for eighteen months (Doherty et al., 2004). A limitation of this study, as highlighted by Doherty et al. (2004), is that the research comprised two parts and used the same participants for both parts and this may have affected the responses of the participants. An additional limitation is the small number of consumer-employee participants (n=2), which could have made it difficult for them to express their views about the team.

A more recent study is that of Dyble (2012), later published as Dyble, Tickle and Collinson (2014), who carried out an interpretative phenomenological analysis (IPA) study. Dyble (2012) found that the transitional experience of becoming a PSW included changes within the sense of self and identity as the PSW developed into their role. There was a sense of personal growth and recovery involved in this, but also difficulties with managing the various identities of service user, staff member and friend. Dyble (2012) also identified difficulties related to the role itself and the organisational culture. Dyble (2012) concludes that the findings suggest that there are positive outcomes to the role, related to personal development and recovery, but cautions that the role can become unhelpful as it maintains the PSW in a “patient identity” (p. 141). However, the findings of this study are limited by the participants being from within the same service and this may have influenced the responses given. It could be that the findings are more a reflection of the culture of that particular service rather than a broader perspective on the experiences of PSWs.

Another notable UK study is that by Gillard, Edwards, Gibson, Owen and Wright (2013), who carried out a secondary analysis of qualitative studies involving three centres in the UK. Within the analysis, Gillard et al. (2013) identified problems with conflicted identities and difficulties with boundaries. They conclude that the introduction of PSWs into teams presented a challenge, and that this was related to constraints placed on the role. However, they also recognise that services can benefit from the inclusion of PSWs and therefore there is a need to support PSW roles by developing clear expectations of the role and by ensuring that the distinctive features of peer support are accepted and valued. Gillard et al. (2017) have since been working to

clarify the principles and values of the PSW role so that the distinctive features are not eroded as PSWs are integrated into services.

It is reassuring that recently there has been more of a focus on the experience of PSWs, and in particular more of a focus on how it affects their own recovery. Studies have highlighted both positive consequences of the role on PSWs' recovery, as well as detrimental aspects of the role. The impact on the PSW is important to acknowledge and understand because the role involves the PSW using their self and experiences therapeutically. It is suggested that an important aspect of appropriate and effective use of self is the awareness and self-care of the practitioner (Taylor, 2008). However, despite the recent focus on PSWs' experiences, the current research is lacking in consistency and also its relevance to the UK population. The role of PSW varies widely and so there is a need to establish research that focuses on PSWs in specific settings and carrying out similar roles. In addition, most studies tend to have a wide remit and do not focus specifically on the experience of recovery for PSWs.

2.3. The need for this research

The employment of PSWs is intended to encourage a greater recovery orientation within mental health services, and PSWs are a symbol of the changing nature of the NHS. However, it is important that this does not occur to the detriment of the workers themselves. If the role of the PSW is to change the culture of services and demonstrate recovery, it is important that the role itself is beneficial to recovery. Therefore, it is essential to find out from the workers themselves how their own recovery is influenced by the role.

Exploring PSW perspectives can be a useful way of understanding recovery and it can help in understanding how this role influences the recovery of the PSW. Research focusing on the recovery experiences of PSWs will also highlight the recovery focus of the role and encourage consideration of the interpersonal nature of the role. In a similar way to psychotherapy, peer support is not just an intervention which can be observed and researched in a manner divorced from the individual providing the intervention; rather, it is an intersubjective experience between two (or more) people. Therefore, acknowledging the individual experience of the PSW and considering the support,

training and supervision necessary to carry out the role is critical in providing an effective and safe intervention to the service users.

A review of the literature has revealed that there is little research focusing specifically on PSWs' experiences of recovery; the majority of the research carried out so far has considered the benefits and limitations of the role without any integration of the recovery literature. In addition, even less research has been conducted within the UK. The experience of working within the NHS in the UK is likely to be a different experience to that of working within the USA for example, because the services are set up differently. Therefore, there is a need for UK-based research. This will help us to further explore the benefits of and caveats to this role for those working in the NHS in order to promote recovery-oriented services.

It is also worth considering that bringing a psychological perspective into services has been found to positively influence the experience of service users (Wykes et al., 2018). Therefore, research into the role of the PSW and recovery is relevant to the profession of counselling psychology, and this will be discussed further in the next section.

2.4. Relevance to counselling psychology

Counselling psychology is a profession rooted in humanistic and existential values which focus on the subjective experience of the client and which emphasise wellbeing rather than pathologising people's difficulties (Strawbridge & Woolfe, 2003; Woolfe, 1990). Problems are not seen as pathology, but instead are viewed as experiences which are part of the human condition (Duffy, 1990). Strawbridge and Woolfe (2003) warn against the medicalisation of mental distress and explain that diagnostic and scientific terms can distance us from the language of those who experience the distress. These perspectives are consistent with a recovery approach, which is also grounded in humanistic values (Stickley & Wright, 2011).

In addition, counselling psychologists are commonly employed within NHS settings where the medical model discourse prevails, and they have to manage the dialectic of being a scientist-practitioner working within a largely medical model environment while holding humanistic values.

This has enabled counselling psychologists to be in a position where they can question and challenge medical discourse and bring a humanistic influence to the NHS.

Interestingly, this is now an endeavour taken up by clinical psychologists (Division of Clinical Psychology, 2013; Joseph & Patterson, 2016), bringing the two professions closer in stance.

Thus, this qualitative study is relevant to counselling (and clinical) psychologists because they can have a role in supporting whole teams to think about the service users in ways other than the medical model. With their humanistic values, counselling psychologists can support staff in working within recovery principles.

Therefore, this qualitative study contributes to the literature within the field of recovery and peer support and aims to encourage counselling psychologists to consider their role in supporting teams to facilitate recovery within services.

2.5. Research aims and questions

The aim of this study was to develop an in depth understanding of the experiences of recovery for PSWs.

The main research question which guided this study was therefore:

- How do PSWs make sense of their experiences of recovery and how does the role of a PSW contribute to their understanding of recovery?

It was hoped that the outcome of this study would also inform the following question:

- How can this research inform the level of support, training and supervision needed by those employed in this role?

3. Methodology

When I become aware of a segment of your lived experience, I arrange what I see within my own meaning context. But meanwhile you have arranged it in yours. Thus, I am always interpreting your lived experiences from my own standpoint... everything I know about your conscious life is really based on my knowledge of my lived experiences. (Schutz, 1967, p. 106)

This chapter outlines the methodology and research design for this study. It details the specific method of data analysis used and the rationale for choosing this approach. In addition, this chapter considers the epistemology and ontology underpinning this study. As is consistent with the values of counselling psychology, there is a reflective element to this section as I reflect on my own epistemological and ontological position.

3.1. Choice of methodology

During my counselling psychology training, I worked with a clinical supervisor who, during one of the supervision sessions, told me the above quote by Schutz (1967). I cannot now recall the context of the discussion. However, I do recall being impacted by the statement, so much so that I wrote it down in my Filofax. Over the years of using my Filofax, that page has remained and has been carried around by me for the last ten years. In coming to write this chapter, I remembered that quote and reflected on how my own personal philosophy is paralleled in my work and within my research. In carrying out this research, my aim was to search for meaning rather than “facts”. I wanted to understand the experiences of PSWs from their own individual perspectives. However, I also recognise that the meanings that emerged from this study were based on multiple perspectives and the data obtained was a reflection of my own interpretation based on my own lived experience.

My philosophical approach has tended to lean towards the values of phenomenology. Phenomenology rejects the idea of truly objective observation and believes there are multiple perspectives, with each individual perspective being valid in its own right: there cannot be one “true” version of events as each person’s view will be influenced by cultural, historical and situational contexts (Warner, 2004). Phenomenology focuses

on questions of what and how something is, rather than why it is. In this way, it honours the data of experience, seeking understanding and searching for meaning rather than collecting facts. It notices the inner subjective experiences rather than the content of the data, aiming to study the “inner essence” of the cognitive processing (Percy, Kostere & Kostere, 2015, p. 77). Counselling psychology grew out of a phenomenological tradition (Sims, 2010), and it was for this reason that I was drawn to training as a counselling psychologist.

The choice of topic within this study and the research questions were influenced by my interest in and preference for a phenomenological understanding. Therefore, my choice of methodology was also influenced by this preference. I chose a qualitative approach because I was interested in developing an in-depth understanding of PSWs’ experiences of recovery, rather than measuring recovery and testing hypotheses (McLeod, 2011; Silverman, 2000).

3.2. Epistemological and ontological perspectives

It is important that the researcher considers the ontology and epistemology underlying their research because it has a significant influence on the chosen field of study, the research questions and the methodology (Hesse-Biber & Leavy, 2010). My own ontological and epistemological positions have been shaped and developed by my personal philosophical stance cited in previous sections of this chapter, and it is these perspectives that took me on the journey of this research. It is my own personal interest in understanding subjective experiences which drew me to the field of counselling psychology, and this then led to my interest in wanting to carry out qualitative research.

Ontology refers to the perception of reality and concerns itself with whether the social and physical worlds are objective or subjective. Epistemology concerns itself with the way that knowledge is constructed and asks questions relating to how we can find knowledge which is valid and true (Urquhart, 2013).

Within this study, I have taken a critical realism perspective (Bhaskar, 1978). This is an approach which helped me to bridge the gap between my earlier phenomenological philosophical leanings and the influence of having worked within the NHS and being

more familiar with an evidence-based practice stance based more in positivism. Critical realism argues that an objective reality exists but that it is not possible to know this reality directly because we are limited by our prior beliefs, assumptions and biases (McLeod, 2011). In this way, reality is a subjective experience which is not fixed but is dependent on the person's perceptions and interpretations (Eatough & Smith, 2007). Research from this perspective aims to develop a clear understanding of "reality" but accepts the conundrum that this reality will be clouded by the beliefs and biases of the participants and the researcher (Willig, 2008). In this way, critical realism is consistent with an ontological perspective that there is an objective and social world which exists independently of humans, but accepts an epistemological stance that this reality can never be clearly known (Urquhart, 2013).

3.3. Interpretative phenomenological analysis (IPA)

The qualitative method of data analysis I have used is IPA (Smith, 1996). This method was chosen because it concerns itself with the "examination of lived experience" (Smith, Flowers & Larkin, 2009, p. 47) and aims to give an "insider's perspective" to the phenomenon being investigated (Conrad, cited in Smith, Jarman & Osborn, 1999, p. 218). Therefore, this was consistent with the aims of this qualitative research which has a focus on PSWs' experiences of recovery.

IPA emphasises the double hermeneutics of the approach: the researcher is trying to make sense of that which the participant is trying to make sense of (Smith & Osborn, 2008). Smith and Osborn (2008) explain that this acknowledges that the researcher is in the same position as the participant: they are both trying to make sense of experience. However, unlike the participants, the researcher does not have direct access to the experience they are examining. Smith and Osborn (2008) also describe the double hermeneutics involved in being empathic and standing in the participant's shoes, while at the same time standing back and being able to observe the participant and be curious about them. The outcome of an IPA is an account of how the IPA researcher thinks the participant is thinking. In this way, I believe the approach is compatible with my critical realist stance. IPA acknowledges that the researcher's beliefs and experiences will get in the way of observing the phenomenon under examination, but it does not

discount that an objective reality exists. The next section considers the philosophical influences underpinning IPA.

3.3.1. Philosophical foundations of IPA

The main philosophical influences of IPA include hermeneutics, phenomenology, symbolic interactionism and idiography (Shinebourne, 2011; Smith et al., 2009). Consideration of these philosophical perspectives helped to confirm my use of IPA as a method for data analysis, and so I describe them further in the following sections.

3.3.1.1. Hermeneutics

IPA is informed by hermeneutics, and this connection relates to the interpretative aspect of the approach. People strive to make meaning out of their experience and so their account will be an interpretation influenced by their own idiosyncratic perspective. The researcher is seen as an active participant in the research process that tries to make sense of the participant's account (Eatough & Smith, 2007). Hence, Smith et al. (2009) consider the IPA researcher to be engaged in a double hermeneutic.

3.3.1.2. Phenomenology

Phenomenology is an approach founded by Husserl (as cited in Crotty, 1998) and was developed as a reaction to the experimental scientific method which he believed to be an inadequate method in which to fully understand human experience. Husserl argued that science offers an abstract view of the "lived world" which is divorced from our actual lived experience (Crotty, 1998, p. 27). Phenomenology aims to offer a method of enquiry which searches for meaning and the essence of experience (Roberts, 2013). It encourages a phenomenological attitude which consists of putting aside expectations and assumptions and engaging fully with the here and now experience of the phenomena we are wanting to understand. This then enables us to experience the "things themselves" and allows meanings to emerge from the experience (Crotty, 1998, p. 78).

3.3.1.3. Symbolic interactionism

IPA also utilises concepts from symbolic interactionism. This suggests that although our interpretations of the world around us are individual, the meaning we give to these

experiences are located within a broader cultural and social context. Therefore, IPA does not focus solely on the participant's experience, but considers the data in relation to its wider social, cultural and psychological meanings (Willig, 2008).

3.3.1.4. Idiography

An idiographic perspective focuses on “the particular” and emphasises the need for a detailed and in-depth analysis of the phenomenon being researched. In addition, it aims to understand the experience of “particular people in a particular context” (Smith et al., 2009, p. 29). In this way, it is able to offer knowledge and understanding about a particular experiential phenomenon (be it a situation, a process or a relationship); this is in contrast to a nomothetic approach, in which data is collected and analysed in a way that provides knowledge related to statistics and probabilities, but does not allow for an analysis of the individuals who provided the data (Smith, Harré & Van Langenhove, 1995).

As can be seen from reviewing the philosophical underpinnings of IPA, this methodology was consistent with the aim of this qualitative research to gain an in-depth understanding of the experience of PSWs. It was not intended to find out why experiences take place, or why there may be differences between them, but to describe and document the lived experiences of the participants. IPA is also consistent with a critical realist stance, and fits with my own philosophical positioning and with that of counselling psychology.

3.3.2. Limitations of IPA

In reflecting on whether IPA was the most appropriate approach to take for this study, I considered the potential limitations to this approach.

IPA is an approach which requires participants to be able to clearly articulate their experience through language, and so the data is dependent on their ability to do this (Willig, 2008). In addition, it does not provide an explanation (Shaw, 2001), nor does it test a hypothesis, and the results cannot be generalised (Pringle, Drummond, McLafferty & Hendry, 2011).

The reliability and validity of IPA have also been questioned (Smith, 2011). Even though the researcher may attempt to bracket assumptions, there is no denying that the data will be influenced by the researcher. Therefore, it is argued that IPA research is not replicable and that each researcher is likely to bring something different to the research; for some commentators this brings into question the reliability and validity of IPA studies (Silverman, 2006). However, many of the criticisms of IPA are made from a positivist stance. In contrast to a positivist perspective, IPA seeks to understand experience and does not seek to find facts (Clarke, 2009).

Although there are potential limitations and some criticisms of IPA, the approach is consistent with the aims of this study and with the philosophical underpinnings of the field of recovery and counselling psychology. IPA studies are able to provide useful insights and can make a valuable contribution to the literature by contextualising the research and making it more accessible (Pringle et al., 2011).

3.4. Other approaches considered

Alternative approaches consistent with my ontological and epistemological positions were considered but were not believed to be suitable for the purposes of this study. The main alternatives considered were grounded theory, discourse analysis and narrative analysis. I think it is worth noting that as a counselling psychologist, I recognise that no one approach to research can give us access to an objective truth. I am interested in PSWs' experiences and want to explore these within this study. However, I think that exploring a topic from different methodological perspectives can add to our understanding of a phenomenon and so could be considered for future research into the area of PSWs and their recovery.

3.4.1. Grounded theory

Grounded theory (Glaser & Strauss, 1967) is frequently considered to be the main alternative method to IPA. It has a longer history in the field of qualitative research, compared to IPA, and has very clear guidance for its implementation.

The aim of grounded theory is similar to IPA in that it attempts to develop an understanding of the experience of participants. However, it aims to develop a

conceptual explanation of these experiences and uses a larger number of participants than IPA, whereas IPA uses a smaller number of participants and offers a more in-depth analysis in order to capture the essence of their lived experiences (Smith et al., 2009). However, the aim of my research was not to provide a conceptual explanation of recovery for PSWs; rather, it was to explore and capture the essence of PSWs' experiences of recovery.

I was also concerned about the practicalities of carrying out a grounded theory study. The suggestion is that the process of data collection is completed once theoretical saturation is reached (Willig, 2008). However, I was uncertain whether I would be able to get enough participants to achieve this, and was also mindful of the time required for carrying out interviews and transcribing data and I was uncertain whether it would be possible to complete this while working full time.

For these reasons I decided that grounded theory would not be a viable option at this stage in the process of researching the topic of PSWs' recovery.

3.4.2. Discourse analysis

I became familiar with discourse analysis as an undergraduate and initially thought it may be interesting to explore recovery from this perspective. There are competing traditions within discourse analysis, and it can be situated at different points between realism and relativism depending on the approach taken. A Foucauldian approach is consistent with relativism and seeks to understand the way in which the phenomena under investigation have been constructed through language (Morgan, 2010).

The aim of discourse analysis within the context of the subject of this study would be to develop an understanding of how PSWs talk about their recovery and how they construct their perspective of their recovery through their discourse (Mancini & Rogers, 2007). An appropriate question for discourse analysis would be "How do PSWs working within mental health services talk about their experience of recovery?" However, the aims of my research placed the lived experience of PSWs at the centre of this study, and I did not feel that the central focus of language was consistent with this. I wanted to know how people make sense of their experiences rather than how

they talk about their experiences. Therefore, I did not consider discourse analysis to be an appropriate method.

3.4.3. Narrative analysis

IPA and narrative analysis are similar in that they both focus on meaning making and consider narrative as a way in which meanings are formed (Salvatore, Dimaggio & Semerari, 2004). A relevant question for this study from the perspective of narrative analysis would be “What is the meaning of recovery for PSWs working within mental health services?” In this case the researcher would be interested in how the PSW constructs their experience of recovery through the stories they tell (Smith et al., 2009) and they would analyse the data with this perspective in mind.

However, although IPA researchers do consider narrative as having particular significance for the individual’s experience, an IPA perspective focuses on a person’s experience in a broader sense, giving more weight to the whole lived experience than the story (Smith et al., 2009). Within this study I wanted to develop an in-depth understanding of PSWs’ lived experience of recovery, rather than develop an understanding of the meaning of their recovery narrative, and therefore IPA was chosen over narrative analysis.

3.4.4. Mixed methods

In keeping with counselling psychology’s openness to methodological pluralism (Cooper & McLeod, 2011), a mixed methods approach was also considered. It may have been useful and of interest to have triangulated the data by the use of surveys or questionnaires. This would have added to the reliability and validity of the findings of the interviews. In addition, incorporating a quantitative approach by using established measures of recovery and investigating recovery at various stages of the PSWs’ development in their role would have offered valuable data and would have enabled the findings to be generalised. However, finding suitable participants was difficult and a study of that type would require a greater number of participants and would have been difficult to organise and carry out given the time constraints when completing research on a part-time basis. Despite the generalisability of quantitative studies, an IPA study generates a depth of exploration which is not possible with a quantitative approach. In

addition, it could be argued that the experiences of the participants within this study are valid accounts of their perspective at the time of the interview (McConnell-Henry, Chapman & Francis, 2011). Although mixed methods can be used alongside IPA (Smith et al., 2009), adding to the reliability and validity of a study through the use of triangulation is not seen as necessary (McConnell-Henry, Chapman & Francis, 2011).

3.5. Procedure

3.5.1. Participants

In choosing participants for this study, I referred to guidance provided by Smith et al. (2009). They suggest that the participants chosen should be able to provide insight into the experience being studied and are therefore purposively selected, seeking a “perspective rather than a population” (Smith et al., 2009, p. 49). For this study, I recruited people who were working as PSWs within the NHS so that I could gain a detailed understanding of their perspective of recovery.

According to Smith et al. (2009), there are no recommendations for the number of participants when conducting an IPA. However, they suggest that between three and six participants is a reasonable number. They warn against viewing a higher number as superior, stating that too large a dataset impedes the amount of time for reflection and dialogue required for successful analysis.

For this study, I recruited six participants. Details of participants are summarised in Table 3. It was a homogenous sample in that all participants were employed in the role of PSW within the NHS. They all had lived experience of mental health difficulties and all had accessed mental health services themselves. There was some variation within the sample. They were recruited from four different NHS Trusts within England, working within a mix of inpatient and community settings, and had worked as a PSW for differing lengths of time.

Table 3. Details of participants

Gender	Male 2 Female 4
Age range	24 - 57 Mean age 38.5
Ethnicity	White British 4 White Other 1 Black African 1
PSW setting	Community 3 Inpatient 2 Both community 1 and inpatient
Length of time in post	Six months to five years Two participants had been involved in informal peer support prior to being employed as a PSW

3.5.2. Recruitment

To contact potential participants, I emailed and phoned organisations that employed PSWs. I found these by searching on the internet and by contacting service user representatives in the NHS Trust in which I work to find out if they knew which NHS Trusts employed PSWs. The services which replied to my initial email and that were happy for me to contact their workers were then sent more detailed information about the study and flyers which could be displayed within their organisation. For IPA research, the sample is required to be homogenous (Smith et al., 2009), and therefore I focused on NHS services and requested participants who had been in paid employment as a PSW for at least three months.

Following consent from the research department and the manager of the service, I emailed literature which gave information about the research. The managers of the services agreed to display the information, and participants were required to directly contact me either by phone or email if they were interested in participating. Participants

were not coerced into participating by either myself or managers. One of the managers suggested that I attend their team meeting to recruit participants, and she suggested that I could then get details of suitable participants and invite them for the interview on the same day. Although I recognised that the manager was intending to be helpful, I did not agree to this because it would compromise the confidentiality of participants and they may have felt compelled to participate. I did, however, consider attending meetings to introduce myself and talk about the research; however, this was not necessary as I was able to obtain a sufficient number of participants without doing this.

Ten potential participants contacted me, and I then sent out a detailed letter (Appendix B) via email with an explanation of the aims of the research, purpose and process. I made it clear that participation would involve an interview and that this would be audio recorded and transcribed. I also made it clear that verbatim sections of the interview would be included in the final thesis. Of the ten people who contacted me, eight met the criteria for the study and six then went on to participate.

3.5.3. Data collection

3.5.3.1. Interviews

Semi-structured interviews (Appendix E) were conducted with each participant to obtain qualitative data. This method of data collection is the one most commonly used in qualitative research (Willig, 2008). In this approach, a number of pre-set questions are asked of each participant. These questions act as triggers, encouraging them to talk about particular aspects of their experience. Participants do not have to answer every question or address each topic, and the researcher allows each participant the space to explore the topic as relevant to them. This method of interview allowed me to remain focused on the research while enabling the experiences and concerns of the participants to be voiced. I conducted semi-structured interviews as they enable the researcher to intervene where necessary, asking the participants either to clarify or to expand on areas of interest (Willig, 2008).

Prior to and during the interviews I was mindful of the double-hermeneutics involved in this approach. I aimed to be empathic while at the same time ensuring I did not get

lost in participants' accounts, hoping to be a curious observer of their experiences and the process in the interview. I was also mindful that I was hearing participants' experiences but through the filter of my own values and beliefs. For this reason, I wrote down comments and field notes of my observations during the interview, and also ensured that I had time and space after the interview to note down any thoughts, ideas or images that arose.

3.5.3.2. Pilot interview

After I had compiled the questions, I decided that the first interview would be a pilot interview and that following this interview, if necessary, I would adjust the questions asked. Carrying out a pilot interview can be useful in order to identify any difficulties, to "tighten up" procedures and to find out how long the interview will take (McLeod, 2003). The pilot interview did not flag up any concerns, and so the data generated was used within the analysis.

3.5.4. Data analysis

After each interview, I listened to the recording a number of times prior to transcribing it, and made notes and wrote down any reflections. When all of the interviews were completed, they were then transcribed. Transcripts were stored separately from the consent forms and any names were not included in the transcript to protect the confidentiality of participants.

During the analysis, I followed the guidelines of Smith et al. (2009) and Shinebourne (2011) in generating the themes and producing the data. According to Pietkiewicz and Smith (2014), the suggested guidelines are intended to be flexible and can be modified by individual researchers. However, Smith et al. (2009) indicate that following the stages suggested may be preferable for novice researchers, and I particularly found the structured guidance helpful.

Once the transcripts were completed, they were read and re-read several times in order to gain an overall picture of participants' accounts. During this time, I wrote notes in the right-hand margin detailing any initial impressions regarding the interviews. Each transcript was then examined further to develop conceptual themes

which captured the meaning of each participant's account. I wrote down these emergent themes in the left-hand margin. For each transcript, I then compiled a preliminary list of themes which were considered in relation to one another and the themes were grouped into related clusters. I initially attempted to do this on the computer, but I eventually found it more helpful to print out the typed themes and physically move them around.

At times I listened again to the recorded interviews in order to check whether the themes identified were a reflection of participants' accounts. I found that as I worked with the themes, I easily became caught up with my own assumptions and expectations. I also found that reading one transcript frequently influenced what I noticed in other transcripts. I therefore found it helpful to maintain a reflective diary to maintain awareness of my own biases and to ensure the themes reflected participants' experiences.

The final step was to integrate all of the identified themes together and to produce the final list of themes.

3.6. Ethical considerations

Throughout the research process I followed the guidelines of London Metropolitan University (LMU, 2014) and the British Psychological Society (BPS, 2006, 2014).

Ethical approval from London Metropolitan University was obtained initially (Appendix H). I also sought advice from the research department of the NHS Trust in which I worked regarding NHS Ethics Approval (Appendix H). I believed that I would need to complete an application for ethical approval via the integrated research application system (IRAS). However, I contacted the above-mentioned research department and was informed that because the participants were NHS staff, I did not need to obtain approval in this way. I also contacted the NHS Health Research Authority and they confirmed that this was the case. I then contacted research departments in a number of NHS Trusts explaining my research and they then passed my details to peer support managers.

3.6.1. Informed consent

To ensure that participants gave their informed consent, I was as transparent as possible when discussing my research with potential participants. I provided written information which included a rationale as to why I was carrying out this study. I made it clear what the expectations would be and included information about the potential costs and benefits of participating. I also provided an opportunity for participants to telephone or email me if they had any questions. When meeting with participants, I went through this information again to ensure that they fully understood the written information. Consistent with BPS guidelines (2014), all participants were informed that their participation was entirely voluntary and so were able to withdraw from the research at any time and request that their data be destroyed.

3.6.2. Confidentiality and data protection

Confidentiality was explained to each participant, including the boundaries around this and the limits to confidentiality. This was also included within the information provided. Permission was obtained to audio record the interview on a portable recording device. The MP3 file was then transferred to an encrypted laptop which was stored in a locked filing cabinet. Any personal data was kept separately from the audio recordings in order to maintain confidentiality of the data. Once the interviews had been transcribed, I reviewed the transcripts and checked that all identifying information had been omitted. Participants were given pseudonyms to maintain their anonymity.

3.6.3. Potential risks

It was acknowledged that during the interviews, participants would be talking about sensitive issues, including their own experiences of mental illness, as well as personal responses to working within a setting in which they may be witness to others' distress. For this reason, PHQ-9 (Kroenke, Spitzer & Williams, 2001) and GAD-7 (Spitzer, Kroenke, Williams & Lowe, 2006) questionnaires were completed by the participants prior to the interview (see Appendix F), and a distress protocol was developed (Appendix G). This protocol was adapted from research by Drauker, Martsof and Poole (2009) and a protocol developed by Haigh and Witham (n.d.). During the interview, I was careful to look for any signs of distress or discomfort. Following the

interview, I ensured that time was available to offer some reflection to the participant with the understanding that anything discussed after the interview would not be used within the data.

All participants spent some time after their interview discussing how they found the interview. None of the participants voiced any concerns and there were no signs of overt distress. Most participants asked questions relating to whether they had answered with what I was “looking for” and also seemed genuinely interested in my study, expressing enthusiasm regarding the topic of recovery and the need for further research.

Despite the positive response immediately after the interview, I was aware that participants may reflect on what they had said and perhaps worry or have doubts. Therefore, I made it clear that they could contact me if they had any further questions or concerns. I was also aware of potential risks to myself. Participants were located from various locations within England, so I was required to travel and arrange to meet people in places I was unfamiliar with. I was mindful of my own safety and followed the guidance of the Suzy Lamplugh Trust (2014).

3.7. Quality assurance

Much has been written in the literature relating to the issue of quality within qualitative research, and it is frequently argued that many of the studies are of uncertain quality because the criteria for assessing quality in qualitative research are unclear (Hammersley, 2008). Smith (1984) claims that attempting to apply quality criteria to qualitative research is contradictory to the ethos of qualitative approaches. However, in a more recent article, Smith (2011) cites criteria suggested by Yardley (2000) and offers guidelines for evaluating IPA studies. During this qualitative study, I referred to the guidance provided by both Smith (2011) and Yardley (2000) and included and reflected upon methods of ensuring quality suggested by other authors. I have included a table in Appendix I which is based on notes in my reflective journal comparing my study to the criteria suggested by Yardley (2000).

3.7.1. Reflexivity

According to Shaw (2001), IPA is challenging for researchers as it requires them to take an active role in analysing and interpreting the data. It is understandable that this involvement with the data will lead to the analysis being influenced by the beliefs, assumptions and values of the researcher. This is well documented within IPA literature (Smith et al., 2009). Thus, the researcher is required to pay attention to their internal and external reactions while also being aware of the effect they may be having on the research topic and participants (Etherington, 2004). Silverman (2000) states that because of this, the researcher needs to engage in continual critical examination of the research process to uncover assumptions and biases.

One method I used for maintaining a reflexive stance in my research was keeping a reflective journal throughout the research process. Within the journal, I made notes about my own experience of the research. This included my emotions, thoughts and experiences and any changes in my perspective which I may have observed. Speaking with other people and gaining their perspective was also helpful in maintaining awareness of my assumptions and biases. For instance, I was aware of my own negativity towards the medical perspective; thus, checking out my observations with others was a useful strategy so that I could gain a more balanced perspective on the literature and the data obtained. It was important to acknowledge that the people I know are likely to share similar values and beliefs. Nevertheless, I found talking with others about my research a helpful way of ensuring that I did not get overly focused on one area while ignoring another.

I also found that it was beneficial to have breaks from analysing the data, as this increased my ability to reflect on the themes which were emerging and prevented me from getting lost within the data.

Research supervision was another space in which I could reflect on the data and explore the way I was approaching the data. However, I also needed to check that I did not get too attached to the ideas offered by my supervisor. On one occasion, my supervisor made a reflection on the data and I found myself thinking “wow that sounds really good” and then believing that this needed to be one of the themes. On reflection, I

realised that I was then trying to fit the data to that idea, rather than allowing themes to emerge.

3.7.2. Member checks

Member checks are the process of the researcher sending copies of the data transcripts and interpretations to participants and inviting their comments. The aim is to provide some external validation of the researcher's perspective (Varpio, Ajjawi, Monrouxe, O'Brien & Rees, 2017). Some commentators argue against this within a qualitative approach because it is based on a positivist and post-positivist position that suggests there is a truth out there which can be objectively known. However, most qualitative researchers, particularly those using IPA, consider the analysis to be valid if it has been deemed to be reasonable to the researcher who has developed it, and if that researcher has used a transparent and systematic approach. If the outcome of an analysis is different when carried out by someone else, this does not mean that the initial version is invalid; rather, it simply means that there is a different way of interpreting the data, and that this is also valid (Webb & Kevern, 2001).

I did not use member checks during this study. It is something that I carefully considered. I reflected on the practicalities, as well as reflecting on my initial gut feeling about using this as a strategy. The decision to not carry out member checks is consistent with my ontological and epistemological position within this research. If the participants checked the data and came up with a different perspective, then this does not necessarily mean that this is a true and valid account; rather, it is a reflection of that person's beliefs and biases at that time. The idea of checking validity is also inconsistent with IPA research, where there is no aim to prove or generalise findings; therefore, from this perspective, using member checking or other means to "validate" the results is illogical (McConnell-Henry, Chapman & Francis, 2011).

4. Analysis

The analysis of this qualitative research focused on identifying main themes and possible subthemes related to understanding PSWs' experiences of their role and recovery, in particular PSWs' perspectives of how the role had influenced their own recovery and whether their views of recovery had changed during this process. Three superordinate themes with respective subordinate themes were identified. These are detailed in the following sections. Pseudonyms are used to maintain anonymity of the participants.

4.1. Summary of superordinate and subordinate themes

Three superordinate themes and eight subordinate themes were identified during the analysis. These are detailed in Figure 1 and Table 4.

1. Early recovery pre peer support work.
2. Adjusting to the PSW role
3. PSW role and recovery

Figure 1: Diagrammatical Summary of Superordinate Themes and Subordinate themes

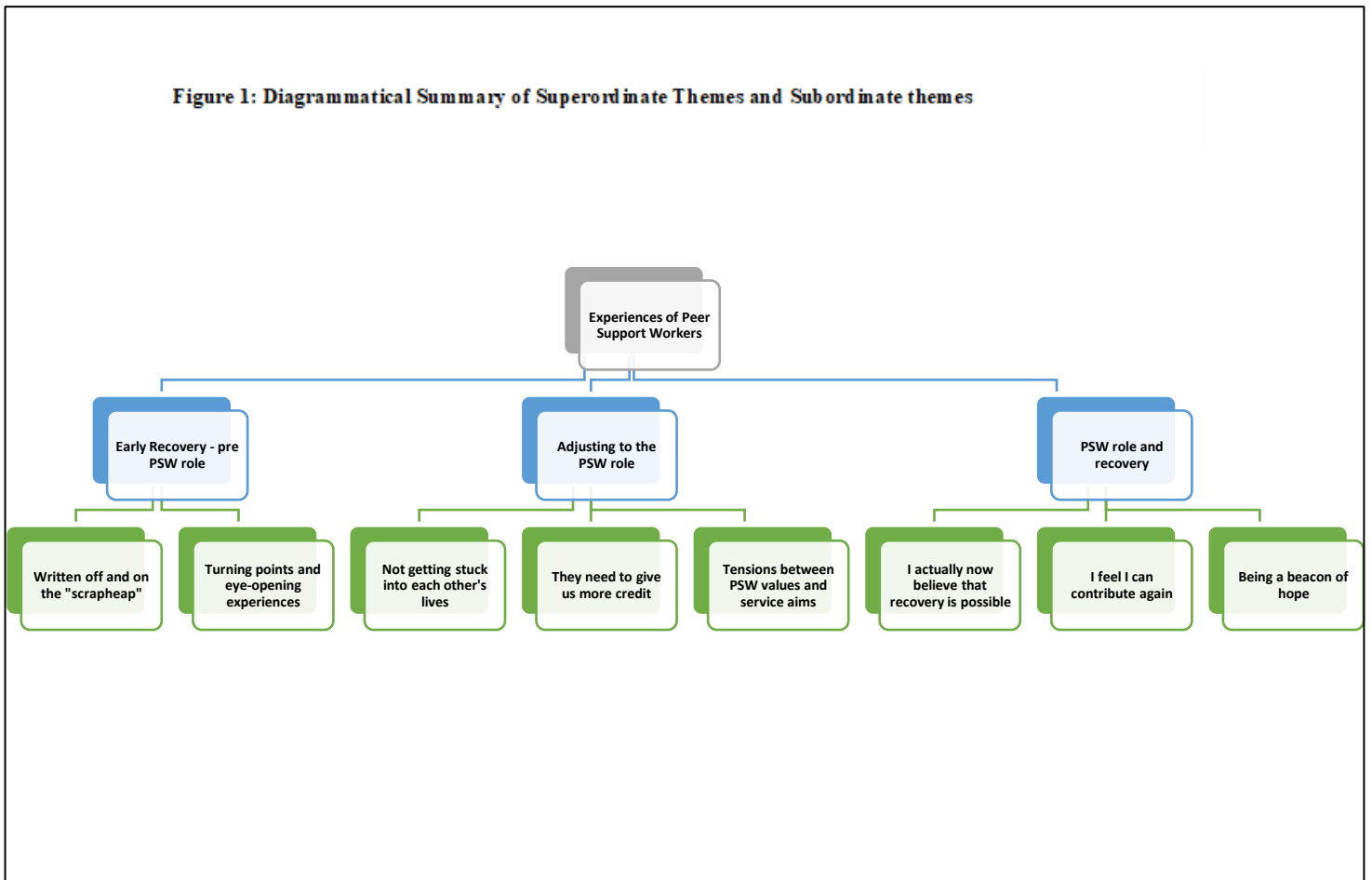


Table 4. Superordinate themes and subordinate themes with key quotes

Superordinate theme	Subordinate theme	Relevant quote
Early recovery pre-PSW Role	Written-off and on the scrap heap	<i>"I felt I was a total dead end, I was a waste, there was nothing more, there was no future." (Richard, 594)</i>
	Turning points and eye-opening experiences	<i>"So it was a big eye opener for me to start learning then about my mental health. I thought to myself there must be so many people out there like me who just think they need to keep getting up and keep going and trying to deal with this in ways which really don't work and they're not really helpful, not really - not really improving their mental health at all, and having no knowledge about mental ill health at all. And so I thought I'm going to possibly start making a change about that." (Richard 77-87)</i>
Adjusting to the PSW role	Not getting stuck into each other's lives	<i>"There was one particular young man there and ... I got very very close to him, working with him and um ... then he left hospital after 3 months, and I got really attached to him, maybe too attached you know. I would go and see him he minute I came in and ... cos I saw him progressing and progressing. When he left hospital I was devastated and I had to actually have a good chat with myself - it was like ... the feeling was like a son leaving home or something like that - that's the way it felt." (Sandra, 688-692)</i>
	They need to give us more credit	<i>"Um ... in the beginning there were quite a lot of issues around sort of people sort of being ... I think people felt a bit ill at ease or concerned. So then my confidence took a bit of a knock, and then it took time." (Fran, 123-125)</i>
	Tensions between PSW values and service aims	<i>"I think there's ... and there's a tension between like the personal work that you do with someone and the issue of well can you move someone forward fast enough to be discharged because there's not a very you know ... there's a tension between like the peer value of taking as long as it takes and giving people the time they need." (Fran, 202-206)</i>
PSW role and recovery	I actually now believe recovery is possible	<i>"Oh ... well that part's actually quite profound. I actually now believe that recovery is possible, whereas before I didn't." (Tom, 338-339)</i>
	I feel I can contribute again	<i>"I feel like I really fit in well ... for the first time in my life. It might sound strange, but it's the first time in my life I feel like I fit in somewhere [...] I just feel relaxed and confident and ... probably selfishly, it helps me feel good helping somebody ... if I can just help one person." (Sarah, 155-167)</i>
	Being a beacon of hope	<i>"But I mean I think kind of the best thing you can do is you know have some people who are further along in their recovery come on board, and then they become champions of their cause. You get people who are clinicians who also become clinical champions for recovery with their colleagues, and it kind of spreads the love you know, I mean it's what we need." (Tom, 269-274)</i>

Note: Symbols used within quotes:
the following indicates removed sections of the quote (...)
pauses are symbolised by

4.2. Superordinate theme 1: Early recovery pre-PSW role

This superordinate theme includes participants' experiences of their recovery journey prior to becoming a PSW. It includes their experiences of being unwell (which seems to serve as a comparison to how life is now), and significant events which helped them to move forward in their recovery.

4.2.1. Subordinate theme: Written-off and on the “scrapheap”

Most participants spoke about their experience of being a PSW by reflecting on how their lives had been early on in their recovery. They described challenging times prior to their work as a PSW. During the interviews, in the process of describing their personal stories, they offered an account of personal events before being a PSW, when they were in the early stages of recovery. By doing so, it was possible in the analysis to compare the before and after being a PSW, as well as a description of changes during the process. In addition, participants emphasised improvements in their life.

In reflecting on his recovery journey, Richard talked about his previous career. He spoke about having been highly motivated and striving to do better:

“I was really really motivated to keep doing the best at everything I could. Left (...) for a high paid job, which I thought oh great ... going, going, going, going..... and then uh ... all of a sudden it started to unravel in front of me.” (Richard, 499-501)

It seems that in telling me about his previous work and presenting it in a good light, he wanted to emphasise the contrast between how he felt at this point in his life and what it felt like when he became ill. The comment “it started to unravel” seems to correspond to the start of him becoming mentally unwell; at this point in the interview, his voice became quieter and slower, and he seemed to search for the words for a moment. This conveyed to me the helplessness and confusion that he perhaps felt at the time of becoming unwell. It could be that life had felt good for Richard, but then when he began to be mentally unwell, his life then became much more difficult. The expression of “going, going, going, going” gives a sense of moving forward and

this together with the “all of a sudden” conveyed to me that his mental illness had been an unexpected shock to him.

In another part of the interview Richard described feeling that he had lost his direction in life and that he no longer had a purpose.

“For me certainly when I became very very unwell I felt I’d totally lost my way, my direction in life, my purpose as it were, and it was this huge transition that I went through ...” (Richard, 50-52)

These two excerpts could perhaps lead to the conclusion that Richard was moving fast in his life, feeling assured that he knew where he was heading, but then faced a “road block” which set him in a totally different direction.

It appears that Richard was also able to compare his previous fast paced job that seemed to be one which required him to “do” with his current employment (as a PSW) in which he needed to be more reflective. In addition, becoming unwell led him to feel “lost” but this contrasted with his work as a PSW, which in other parts of the interview he referred to as meaningful and purposeful.

Another participant, Sandra, also spoke about her previous work. She presented this work as a source of discomfort and dissatisfaction, citing it as a possible contributing factor to her mental health problems. It seems that her experience of previous work was different from that of Richard, in that she felt unhappy in her job.

“Cos I did a job for 28 years where I was a square peg in a round hole (...) But I wish I’d left it years ago because I think my job was part of my problem.” (Sandra 119-123)

Sandra’s comment of being “a square peg in a round hole” perhaps implies that she did not fit into her previous workplace, and in the context of the interview it seems that this was also in contrast to how she currently felt about her work as a PSW. Her statement that her previous job was “part of my problem” suggests that she views her

previous job as being a contributing factor to her mental health problems, and again this seems to contrast with how she describes her role as PSW in other parts of the interview.

Despite having a different experience from Richard within her previous job, she described it in a way that conveyed a contrast to the way she seems to feel now (emotionally well) and the way she perhaps felt then (emotionally unwell). This is similar to the way Richard contrasted the development of his mental illness with how he feels now.

In addition, Sandra explained that in the early stages of her recovery she believed that she would never be able to work after becoming unwell, and felt that she was “on the scrapheap”.

“...when I left my last job, my psychiatrist wrote a letter for my employer saying ... I mean he did me a favour, but also it was very difficult to read it ... that he never saw me working in any meaningful employment again ... it was that feeling of being written off, that I was on the scrapheap.” (Sandra 220-226)

This comment appears to convey a powerful contrast to how she feels now: she felt she could never work again but was now in employment as a PSW. The idea of not working seemed to be something so awful for Sandra, as if she had no purpose. The term “on the scrapheap” suggests that she felt completely useless and spent; that she meant nothing and had no purpose. This comment perhaps emphasises the importance of work to Sandra’s sense of self and feelings of value, and therefore how valuable the role of PSW is for her.

Sarah’s story also describes contrasts between her experiences pre-PSW and now. For Sarah, in talking about her life before being a PSW, she said that she expected other people to not like her and she thought they would think of her as “rubbish”.

“I used to think people [were] looking at me, and thinking, I was rubbish, I couldn’t do anything. Even like strangers, thinking oh look at her – she’s fat, she’s ugly. But expecting people to not like me.”
(Sarah 424-430)

Furthermore, Sarah described previously lacking confidence, and wanting to hide away, but now being able to smile and speak to people.

“I just feel more confident in myself (...) more often I like ... walk down the street, smile at people, say hello to people.” (Sarah, 407-410)

These two comments seem to be demonstrating a positive difference within Sarah’s life as a result of the role of PSW. By saying “I used to think”, this can imply that now she has a different view. She also highlights different body language and behaviour, and when explaining this in the interview, she sat much more upright and made more direct eye contact than in other parts of the interview, thus emphasising this change.

Regarding her life prior to the role, Celia spoke about having felt ashamed of her mental health problems, and as with Sarah, her account suggested that she had felt lacking in confidence for quite a while. In the interview, she described having problems with her body image, before becoming unwell and being admitted to hospital. In her account of becoming unwell, it would appear that she felt a great deal of shame, and, similar to Sarah, had an expectation that other people would be thinking negatively of her.

“I was extremely ashamed, I thought people were just thinking ‘mad cow disease’ or just be having all these like thoughts about me, like just ha-ha this person has lost their mind, etc.” (Celia 413-415)

For Celia, it seems that the shame and expectation of criticism were linked to the stigma she perceived of becoming unwell (as indicated by her reference to “mad cow”

and “this person has lost their mind”). She used the past tense to describe her feelings of shame, suggesting that she no longer felt this way.

Like Celia, Tom spoke about becoming mentally unwell and spoke about the awfulness of this experience:

“... because it was pretty much the most horrible experience I ever had in my life with just this complete void.” (Tom, 111)

The use of the words “complete void” remind me of the “lost” feeling that Richard had spoken about. The past tense indicates that it is something that Tom no longer experiences.

Another participant, Fran, did not talk in any detail about her experience of having been unwell. However, she did allude to some difficulties by explaining how the role had helped her to make sense and come to terms with her experiences.

“It’s made me think a lot more about my own experience in the mental health system and sort of try and integrate it into my life and come to terms with it, which in a way hasn’t been very easy, and it’s still like a process ... whereas before I would shut the door on that.” (Fran 382-385)

Fran spoke of “coming to terms with” her experience of accessing mental health services, suggesting that she had been through difficult times but she was able to adjust. The comment of “whereas before” could indicate a comparison between now and before the PSW role and seems to be an indication that she was now much more accepting of her mental health difficulties.

4.2.2. Subordinate theme: Turning points and eye-opening experiences

Participants described moments in their recovery journey where they recognised their own abilities and where change felt possible. They began to take their power and transitioned from being passive receivers of care to being active seekers of their own

recovery. This enabled them to eventually get to a point in their recovery where they wanted to give something back, or they felt confident enough to pursue the role of PSW.

Sandra described an experience within mental health services when her therapist challenged her view of recovery in which she expected the therapist to be the one doing all the work. Although painful, this challenge helped her to become more involved in her own recovery. She commented:

“And she [therapist] said to me ‘Who’s going to be doing the work here?’ and I was saying ‘You’ I said to her. And she said ‘No, you’. And I said ‘What? Why should I ... What’s it got to do with me? You’re paid, you’re here to you know fix me’ ... and we had this big dispute and argument about it. I was horrified and left very disillusioned and disappointed, but it was all I had left in the end. Maybe she shouldn’t have said it to me so early on, but I did come back and I realised yeah, she could guide me along the way and give me these skills to cope with difficult situations, but unless I actually went and put them into practice, and practised and practised and practised – I hadn’t a hope in hell really.” (Sandra, 647-656)

Sandra’s experience with her therapist initially left her feeling “horrified” that she would be the one “doing the work”, but at the same time it seemed to have led her to realise that she had a critical role in her own recovery. This painful challenge and realisation could be interpreted as a major turning point in her life which set her on the path to further recovery.

As with Sandra, Celia also spoke about an experience with mental health services which marked a turning point in her recovery. In Celia’s interview, she described her experience of being an inpatient and how the confusion she felt during that time prompted her to want to help others to have a more positive experience of being on a ward. She explained:

“I felt like the hospital environment really actually increased my psychosis, it was just such an unfamiliar environment, and I wanted to be a peer support worker because I wanted to be that person that would explain to someone why the nurses always say ‘handover’ or why there’s such specialised language that people are using.” (Celia, 24-28)

Celia could be implying that the mental health system had not been helpful to her. She had been in hospital to recover from psychosis, but it somehow made it worse. It seems that the jargon on the ward made the ward environment confusing, and this experience may well have been the catalyst to her wanting to be a PSW, because she wanted to make the ward a less confusing place for others.

For Richard, it appears that contact with mental health services enabled him to learn more about mental health and he found it quite a revelation. He began to think to himself that there must be other people like him, who just try to keep managing on their own without seeking help. He then wanted to help other people to learn about mental health:

“So, it was a big eye opener for me to start learning then about my mental health. I thought to myself there must be so many people out there like me who just think they need to keep getting up and keep going and trying to deal with this in ways which really don’t work and they’re not really helpful, not really - not really improving their mental health at all ... and having no knowledge about mental ill health at all. And so, I thought, I’m going to possibly start making a change about that.” (Richard 77-87)

From Richard’s description, it could be concluded that becoming more aware about his own mental health was a critical turning point in his recovery and provided the motivation for him to make a change in his life. It seems that he was explaining how he had developed greater insight into the behaviours which had contributed to and maintained his mental illness. It is perhaps this realisation which spurred him on to want to help others, and that this gave him a goal and purpose to work towards.

The language Richard used emphasises the significance of this experience. During the interview, he spoke about contact with mental health services being “a big eye opener”, and when talking about his increased knowledge with regards to mental health difficulties, his body language and tone of voice seemed to convey feelings of empowerment and a drive to make a difference for other people experiencing mental illness by sharing the knowledge he had gained.

Similar to Sandra, Celia and Richard, Tom also indicated that contact with mental health services provided a turning point for him. In his interview, he indicated the experience of mental health problems for a long period of time, but then being in hospital helped him to become more connected with others.

“Oh um ... well ... to tell you the truth, when I was in my twenties even psychiatrists were giving up on me. I had a 5-month hospitalisation in 2009 that turned things around a bit because I learned to reconnect with people again. (...) A couple of years later, two three, the opportunity for the peer support worker training came up (...) my worker recommended that I give it a shot.” (Tom, 146-157)

Tom’s comment that “even psychiatrists were giving up on me” seems to emphasise the hopelessness he felt. There was the implication that psychiatrists usually have the answers and keep trying, but that his situation was so bad that even the people who usually have the answers could not help him. The fact that he mentioned that he “learned to reconnect” may imply that he felt disconnected from everyone and felt beyond help. Although he did not mention what actually happened when he was in hospital, I had an image of him sitting in a group with others (probably influenced by my own experience of working on a ward) and being in a situation where he could not avoid being in a relationship with others. The words “turned things around” suggest that this had been a turning point in his recovery, and from this turning point he eventually arrived at a stage in his recovery where he felt ready to work as a PSW.

As with the other participants, Fran also spoke about a time in her recovery where working as a PSW became a possibility. She described how this came about following a period of being mentally unwell, and then the role being suggested during the employment support she received as part of her care.

“And then I was very ill at the end of the year, got some help ... and as part of that they gave me some help around employment. So, I was looking for jobs and starting to think about what I wanted to do, and then the employment specialist ... I’d said oh I’d be quite interested in working as a support worker ... the employment specialist said well ... brought me information about working as a peer support worker ... and that was how I got into doing it” (Fran, 90-97)

Fran’s experience was another example, of being unwell and experiencing support from services, which played a role in helping her to find a job that had significant meaning for her. However, in her case, it seems that the employment support itself held particular meaning for her in terms of her recovery.

Fran’s description appears to convey a gradual process of getting back on track after having been unwell. She does not suggest “an eye-opening experience” in quite the way that other participants described. However, the focus on employment seems to have been important in her recovery and could conceivably be regarded as a “turning point”.

With regards to a turning point in her recovery, Sarah explained how attending adult education classes had been important in helping her to move forward in her recovery and gave her the confidence to pursue the peer support role:

“Cos um ... my self-confidence built up by going to adult education classes that’s what set me on the thing (...) it’s given me the confidence ... I’d been thinking about it [peer support] for a long time but I didn’t have the confidence to do it.” (Sarah, 128-135)

In contrast to the other participants, Sarah seems to give less emphasis to the mental health support she received, but it appears that she attributed her increase in confidence to education. Sarah's account seems to suggest that the increase in confidence she gained through adult education prepared her for beginning work as a PSW and made it seem more achievable. Confidence seems to be the element which was missing before and developing her education was something which made a difference.

4.3. Superordinate theme 2: Adjusting to the PSW role

All participants discussed a period of adjusting to the PSW role. There were some struggles highlighted with boundaries and juggling different roles such as that of service user, staff member and friend/peer. Participants also spoke about an increased awareness of the realities of the role, and developing a realisation that staff were just human, that resources are limited, and that recovery was a process and not an end point to be achieved. In addition, they spoke about the complexity of figuring out where they fitted in the service. This was often personal and related to their own identity as a patient, rather than necessarily a result of staff members' attitudes towards them. If anything, they did experience staff as being over-protective, rather than rejecting.

4.3.1. Subordinate theme: Not getting stuck into each other's lives

It seems that early on in the role, PSWs were vulnerable to over-identifying with the service users they were working with. It seems that they were enthusiastic about recovery, but at the beginning this was frequently based on the view that "what worked for me will work for you".

Richard's account illustrates this. He explained how it was difficult for him to not take a personal view when working with service users.

"I think initially it was very hard not to look at things other than through my own perspective of mental health and depression and what made me better and what helped me get better." (Richard, 310-312)

It could be implied that at the start of the role as a PSW, his stance was that he wanted to “fix” (which perhaps reflected his personal view of recovery at that time), and it would seem reasonable that there was a period of adjustment where he had to learn to not force his perspective onto others.

In the following quote Richard explains how this was particularly difficult early on in his role as a PSW.

“Certainly, early on, because it was still a big part of my life, it was still something I was doing. And it was almost like ‘Well come on, why aren’t you bloody doing it, I can do it, you can do it’ – and of course it doesn’t work like that at all. To realise people will learn at their own paces, do things at their own paces, and also need many different things to what I needed and things like that. So ... yeah.” (Richard, 332-337)

The use of the word “bloody” may suggest that he felt frustrated with people if they did not seem to be moving forward in their recovery, and the “I can do it, you can do it” comment could be interpreted as a projection of his own experience of recovery onto others.

Sandra also spoke about sometimes taking a stance which implied “knowing best” and she explained that sometimes she still has to hold back from telling service users what to do, and she can feel frustrated when they cannot do what she thinks may be best for them. In the following extract, she explained how she uses reflection as a way of helping herself get back to a more neutral stance:

“You know sometimes I find myself going down the track now that I’m well maybe thinking ‘Oh for God’s sake, just do it!’ I’m thinking with a patient you know ‘Why can’t you just do it? It will help you’. But I have to stop and think ‘No, Sandra, you’ve been there, it is not just a matter of just doing it’ - getting up and going to mindfulness or something like that – it’s not as easy as that when you’re in that place ... but I have to keep reminding myself that.” (Sandra, 139-144)

It seems that part of her adjustment to the role had been similar to Richard's in that she had to recognise the individuality of recovery and learn to not project her own experiences onto service users. The words "oh for God's sake" implies the frustration she felt, just as the word "bloody" did in Richard's account. Sandra's account raises the importance of reflection as a way of reducing unhelpful re-enactments. The way that she described talking to herself ("No, Sandra") may suggest that she had developed the ability to observe her own responses and be more reflective in her response to service users.

For Fran, a difficulty she found in her relationships with service users manifested as a struggle to instil hope in others when it was still early days for her own recovery:

"I mean it was difficult for me in the beginning because obviously I'd only just been unwell, and I was still putting things back together ... it was difficult for me to be instilling that kind of hope in people. But now that it's been longer, you know I do feel like I can sort of ... like I always say like oh it takes time, or you'll get there ... and now I believe it."
(Fran, 551-556)

The words "still putting things back together" could be interpreted as meaning that she was in the early stages of her recovery and still figuring out how to manage after having been unwell. The phrase "now I believe it" suggests that at the start of the role, and at the early stage of her own recovery, she did not fully believe that recovery was possible.

The potential for becoming over involved is also reflected in Celia's account:

"Like sometimes you get really attached to them without even meaning to ... so if someone like self-harmed ... I remember one girl, we used to get on so well, and then she self-harmed ... then I had to sit with her ... it was just so ... you become involved. I was so annoyed with her, and obviously I had to keep my professionalism, but I think perhaps my

answers to her were short, and she was like ... she didn't say why am I being grumpy, but I think she said something along those lines." (Celia, 227-233)

Celia's quote could be considered as an example of the difficulties of the PSW role and being able to balance an authentic response with a professional one. Celia was aware that she was required to demonstrate some "professionalism"; however, her comment of being "really attached" could be viewed as her being over-involved and then being more likely to respond emotionally, which could get in the way of being neutral.

Celia did not go into details in her interview as to how she managed these experiences. However, the above direct quote is indicative of the difficulties with boundaries in the work as a PSW, and how this perhaps requires adjustment.

Tom also made reference to issues relating to boundaries in his interview when considering what he might say to someone who is thinking of becoming a PSW.

"And make sure that you're in a good enough place that you're not going to latch onto somebody else's problems and live it with them, rather than experiencing just sharing. It's about sharing – shared experiencing but not kind of getting stuck in each other's lives. If people aren't far enough in their recovery, that will happen." (Tom, 413-417)

Tom used the term "latch onto somebody else's problems" which could be related to a person over-identifying with another person's difficulties. He explained how it is possible to "get stuck into each other's lives" (which could be interpreted as being over-involved) if a PSW is not far enough ahead in their own recovery. This may imply that a person needs to be "ready" to start the role and that there perhaps needs to be a process within the PSW supervision that supports PSWs' adjustment into this role.

Sarah did not mention difficulties with becoming over-involved or attached, but highlighted another boundary issue when she explained the problem with knowing people who attend some of the groups she has co-facilitated. She explained:

“... one of the groups I supported there was a lady in it who I knew. So ... I had a word with [her manager] and she said ‘well it’s up to you if you want to stay here’ kind of thing. And obviously she [manager] spoke to me about confidentiality if I shared anything, like confidential ... and I stayed in the group, but it was difficult because I knew her [the service user].” (Sarah, 267-272)

Sarah’s experience not only raises the issue of boundaries, but also highlights the different roles that a PSW has to negotiate and manage. It seems that for Sarah it was a difficult experience, but having a member of staff she could discuss these problems with was important and helped her to remain co-facilitating the group even though it perhaps felt uncomfortable for her.

4.3.2. Subordinate theme: They need to give us more credit

Related to role adjustment, a theme which featured in PSWs’ experiences was the reaction of other staff members to the role, and the difficulties of working with other staff who had supported them when they were unwell. Based on several comments of participants during the interviews, this aspect of the role was not something they were prepared for, and it was experienced as difficult at the beginning. However, as indicated in the theme “not getting stuck into each other’s lives”, as participants progressed in their role as PSWs, they seemed to be able to manage these dynamics with more confidence and also the anxiety of the staff appeared to reduce.

An example of how participants generally felt unprepared for the reaction from staff is illustrated in Sandra’s account:

“I didn’t think the challenges were going to be as severe with the staff that I thought. I went in very naively thinking I’d be accepted there, but of course in hindsight that was naive – I was a patient there ... and from

their point of view... I do understand where they were coming from. You know they hadn't seen me when I started to recover you know ... I would have liked a lot more support and preparation for that.” (Sandra, 928-934)

Her account implies that she had some inkling that it would not be completely straightforward, but she did not expect it to be so much of a challenge. Her use of the word naive suggests to me that she experienced some self-criticism, that she should have somehow known that this difficulty could arise. It seems that she had perhaps been overly positive about how staff would respond to her. It appears that being informed of the possibility of unhelpful responses from other staff would have been helpful to her adjustment into the role. In her account, there also seems to be the suggestion that she did not get as much support as she would have liked.

Similar to Sandra's account, Fran also described some difficulties with other staff, and explained that within her service, there had been some concern about employing PSWs, and this had undermined her confidence.

“Um ... in the beginning there were quite a lot of issues around sort of people sort of being ... I think people felt a bit ill at ease or concerned. So, then my confidence took a bit of a knock, and then it took time.” (Fran, 123-125)

Within this comment, it could be interpreted that there had been concern from clinical staff about the mental health of the PSWs and whether people with lived experience would be able to do the role. In saying that her confidence took a knock suggests that it was an experience she was not expecting and so internalised the concerns of the staff, perhaps questioning herself whether she was able to do the role. However, as she said “in the beginning”, it seems that this was not an ongoing difficulty and that perhaps other staff needed a period of adjustment to the new role.

Some of the difficulties indicated by the participants were a result of staff being overprotective and also a lack of clarity with boundaries. Clinicians are taught that

dual roles are unprofessional and damaging to service users (e.g. Nursing & Midwifery Council, 2015), but in these services the expectation was that PSWs and other staff would seamlessly be able to work with each other despite having previous patient/clinician roles.

The difficulty this can create is illustrated by Sandra in the following quote:

“... and there was one member of staff – she was fantastic to me when I was in hospital, but I found it next to impossible to work with her, because she keeps going on to me about ‘I’m worried about you getting unwell’ – and I get this every time I’m on a shift with her. And ... you know, I had to say to her in the end, ‘Look I don’t need to work in this job for money, I can survive without it – believe me I value my own wellness so much I would be walking out of here the minute it’s affecting me’...” (Sandra, 258-266)

Sandra had said prior to this quote that this member of staff was someone who had provided care to her when she was on the ward, and so this response from the staff member can possibly be understood as a consequence of their own transition from seeing Sandra as a service user, and someone she was clinically responsible for, to a colleague. This indicates that adjustments to the role not only take place for the PSW, but also for the staff working alongside them.

Tom also spoke about responses from staff and explained how the “Responsible Clinicians” (RCs) “might not see what’s in it”.

“Right now, kind of in peer work across the country, the real kind of difficulty is some of the RCs might not see what’s in it, (...) But really what it is, is ... I think it’s the psychiatrists who really can’t handle it, it’s just the case that they need to give us more credit – and that’s where a lot of the problem is.” (Tom, 216-223)

Tom had, perhaps, experienced some difficulty with psychiatrists (who are usually the RCs) being accepting of the role, and that it possibly signals some adjustment needed by the staff, but also an adjustment for the PSW. Tom was not speaking of a personal experience, but rather something that he voiced being aware of generally in the area of peer support. This would suggest that it is perhaps a common phenomenon.

As with Sandra's account, Tom's quote indicates that he believes the difficulty originates in the RCs' concern about the resilience of the PSWs (as indicated by "it's the psychiatrists who really cannot handle it..."). Tom's statement that "they need to give us more credit" emphasises the resilience of PSWs, which is perhaps sometimes overlooked.

In Richard's account, he also brought up the issue of dual roles and boundaries:

"Sometimes whilst becoming this peer support worker and things like that it was ... it did sometimes feel uncomfortable to a certain extent because the people who were caring for me were now ... I was now with as it were. Or the people who knew my innermost darkest secrets, my darkest thoughts, my darkest plans as it were for things around suicide and things – they were in the same room as me and I was expected to work with them." (Richard 161-166)

Richard's emphasis, however, is on his own discomfort and perhaps a sense of shame that he was now working with people who knew his "secrets". He speaks using the past tense and this possibly implies that this was a difficulty he was able to manage and overcome.

Sarah did not voice any concerns in relation to the reaction of staff towards her. She described staff as being supportive and gave examples of where she felt her point of view was valued, for instance:

"The staff talk to me and ask me my point of view as a service user, how do I think they've done like, how they've put it over, and can we improve on

anything. Is there anything that I picked up on from my point of view that they're doing wrong?" (Sarah, 228-230)

This perhaps implies that difficult responses from staff may not be a universal experience for all PSWs. From Sarah's description, it seems that she feels listened to and her perspective is valued. It is possible that this is related to the recovery focus of the service, and perhaps staff have more understanding of the PSW role within that team.

4.3.3. Subordinate theme: Tensions between PSW values and service aims

The majority of the participants spoke about the tensions that arose between their own aims as a PSW and those of the service. It seems that this was challenging, and although the PSWs gave some indication that they were able to adjust to this, it continued to add a sense of frustration to the role. This adjustment appears to be related to a realisation that their expectations of the role were not quite as they expected.

Richard described the struggle he had with being a service provider rather than a service user:

"It's quite an eye opener, it was um ... I still really really struggle to step away from the patient side of it as it were, or the service user side of it. Because it gets me quite emotive, I want people to be able to access help now here, there, whenever ... and it's just not doable (...) potentially I could at some point come back into the system. And as much as I hope that would never happen as well, if it were to happen I'd want to know that the services there were ..." (Richard, 226-230)

Richard referred to the experience of working within mental health services as an "eye opener", which implies that he became aware of some aspects of the service that he had not been previously aware of, and conveys surprise. This suggests that he had not realised the limitations to the resources when he was using the service. He spoke about the strong emotions he felt in relation to this problem, and from his description,

it seems that these emotions felt difficult to contain. In addition, it gets him thinking about his own situation and what would happen if he needed services in the future. Having this “inside knowledge” of how stretched services can be could potentially leave someone feeling more hopeless if they became unwell and needed help themselves.

The discomfort of service limitations was also raised by Fran, and she described it as a tension between the values of peer support, where you want to support people to move forward at their own pace, and the service aims, which may be to move someone forward and discharge them as quickly as possible:

“I think there’s ... and there’s a tension between like the personal work that you do with someone and the issue of well can you move someone forward fast enough to be discharged because there’s not a very you know ... there’s a tension between like the peer value of taking as long as it takes and giving people the time they need.” (Fran, 202-206)

Service limitations and funding issues also meant that PSWs were not always employed in specific PSW roles. Sandra highlights the lack of available funding as an issue for her role as a PSW. She said that she agrees with the view that it is possible to use your lived experience in any role; however, from her account, it seems that this results in her doing a watered-down version of what she had initially hoped to be doing:

“Unfortunately, I can’t do the role to the best ... to the way I want it, because the only way they would employ us, due to the lack of funds, was by giving us health care support worker duties as well. Cos they believe you can do peer support ... and to a certain extent I agree ... no matter what you’re doing. When I went into it first I envisaged myself running all these groups, like recovery groups, groups about hope, gratitude groups ... Mindfulness groups ... I have achieved that, I do run that. Drop-in sessions, all that, but there is no time for that unfortunately.” (Sandra, 154-161)

Sandra's account indicates the tension between what she would like to do and the reality of the role. Although she believed it is possible to offer peer support no matter what the role, within her account is the suggestion that the PSW role is limited by the addition of duties other than peer support. Although she has achieved some of what she wanted, she has not been able to offer everything she perhaps views as beneficial to peer support.

The impact that additional duties could have on the role of a PSW is evident in Celia's account:

"I think there's too much similarity between peer support worker and support worker roles, or when you're a peer support worker on an acute ward – you still have to do everything a support worker does - and then you will hopefully bring in your peer support as an additional benefit to the ward." (Celia, 141-144)

For Celia, it seems that it was difficult for her to define her role as separate from other roles on the ward. The use of the word "hopefully" suggests that from her experience, the peer support role is viewed as less important than the support worker role, because it implies that a person could be employed as a PSW but focus on the practical support and not necessarily bring in the values of offering true peer support. This is similar to Sandra's account in that the role of a PSW can perhaps be viewed as being diluted by additional tasks, or the role can become too similar to other roles, potentially creating confusion for the role for both PSWs and for other staff.

4.4. Superordinate theme 3: PSW role and recovery

Participants all spoke about their understanding of recovery changing while in the role. Their view of recovery seemed to become more consistent with a personal recovery perspective. It seems that they noticed positive changes to their own recovery and also benefits for the service users.

4.4.1. Subordinate theme: I actually now believe that recovery is possible

Participants discussed how their view of recovery changed during the role and they seemed to attribute this change to the role itself. Their views of recovery appeared to change from a fixed state where a person is free from symptoms, to viewing it as a process which is idiosyncratic and which may change over time.

The following quotes illustrate the effect that the role has had on participants' views of recovery.

"I actually now believe that recovery is possible, whereas before I didn't." (Tom, 338-339)

"Before I went in the role I had a very narrow view of recovery, which was when the person is in hospital and once they leave – that's it, that's recovery to them." (Celia, 428-429)

"... because in the beginning I was quite sceptical about recovery, that I always thought well people talk about it like it's something magic (...) And now as time's gone by I do think that maybe ... that it is something you can kind of understand and learn about if that makes sense." (Fran, 293-298)

These responses were in answer to the question about how the role had influenced their view of recovery. The role itself could be interpreted as a contributing factor to this change of perspective. Both Tom's and Fran's responses suggest that they did not previously believe recovery to be possible, which implies that their view was that it was not possible to have a meaningful life once being diagnosed with a mental illness. In Celia's account, it appeared that she had a medical perspective of recovery, that a person became unwell and then would be admitted to hospital to be "cured" and then sent home to go back to their pre-illness life. Within this, there is the perspective of recovery as being a passive phenomenon, and this is also reflected in Fran's account and her use of the word "magic".

Likewise, Sandra explained about the ongoing process of recovery:

“But since I came into this job I realised now actually I need to be working at growing every day. And this is what recovery is about, and that will stop the day I die really. And that’s when ... otherwise I’m not going to have a meaningful life. And changing all the time, and it’s an ongoing thing, recovery. And it’s not something ... recovery is not something you start and finish – which is what the view I had.” (Sandra, 788-795)

Sandra appears to be describing recovery as something which needs to be worked at: it is not something that is given to you by someone else. In addition, she spoke about recovery as having no beginning and no end: it is an ongoing process. This is in contrast to how she felt previously, when she had the view that it was possible to “finish” your recovery. This may indicate a movement from seeing recovery as a passive experience to one in which the individual is actively involved in and responsible for.

4.4.2. Subordinate theme: I feel that I can contribute again

All participants spoke about the benefits of the PSW role on their own recovery. They all felt that this role had positively influenced their recovery. As described in the previous section, they found that their view of recovery changed, and they had less of an “illness-cure” stance. This seemed to enable them to become more accepting of themselves and appeared to reduce self-stigma. In addition, they spoke about the role helping to increase their confidence, giving them meaning and purpose, and improving their ability to interact with others.

Celia explained that the role had given her more of an understanding of mental health problems, and has helped her to feel less stigmatised. She spoke about how prior to being in the role she felt that she could not be in her community:

“... I guess it’s made me more understanding of mental health as a whole and like the different types of people it can affect. And it’s just like

broadened my understanding of mental health, I think it's made me ... it has... less stigmatised. Because before I went into the role ... I felt extremely like ... I don't know the words to use ... I felt I couldn't be in my community." (Celia, 385-391)

It seems that the role helped her to feel part of the community again and more accepting of herself. She mentions feeling “less stigmatised” and in other areas of the interview she mentioned the feeling of stigma she experienced. Celia’s account perhaps suggests that the PSW role has helped to reduce this feeling of stigma and has enabled her to integrate within the community. However, the use of the word “less” also suggests that she may still feel some stigmatisation. She mentioned her understanding of mental health being “broadened” and from this, it could be interpreted that she has developed a greater understanding of mental illness and that this could have contributed to the reduction in her feelings of stigma, perhaps suggesting that some of the stigma came from within her (self-stigma) rather than all from others.

Other participants spoke about how the role adds meaning or purpose to their lives. For instance, Richard explains that he is now more able to look forward in his life and that he has a purpose:

“... certainly, it's opened my mind up to a lot lot more. And it's meant that I can now look forward again. I look forward sometimes with a certain amount of uncertainty, but at least I have again a purpose, a role. ... I feel that I contribute again, whereas before I felt I was a total dead end, I was a waste, there was nothing more, there was no future. Whereas now I feel I've got a place again.” (Richard, 586-589)

In Richard’s quote, there is the suggestion that the role has given him a purpose, but also it has given him hope, with a sense of future ahead of him. The word “contribute” could mean that he can now give something back to the community; he is now valuable, rather than “a waste”. He spoke about having “a place”, which could mean that the role gave him a sense of belonging.

Sarah also describes the importance of the role in providing a purpose, as illustrated in the following quote:

“Um ... like I said before it’s like ... helps my recovery because I’ve got a purpose. ... Something to get out of bed in the morning for. Something to go out the door for.” (Sarah, 383-388)

Sarah’s account suggests that the role encourages her to continue to engage in life, because it is a meaningful role and other people rely on her, and that (in considering what she has said in other parts of the interview) perhaps without it she would become more withdrawn and isolated.

Similar to Sarah’s account, Tom explains that the role means he is now more likely to get up in the morning:

“I’m more likely to get up in the morning, have a shower and have a proper breakfast now.” (Tom, 280-282)

Tom’s account perhaps indicates that his wellbeing benefits from the role. Perhaps he values himself more and so is better able to take care of himself, or it could be interpreted that his changed perspective of recovery encourages him to actively participate in his own wellness.

Fran also explains how the role has improved her self-care, through giving her a purpose:

“... like it’s forced me to look after myself a lot better. So, it’s forced me to completely stop drinking alcohol which was a good ... which was like a good thing. You know if I felt like I wanted to stay up all night cos I couldn’t get to sleep I’d be like ‘No I have to sleep, cos I’ve got work in the morning’ ...” (Fran 461-466)

Fran uses the word “forced”, which implies that it sometimes is an effort to look after herself. This reinforces the view that recovery takes effort and the individual has to make decisive choices to take care of themselves in order to maintain their mental health. However, it does also imply that Fran is doing this for the job rather than actually valuing herself enough to take care of her health. This then suggests that without the role, her recovery could be compromised.

Sandra described how the benefit to her own mental health was completely unexpected, and she voiced having felt feelings of guilt in relation to this:

“... and oh, this is something I want to say ... initially when I found myself getting this enormous wellness and feeling really good and thinking ‘Mm, my mental health is getting so good’ I felt enormous guilt because I thought I’m meant to be there for the patients, and I’m getting it all.” (Sandra, 1035-1047)

The feeling of guilt which Sandra experienced could suggest that, as in Fran’s account, she does not value herself sufficiently to be able to accept the improvement in her own mental health. However, there is perhaps also a societal view that the role of caring should be selfless (Fealy, 2004). Sandra had explained, in another part of the interview, that improved wellness was not alluded to in the PSW training, and so it was possible that she was viewing herself as being happy because of other people’s misfortune, and therefore seeing this as selfish. The energy that Sandra brought to this part of the interview indicates that it created some dissonance within her and potentially could have negatively affected her own recovery through the level of guilt she experienced. However, it does also emphasise how the role can improve an individual’s wellbeing even when they have strong beliefs that it “should not”.

4.4.3. Subordinate theme: Being a beacon of hope

This theme relates to how participants regarded the PSW role as being able to make a difference to service users’ care and promotion of recovery. Participants also regarded the role of PSW as having an impact on the culture of services. They appeared to have

a positive view that the role was helpful to others and offered examples of their work which illustrated this.

Sandra explained that an incentive for going into the role was to give hope to others and to be able to share her experiences:

“Um ... my understanding of it was that I would be there for people in despair really and that I could give them hope. And that we would have you know a shared, a truly shared understanding - it would be something I would enjoy sharing mutual sort of experiences.” (Sandra, 129-132)

Sandra did not explain how she would give service users hope; however, it seemed that the instilling of hope was a relational process which required her to “be there” and have a shared understanding of the despair that the individual was experiencing. Perhaps implied in this is that because the PSW has lived experience of mental illness, they would be able to offer an understanding which was real and based on personal experience. As the PSW is able to offer this support, this in itself offers hope because it suggests that the PSW is further along the recovery trajectory.

This is consistent with the following quote from Sarah, which demonstrates how she instils hope in others by using herself as an example:

“Yeah. I say to people it’s a lot of steps forward and a lot back, but eventually ... you can do it, cos I managed it.” (Sarah, 358-359)

The way she seemed to illustrate recovery as steps forward but also “a lot back” suggests that she offers a non-linear perspective of recovery, not idealising it but letting people know that there will be ups and downs, but in the end, they will get there. She viewed herself as an example, by implying a perspective of “look at me, I was where you are, but now I’m here”.

Fran also spoke about how she gets positive feedback from service users:

“... I’ve had a few people say to me like, ‘oh you know it’s really good for me to see that you’ve got this job’ or ... you know and, ‘you’re like me’.” (Fran, 267-269)

The words “it’s really good for me” may denote that seeing Fran in her role gave the service users an indication that it is possible to have a productive and valued life after becoming unwell, thus offering a hopeful view of the future. She gave service users a sense of hope and was a role model for the possibility of recovery.

Tom described peer support as offering a “beacon of hope” to services as well as service users:

“But um ... you know really peer support is something for statutory services in my opinion as a kind of beacon of hope. Because we can have a lot more people who are chronically hospitalised do more in the community and have voluntary roles leading to paid work and stuff like that.” (Tom, 385-388)

The phrase “beacon of hope” provides the image of a light within the darkness. However, his focus was not just on offering hope for service users at an individual level but hope for the services themselves – perhaps that they will be able to be truly recovery focused. Implied within this is that this would result in better services. His statement suggests that he considers this to be about making change at a political level as well as on an individual level.

5. Discussion

This chapter aims to explore the findings detailed in the analysis section in the context of the research questions and the existing literature. The implications of the findings will be discussed in relation to counselling psychology and service delivery. Within this chapter there will also be an evaluation of the strengths and limitations of this study, together with suggestions for further research.

This qualitative study aimed to explore the experiences of recovery for people with a lived experience of mental health problems who had been working within mental health services. Specifically, this research focused on individuals who are employed in the role of PSW within the NHS. I was curious whether PSWs' views of recovery had been influenced by their role. I was also keen to understand what the role had meant to them in terms of their own recovery.

5.1. Early recovery of the PSW

All participants spoke about their recovery journey and explained about past experiences prior to working as a PSW. This provided a temporal context for their recovery and the role of the PSW. The subordinate theme of “written off and on the scrapheap” relates to the difficult life events which participants experienced early on in their recovery. Three of the participants described having felt particularly hopeless about the future when they first became mentally unwell. Sandra's experience of services in the early stages of her recovery echoes the accounts of Deegan (1993) and Bassman (2000), who were both told they would never be able to work again (although they did). Deegan (1993) describes feeling as if she were “among the living dead” (p. 361) during this time in her life, and this emphasises the level of despair an individual may feel after developing a mental illness. The results of this study therefore indicate the need for services to be recovery focused in order to instil hope in service users. The inclusion of PSWs within services can help to facilitate a recovery focus by modelling that it is possible to have a meaningful life and be employed after a mental illness diagnosis (Radohl, 2016; Wroblewski et al., 2015).

This qualitative study found that following a period of feeling “written off and on the scrapheap”, something significant occurred in participants' lives which provided a

turning point in their recovery and helped them to see that change was possible. All participants spoke of the life experiences which had prompted them to take a different approach or have a different perspective in their life, and this was reflected in the subordinate theme of “turning points and eye-opening experiences”.

For Sandra, her turning point was related to having a sense of having reached “rock bottom” and realising that services did not necessarily have a magic “cure”. For other participants, it was more of a sense of insight that they had already managed to move forward and so further recovery was possible. These transformational experiences have been highlighted in previous research into recovery and have been identified as “threshold moments” (Gianakis & Carey, 2011), “innovative moments” (Ribeiro et al., 2014), “tipping points” (Shepherd, Reynolds & Moran, 2010) and “turning points” (Mancini, 2007).

In consideration of the stages of recovery highlighted in the literature, this study captured experiences which were consistent with the awareness and preparation stages of the psychological model of recovery (Andresen et al., 2011). These stages occur when a person becomes aware that life is possible beyond mental illness and begins to work towards recovery. Andresen et al. (2011) suggest that people start to recognise the need for purposeful goals and begin to “take stock” (p. 81) and try out new activities. It is also suggested that within the awareness and preparation stages, people begin to recognise that they have not “lost” themselves, but that they perhaps just need to apply their skills in different ways (Andresen et al., 2011).

All participants gave the context of their own recovery by reflecting on the earlier stages of the recovery journey and comparing this with how their lives are now. They gave a perspective of their lives having been enhanced through the PSW role. This supports the view of Bailie and Tickle (2015), who suggest that the PSW role helps the PSW to move from an “illness story to a recovery story” (p. 56), and the findings of Dyble et al. (2014), who suggest that the PSW role leads to positive “identity transformations” (p. 86), thus indicating that the PSW role has a positive impact on identity.

The findings of this qualitative study provide support for the wider recovery literature that suggests recovery involves a redefinition of the self where the individual no longer defines themselves by their illness, but rather they see mental illness as being one small part of their identity (Andresen et al., 2011; Davidson, 2005; Leamy et al., 2011). Furthermore, Andresen et al. (2011) suggest that this self-redefinition occurs in the “rebuilding stage” of their model and is an important part of the recovery process. Therefore, it can be considered that the PSW role facilitates recovery and can help the individual move through the rebuilding stage, to the growth stage where the individual is able to manage symptoms, and feel hopeful about the future (Andresen et al., 2003; Andresen et al., 2011).

According to McAdams (1993, 2001), meaning is developed when memories are told to others, and memory telling serves an important purpose in identity construction (Thorne, 2000). This perhaps offers some understanding as to how the PSW role can be beneficial to the individual: as PSWs tell their stories to others who are “less recovered”, they are able to reconceptualise themselves as “more recovered”, and so the sharing of their experience is therefore beneficial to the PSWs’ recovery identity. In addition, conceptualising their job as being meaningful and having value (as in Fran’s account) gives them a sense of having value as a person.

Despite the findings which indicate that the PSW role has a positive influence on recovery, Dyble (2012) and Dyble et al. (2014) also highlight the potential dilemma that the PSW has to have had a patient identity in order to be in the role, and therefore can never be fully free from the mental illness label. The authors suggest that having to identify with their previous mental illness could put PSWs’ recovery in jeopardy. However, despite these concerns, participants within this qualitative study did not raise issues with having to identify with having been unwell; rather, they used their past experiences in a positive way to promote acceptance and emphasise their recovery.

5.2. Adjusting to the PSW role

Once participants had started in the role of PSW, they had to make the adjustment from being a service user to a service provider and begin to convert their experience into expertise (Austin et al., 2014). Being positioned within the system rather than

being outside of it offers the PSW a new perspective on mental illness and the help that services can offer (Austin et al., 2014; Moran et al., 2012). For participants within this study, this included an increased awareness of challenges related to boundaries and the limited resources available within mental health services.

A boundary issue voiced by all but one of the participants was that of the potential for over-identifying or becoming over-involved with service users. This was considered under the subordinate theme of “Not getting stuck into each other’s lives”. Becoming over-involved has been a concern in other studies within the field of peer support (Collins, Firth & Shakespeare, 2016; Doherty et al., 2004; Mowbray et al., 1998). For instance, within the study by Doherty et al. (2004), one of the participants stated: “There is a tendency of being much more protective ... of being emotionally attached to the client. Sometimes it’s difficult to be professional about it” (p. 77). Over-involvement could lead PSWs to become overly responsible for service users, and to feel guilty, anxious and stressed if service users do not make the progress they expect (Mourra, Sledge, Sells, Lawless & Davidson, 2014). In addition, personal involvement when working within mental health services could lead PSWs to become emotionally exhausted and this could lead to burnout (Blau, Tatum & Ward Goldberg, 2013).

Difficulties related to boundaries and the potential for becoming over-involved could be intensified if the PSW knows the service user personally outside of the role (Mowbray et al., 1996). Within this study, one of the participants explained that she found it difficult when someone she knew attended a group she was facilitating. The nature of the role means that there are likely to be occasions when the PSW may personally know some of the service users they are working with, particularly if the PSW is working within an area where they have attended services themselves.

However, the results within this study seemed to indicate that PSWs adjusted to these difficulties and developed an awareness of when they were perhaps projecting their own needs onto service users. This finding was consistent with interviews conducted by MacNeil and Mead (2003), where it was found that the ability of PSWs to set boundaries and recognise their own limits developed as the PSW gained experience.

In addition, the recognition that PSWs are able to adjust to these difficulties was also reflected in the study conducted by Vandewalle et al. (2018), where it was found that PSWs needed to manage the balance between looking after themselves and supporting service users, and that through the work PSWs learned that service users had to discover for themselves what facilitated recovery.

The findings within this study also indicated that there were some boundary issues related to working alongside clinical staff, and the participants needed to adjust to this. The subordinate theme “they need to give us credit” related to the boundary dilemmas that can occur for PSWs in this respect. The analysis revealed that participants found the boundary between themselves and other staff to be difficult to manage at times, with staff seeming to be concerned about the employment of PSWs, and sometimes being over-protective of the PSWs.

This is consistent with previous research which examined the PSW role. For instance, Vandewalle et al. (2016) identified misunderstandings by and negativity from professionals as frequent barriers experienced by PSWs. The authors also reported that some PSWs experienced feeling over-protected and patronised by clinical staff. Gillard et al. (2013) describe this as “benevolent power” (p. 10) which could be constraining and may prevent PSWs from carrying out the role in a way consistent with peer support values. Tom’s comment that “they need to give us credit” highlights the need for a culture change within mental health services so that other professionals can begin to recognise the strength and resilience of PSWs.

Within this qualitative study, two of the participants described having to work alongside clinicians who had provided care for them when they had used the service. One participant found it particularly difficult that a staff member knew details of his experience, which ordinarily he may not have wanted to disclose to a work colleague. This finding raises the question of boundaries and dual relationships when employing PSWs. When staff have worked directly with the PSW as a service user, although the therapeutic relationship may have come to an end, there is still a power differential (Moleski & Kiselica, 2005) and, as indicated in the findings within this study, the clinician will know sensitive information about the PSW.

Working alongside clinicians who have provided care to them could potentially undermine the PSWs' recovery as they are reminded of, and perhaps sometimes pulled back into, the patient role. This finding reflects that of Dyble et al. (2014) and highlights how PSWs have to manage multiple identities. Previous studies have also shown that this can create confusion and stress for some PSWs (Dyble et al., 2014; Kido & Kayama, 2017). However, within this study, participants seemed to indicate that they had been able to address these difficulties. One participant seemed to have been able to directly challenge the over protectiveness of the clinician, and another participant found their concerns became less of an issue as the role progressed.

Zerubavel and O'Dougherty Wright (2012) suggest that providing supervision and having a safe forum in which to discuss emotional responses to clinical work is vitally important in order to reduce the potential of unhelpful relationships and burnout. This is also echoed within the peer support literature (e.g. Daniels, Tunner, Powell, Fricks & Ashenden, 2014; Kemp & Henderson, 2012) and was consistent with the findings within this qualitative study, with participants highlighting how reactions from staff can affect their confidence. For example, Fran stated that the response of staff initially knocked her confidence, whereas Sarah had a more positive experience and explained how the support and acceptance of staff enabled her to manage a potentially difficult boundary issue with a service user.

The third subordinate theme relating to the adjustment that PSWs had to make was "tensions between PSW values and service aims". In this qualitative study, all participants had experiences of becoming aware of the limits of the service, and then had to re-evaluate the expectations of their role. For one participant, this was considered as a difference between the values of the PSW role and that of the service. For most participants, there was a process of letting go of unrealistic expectations and they began to recognise that limited resources meant they could not always work in the way they would really like to, or that their role as a PSW had to be carried out alongside other roles, such as that of a health-care assistant or support worker. This presented a challenge, and although it was identified as an adjustment they had to make, their accounts indicate that they experienced it as an ongoing difficulty.

Other qualitative peer support studies have identified similar concerns in relation to integrating the PSW role into mental health services and being able to establish the PSW role within the culture of the NHS (Hurley et al., 2018; Kilpatrick et al., 2017; McLean, Biggs, Whitehead, Pratt & Maxwell, 2009; Vandewalle et al., 2016). This qualitative study has also captured more detail of the experiences of participants with these issues, including the feeling of being “in the middle”, feeling the tension of working between two different value systems and the sense of disappointment that the role was not quite as expected. The findings of this study suggest a process of initially having an idealised expectation of the PSW role, but then becoming more aware of the barriers to this and eventually having to accept the limited resources available to the service.

Existing research suggests that employee burnout can occur where there is a discrepancy between the worker’s expectations and hopes of the role and the reality of their day-to-day experience (Schaufeli & Buunk, 2003). This could indicate that the tensions identified within the PSW role may leave the PSWs susceptible to burnout and thereby put their recovery in jeopardy. Therefore, the expectations of PSWs require consideration prior to them commencing the role, in order to help reduce the potential of burnout.

5.3. How the PSW role influences recovery

Within this study there were three subordinate themes which highlighted the influence of the PSW role on each participant’s perspective of recovery.

The subordinate theme “I actually now believe that recovery is possible” highlighted how participants’ views on recovery seemed to change as they worked as a PSW. From the accounts within this study, it seems that participants’ views of recovery became more consistent with the recovery approach: rather than having a recovered/not recovered stance, they began to view recovery as a process. This finding was consistent with the study by Andresen et al. (2011) which suggested that service users’ perspectives of recovery are not always as contradictory to the medical model as some of the literature would suggest, and that their accounts may integrate

aspects of the medical model, rather than being opposed to it. It is likely that as the participants became more exposed to the recovery model in their training and through contact with other PSWs, these views became more integrated into their own beliefs about recovery.

It may also be that having contact with other service users who are “less recovered” may increase their awareness of how they have progressed in their own recovery journey, thus increasing their belief that recovery is possible. This has been suggested as a factor in other research, such as that by Henderson (1995), who carried out a study on peer support within a women’s refuge. The outcome of the study suggested that the women benefitted from offering support to newcomers to the refuge and viewed this as a sign that they were further on in their own recovery.

The identification within this study that the participants’ views of recovery changed during their role highlights the role’s potential for promoting recovery in the PSW and helping them in their own recovery journey. As the PSWs learn more about recovery while in their role, their own hope and motivation is increased. Increased belief in recovery would also mean that they can be authentic when promoting recovery with the service users, and this would increase the quality of the recovery-focused interactions between the PSW and the service user.

This finding again raises the importance of recovery-oriented services, as otherwise any negativity about recovery within the PSW could be reinforced and this is likely to be detrimental to the PSWs’ recovery, as well as detrimental to the support offered by them to service users.

Participants cited a number of benefits to their own recovery which they attributed to the role. Specifically, participants felt they were able to be part of their community again; they had a purpose and were able to contribute to their own recovery in positive ways. This is illustrated by the theme “I feel that I can contribute again” and is consistent with the existing literature which has identified the benefits of working as a PSW. The reported benefits of previous studies include increased confidence and self-

esteem, and improved relationships (Bailie & Tickle, 2015; Johnson et al., 2014; Kido & Kayama, 2017; Walker & Bryant, 2013).

In addition, stigma has often been cited as a reason for not entering employment for people with a history of mental health problems (Marwaha & Johnson, 2004). However, the PSW role has been found to reduce self-stigma (Vandewalle et al., 2018; Vayshenker et al., 2016) and to reduce the fear of stigma from others, hence giving people the confidence to go into employment (Ochocka, Nelson, Janzen & Trainor, 2006). These findings are supported by this qualitative study. For instance, Celia spoke about feeling less stigmatised, and in other areas of the interview, she explained that she had plans for the development of a career.

The results of this study suggest that being able to contribute by working in the PSW role, and being able to support others, gave participants a sense of meaning and purpose. The recovery literature writes extensively about developing a meaningful life (Andresen et al., 2011; Leamy et al., 2011; Piat, Seida & Sabetti, 2017; Torrissen & Stickley, 2018). According to Andresen et al. (2011), within the awareness stage of their model, the person begins to recognise the need for meaning and purpose in their life. The final stage of “growth” involves a person finding a “deeper sense of meaning” (Andresen et al., 2011, p. 109). The authors suggest that occupational activities consistent with an individual’s values not only provide a purpose, but also help to create a level of meaning. In view of this, the results of this qualitative study support the notion that the PSW role facilitates recovery through increasing an individual’s sense of meaning and purpose in life (Steger, 2017).

It is interesting that within this qualitative study, a couple of participants did not expect to experience benefits to their own recovery and voiced having felt guilty. These self-critical reactions could potentially limit the PSWs’ recovery. Sandra indicated how the training emphasised potential difficulties, and this left her unprepared for the increase in her own positive wellbeing in relation to the role. Emphasising the potential difficulties within training was perhaps an effort to prepare the trainee PSWs for the difficulties of the role and to reinforce the importance of self-care. Therefore, it is

important that PSW training offers a balance of perspectives in order to alleviate concerns about positive gains from the work.

Within this study, participants viewed peer support as providing a “beacon of hope” within mental health services. The promotion of hope has been cited as an important aspect of the PSW role in the existing literature (Lawton-Smith, 2013; Repper & Carter, 2011; Rooney et al., 2016; Walker & Bryant, 2013). When service users are diagnosed with a mental illness, it is important that they are able to look forward to the future with a sense of hope and to know that they can have a valued life despite experiencing mental illness (Milton & Mullan, 2015; Rooney et al., 2016). Within this study, the results suggest that the PSWs are seen as role models of recovery and that their presence within services demonstrates that recovery is possible. Therefore, this suggests that PSWs can play an important role in establishing a recovery focus within services.

5.4. Implications for counselling psychology and service delivery

The following section considers the implications of this research on the field of counselling psychology.

5.4.1. Counselling psychology’s role in improving the recovery focus

When considering the role of PSWs in the NHS, and the need to improve the recovery orientation of services, counselling psychologists are in a good position to reconcile the differences between the ethos of the recovery approach and that of the medical model.

Counselling psychology within the UK developed as an approach which worked collaboratively with the client in a “non-expert role” (James & Bellamy, 2010, p. 398). The training has traditionally been independent of the NHS and counselling psychologists have tended to work in private practice more frequently than clinical psychologists (Cutts, 2013; Jones Nielsen & Nicholas, 2016). However, in recent years more and more counselling psychologists have completed placements during their training within the NHS and have then gone on to become employed within the NHS once qualified (James & Bellamy, 2010; Jones Nielsen & Nicholas, 2016; Strawbridge & Woolfe, 2010).

Counselling psychologists' training prepares them to work in many different settings (Jones Nielsen & Nicholas, 2016). Their training is well grounded in theory but does not value any one theoretical approach above another (James, 2011). Counselling psychologists have the ability to integrate different theories and approaches in a way which is helpful and consistent with the client's own understanding, rather than trying to fit the client to the theory (Lambert & Norcross, 2017). The employment of counselling psychologists with their humanistic values within the NHS will help to facilitate a therapeutic milieu consistent with recovery principles.

Encouraging psychologically informed environments within services has been found to increase the recovery orientation of services (Araci & Clarke, 2017; Chang et al., 2014; Wykes et al., 2018). Therefore, counselling psychologists can support recovery by offering psychologically informed support and training, encouraging alternative ways of thinking than the medical discourse (e.g. through the use of psychological formulation) and facilitating reflective practice. A service with values compatible with the recovery approach will ease the transition of PSWs into their role (Gillard et al., 2013; Walker & Bryant, 2013). However, because of the dominance of the medical model within the NHS bringing in a different perspective will not be without its challenges (Larsson, Brooks & Loewenthal, 2012), and it has been suggested that working within the NHS can bring a "clash of paradigms" for counselling psychologists (James & Bellamy, 2010 p. 399) making it difficult for them to maintain their humanistic focus and unique identity (Gazzola, De Stefano, Audet & Theriault, 2011).

Indeed, the dominance of the medical model within the NHS leads some commentators to question whether counselling psychology can stay true to its humanistic values while working as a minority profession in such a setting (Bury & Strauss, 2006; Hage, 2003). Even within the field of psychotherapy the medical model is beginning to shape how services are developed and how therapies are offered (Deacon, 2013), with the emphasis on a clinical recovery perspective with randomised control trials (RCTs) being the gold standard when deciding on a particular therapy approach (Gazzillo, Schimmenti, Formica, Simonelli & Salvatore, 2017; Henton, 2012). Although counselling psychologists can see the value of RCTs, they are not easily generalisable

to everyday clinical practice and the focus on the reduction of symptoms alone runs counter to the ethos of counselling psychology (Blair, 2010; Henton, 2012) and the recovery approach (Slade, Leamy et al., 2012).

A further challenge for counselling psychology is that although psychological therapies are being promoted within the NHS, services have been developed which do not rely on psychologists to provide therapy. Psychological interventions are provided by specifically trained practitioners who have been indoctrinated into the IAPT way of thinking and focus on diagnosis-informed models and symptom reduction and there is concern that psychology professions are being eroded (Carter, 2016; James, 2011; Mollon, 2009).

Therefore, counselling psychologists need to be willing to change with the times and adapt to service changes. They need to be willing to take on differing roles and to question the medical perspective while at the same time accepting that this way of thinking may be helpful for some service users. Engaging with the medical perspective rather than rejecting it will help to demonstrate equivalence with other applied psychologists and does not necessarily mean counselling psychology cannot stay true to its origins (Larsson et al., 2012; Sequeira & Van Scoyoc, 2004).

Counselling psychologists will find themselves working within more diverse settings and they will need to be willing to take on roles other than providing therapy (James & Bellamy, 2010). This again emphasises the role that counselling psychologists can have in working with teams to encourage psychological thinking rather than focusing solely on the provision of psychological therapy.

There is some concern, however, that as counselling psychologists begin to take these different roles and become embedded in the NHS, they may lose some of the uniqueness of their professional identity (Bury & Strauss, 2006). The difficulty is that the identity of counselling psychologists is not so much embedded in what they do, but in how they do it (Cooper, 2009). Therefore, the counselling psychologist will fulfil the same task with a different philosophical approach and attitude to the clinical

psychologist. The counselling psychologist will also place the therapeutic relationship at the centre of all they do (Gillies, 2010).

The different stance of counselling psychology is positive for developing services which are compatible with a recovery focus. However, it can be difficult for the counselling psychologist to hold onto their identity when they are perhaps the only counselling psychologist in a service working alongside clinical psychologists in the same role and potentially even being managed and supervised by clinical psychologists (Hemsley, 2013). Working in isolation from colleagues with similar values can affect the professional identity of that individual (Mrdjenovich & Moore, 2004) and although having a practitioner in a team who holds different values may influence the wider team, there is also the danger that the individual clinician's values will become more similar to those of the team over time (Gazzola et al., 2011; Mrdjenovich & Moore, 2004). This difficulty is even greater for the newly qualified psychologist who is still developing and consolidating their identity, and the danger is that counselling psychology can become subsumed by clinical psychology and lose its unique humanistic stance (Cooper, 2009).

Despite these concerns for counselling psychology, the recovery approach is encouraged by NHS policy and frameworks are being put in place in order to increase its presence within the NHS. For instance, recovery colleges are now well established within NHS Trusts, there are many PSWs now employed and there is an established research agenda which is now focusing on developing recovery-oriented services. In this way, there is some acceptance of a drive towards approaches other than the medical model and counselling psychologists who have their humanistic values and are trained in the ability to hold a pluralistic stance will be in a good position to support this drive within services and can help to bridge the gap between the medical model and the recovery approach.

In summary, introducing PSWs into services is one way in which the NHS is attempting to increase its recovery focus but the role is fraught with boundary and role dilemmas. Vandewalle et al. (2016) suggest that, in order to overcome these difficulties, the services in which PSWs are employed need to be recovery-oriented,

thus demonstrating a circular process. This indicates that developing recovery-oriented services requires much more than employing PSWs and that there needs to be a systemic change in order to alter the culture of services. Research has indicated that developing psychologically informed services can improve the experience of a service for service users and improve the recovery focus (Araci & Clarke, 2017; Wykes et al., 2018). This suggests an important role for counselling psychology.

The recovery approach is consistent with the humanistic values of counselling psychology and so counselling psychologists are in a strategic position to promote recovery principles and to help facilitate the involvement of PSWs within services. Counselling psychologists can support recovery and PSWs by offering support and training, encouraging alternative ways of thinking other than the medical discourse (e.g. through the use of psychological formulation) and facilitating reflective practice. The way in which counselling psychologists can bring their skills and their humanistic values to use in this endeavour will be discussed further in the next sections.

5.4.1.1. Psychological formulation

Counselling psychologists working within the NHS are in a position where they can question and challenge medical discourse and bring a humanistic influence to services. Counselling psychologists can have a role in supporting whole teams to think about the service users in ways other than the medical model (Joseph & Patterson, 2016; Lane, 2016; Strawbridge & Woolfe, 2010). This may then help to change the culture of mental health services towards greater recovery orientation and can help with the integration of PSWs into teams.

One way in which counselling psychologists can encourage a move away from a medical discourse is by offering a psychological formulation. A psychological formulation (as opposed to diagnostic labels) can help teams to understand the processes and context of a person's difficulties, and this can promote thoughtful responses rather than team members reacting emotionally and ending up in unhelpful re-enactments (e.g. a person who has experienced many rejections then being rejected by services). It also helps staff to listen to their own thoughts and emotions in response to the service users they are working with, and to be able to make sense of these

responses. Keats, Cockersell, Johnson and Maguire (2012) suggest that this helps to reduce burnout in staff. In addition, this can help to promote a more reflective environment and facilitate the team towards a recovery orientation.

5.4.1.2. Staff support and training

According to Feeney, Jordan and McCarron (2013), training is an essential part of educating staff and increasing their knowledge of recovery, as well as helping them to develop more positive attitudes towards mental illness. Vandewalle et al. (2016) also suggest that strategies to manage the responses of other clinical staff need to address the thoughts and beliefs of the professionals and help to change those in order to develop “recovery-oriented cultures” (p. 248).

The ability to plan and provide training to staff and offer supervision and consultation is included within the Standards of Proficiency for all practitioner psychologists (Health and Care Professions Council, 2015), and counselling psychologists are likely to offer training to other clinicians and trainees at some point in their career (Gkouskos, 2016). Therefore, counselling psychologists have the necessary competencies and consistent values to support peer support services and to offer training alongside PSWs to clinical staff within mental health services. This will help to promote services which are more compatible with PSW values and aims.

Counselling psychologists can also facilitate a recovery approach within services through the development and promotion of recovery pathways and frameworks such as the Recovery Focused Care Transfer (ReFleCT) pathway, recently published in the *Counselling Psychology Review* (Mercer-Quinn & Wright, 2017).

5.4.1.3. Reflective practice

This qualitative study, together with existing studies, emphasises how the PSW role helps the individual to reflect on their own recovery and develop a healthy narrative of their journey from illness to wellness. Therefore, the need for reflection and supervision within teams to support this development is essential. Within busy teams, such as those in inpatient wards, there is often a culture of doing and reacting rather than thinking and reflecting (Johnston & Paley, 2013). As a result of this, it could potentially be difficult

for the PSW to find the time and space for this reflection. In addition, without a reflective space to think through their relationships with service users, PSWs may get pulled into a “rescuer” position (Karpman, 1968), and this can become unhelpful (Jenkins, 1997; Nelson, 2015).

Martin (2010) considers the two leading models within counselling psychology to be “the scientist-practitioner” and the “reflexive practitioner” (pp. 552-553), and Woolfe (2016) states that “reflective practice and the reflective practitioner is at the heart of counselling psychology” (p. 15). Therefore, counselling psychologists are well placed to support and encourage services to be more reflective, and to lead on reflective practice. Within reflective practice groups the psychologist will aim to encourage reflection on differing perspectives rather than focusing on one. The PSW will be a valued part of this as they will be able to bring a recovery perspective to the reflective practice group and can ensure that the service user’s voice does not get missed. This will help to increase the recovery orientation of the team by bringing in a recovery-focused perspective.

5.5. Strengths and limitations of this research

This qualitative study explored the experiences of PSWs employed in mental health services within the NHS and has therefore been an important addition to the sparse literature within the UK. It has been able to offer support for the perspective that the role is a facilitator of the PSW’s recovery journey, but in addition has also highlighted areas which need further attention in order to reduce any detrimental effects to the PSW’s recovery.

The wider literature suggests that services need to be recovery-oriented in order to gain the full benefits of PSWs, and within this study I have suggested that counselling psychologists can offer a valuable contribution to encouraging recovery orientation within teams by supporting teams to be psychologically informed and to offer relevant training and reflective practice. In this way, counselling psychologists can offer an alternative perspective to the medical model within mental health services and can support the development of recovery-oriented services. There are some caveats to this,

as described in the previous sections within this study. However, the NHS is in a state of change and this can provide an opportunity for counselling psychology.

I consider a strength of this study to be that it gives a voice to PSWs who are employed within the NHS, and the IPA approach used within this research has enabled an understanding of the recovery journey for PSWs at the level of experience rather than reducing the data to numbers and statistics. This provides more of an in-depth understanding of what it actually feels like for the PSWs. Of course, the themes identified are influenced by double hermeneutics and are therefore my interpretation of participants' interpretations, rather than being a "factual" account, and these will be further interpreted by those who read this study. However, throughout this study I have been open about some of my own experiences which are likely to influence my interpretations. I have also maintained a reflective journal throughout my research journey and have attempted to be aware of and bracket my own assumptions.

Several limitations to this research need to be considered. This qualitative study explored the experiences of PSWs employed within mental health services. However, because of the small number of participants, this research cannot be generalised to other PSWs. Also, the experience of the role is not static and may be influenced by many different factors. Therefore, it is important to be aware that this research details participating PSWs' experiences captured at a single point in time. The number of participants also precluded any comparison in terms of the individual settings or specific tasks of the role.

In addition, although purposive sampling was used within this study, it could be argued that the sample was not fully homogenous. There were participants from different services, different settings, different backgrounds and with different lived experiences of mental illness. This was as a result of PSWs being relatively new in the UK, and because I was not based within a service with an established cohort of PSWs, I needed to contact a variety of services. However, for the purpose of this study, the homogeneity of the group was sufficient and within the guidelines of IPA research (Smith et al., 2009). It is suggested by Smith et al. (2009) that future studies can

define their samples from previous studies, and so my study can be helpful in informing future research.

The face-to-face interviews may also have been influenced by social desirability and respondents may not have wanted to reveal how they were truly affected by their work. In particular, as they were aware that I was a psychologist, their previous experience with psychologists may have influenced the interview. In addition, my being a health professional may have created a power differential and they may have wanted to emphasise the positives of the role for this reason.

A final consideration is that I have been cautious in the way I have presented the demographic data. This was a conscious decision to protect the anonymity of the participants as the world of peer support within the UK is relatively small. However, this prevents the reader of this study from making any reflections on individual quotes in relation to age, ethnicity, work setting and length of experience. These differences may affect the recovery journey and the experience of the PSW role. For instance, research has highlighted differences within the recovery journeys of BAME participants, such as a greater emphasis on spirituality and stigma (Leamy et al., 2011).

5.6. Suggestions for further research

Following on from the limitations highlighted in the previous section, further research may be helpful to address some of these areas. This could include focusing on specific groups such as PSWs within certain settings, or within certain services, as well as on other differences, for instance focusing on BAME participants, to understand a wider variety of experiences. In addition, involving service users within research will be beneficial in addressing potential perceived power differences and will also be consistent with the ethos of recovery and peer support.

It will also be helpful to focus on how recovery-oriented services can be developed in order to support the PSW role. It may be helpful to compare different services in terms of their recovery orientation, and to identify whether this affects the experience of recovery for PSWs. In addition, research into the effectiveness of peer support as an intervention is mixed and so it may be helpful to identify factors within peer support

which can help to increase the effectiveness of the intervention. Research focusing on symptoms is unlikely to be the best measure of effectiveness as the recovery approach emphasises that it is possible to live a meaningful life with or without symptoms (Roberts & Boardman, 2013). Therefore, further work on establishing clarity as to what constitutes peer support intervention and utilising recovery measures rather than symptom measures is essential (Leamy et al., 2011).

Further research which explores PSWs' beliefs about recovery and whether these are influenced by the recovery orientation of the service and also how much these beliefs contribute to the effectiveness of peer support intervention would be beneficial.

Within my recommendations I have made the case that counselling psychologists are well placed to encourage reflective practice within teams. My view is that reflection reduces re-enactments, and this is supported in the psychotherapy literature, as well as in the literature from other professional groups (e.g. Aiyegbusi, 2009; Dallos & Stedman, 2009). This is particularly relevant as this study has highlighted the potential for PSWs to become over-involved with service users (although please note this is not specific to PSWs) and this may adversely affect the PSWs' recovery and the helpfulness of the support they are able to offer. In addition, I have suggested that integrating reflective practice into teams will help them to be more recovery-oriented and will help the integration of PSWs. However, I am not aware of any research that explores these areas and so this would be a useful avenue to explore in further research.

5.7. Conclusion

This qualitative study has contributed to the peer support literature by exploring the experiences of PSWs employed within mental health services. The emergent themes suggest that the PSW role helped to facilitate the recovery of participants by helping them to redefine their identity from someone who is ill to someone who is ahead of others in their recovery journey. The role also helped to increase their belief in personal recovery, and their perspective changed from a desire to be "fixed" and to be able to "fix" others to viewing recovery as something individual and which can occur even in the presence of symptoms. However, some of the themes highlighted challenges which could potentially be detrimental to PSWs' recovery.

Participants highlighted difficulties with boundary dilemmas and tensions between the PSW values and the requirement of the services. In addition, some participants indicated that it was easy to become over-involved with service users and, early on in the role, they tended to have an expectation that what worked for them will work for others. However, the PSWs within this study managed to adjust to these difficulties and found ways of managing them. In reflection on these findings, and in considering the wider literature, this study suggests that it is necessary for PSWs to work within services which are recovery-oriented. This will help to reduce the tensions between the values of peer support and those of mental health services and will help other staff to recognise the benefits of peer support.

In addition, this study suggests that counselling psychologists can play a valuable role in supporting the recovery orientation of a service through the provision of supervision and reflective practice, offering a psychological perspective rather than a medical one, and promoting humanistic values within training, staff support and future research.

6. Final Reflexive Statement

This section follows on from the initial reflexive statement (page 9) and reflects on my experiences during this study, from being accepted onto the doctoral course through to completion.

6.1. Starting the doctoral course

At the very beginning when I was applying for the course, I was uncertain whether it would be possible for me to complete a doctorate. I doubted my ability and so when I was accepted onto the course it felt such a big achievement. When I finally started the training, my confidence began to grow, and the completion of this research felt much more possible. At the same time, the recognition grew that, although it felt possible, a doctorate was not going to write itself. I realised that I had to put some effort in!

I think that it really began to feel real when I began looking for participants. Prior to that point it had been a theoretical venture, but when I actually began to contact research departments and services in order to find participants, I thought “I’m really doing it. I’m a doctoral student.”

6.2. Finding participants

The process of finding participants was very difficult. The most difficult part was juggling full-time work while trying to make phone calls and contact potential organisations and participants. I wondered if I had taken on too much. Then, after finding participants and interviewing them, I felt a huge surge of excitement, enthusiasm and motivation. Meeting the participants not only enthused me about my research, but about my work generally. Hearing their experiences reminded me of the importance of this research and why I was doing it. Their experiences connected me with my own values and beliefs, and added much more meaning to the research process.

6.3. Interviews

At the beginning of this research I was mindful of the impact that I may have on the participants. I had thought about how my own experiences, values and beliefs would affect the relationship between myself and the participants. I was aware that the

questions chosen were likely to be a reflection of my values as they were developed by me. I wanted to be open and approachable, and to put participants at ease. I felt comfortable with this because of my clinical training. However, I was also aware that by virtue of being a psychologist and a researcher, participants would be influenced by this, perhaps wanting to please, or show the PSW role from a positive stance, depending on their previous experiences of psychologists and their assumptions about what I, as a psychologist, wanted to hear.

Additionally, I was aware that my own background, as indicated in the reflexive statement in the Introduction, would perhaps lead me to have certain expectations. As a woman from a working-class background, and having my own experiences of feeling disempowered because of that background, I am sensitive to hearing experiences of disempowerment in other people's stories. I was aware at the start of this research that I expected the role of the PSW to be difficult. I do not think that this was because I do not give those with mental health difficulties "enough credit", as in Tom's experience, but rather I think it stemmed from my own experience of finding starting work in mental health services painful at times. In view of this, I was careful to have a more neutral perspective of what I would find and to bracket my own expectations.

As a clinician, it is far more familiar for me to be in a one-to-one situation as a therapist rather than a researcher; therefore, in the interviews I had to consciously focus my attention on the participant's experience of the role and their recovery rather than on other aspects of their experience or the relational aspects of our interaction. I was also conscious that I felt some confusion as to the difference between the reflective listening that a researcher may undertake and that of a therapist. I wanted to encourage the participants to reflect on their experiences but did not want to turn the interview into a counselling session. However, I realised that the participants were aware that I was a psychologist and because I was being attentive to their experiences, the participants may have been encouraged to disclose the detail of their recovery story. I therefore had to be mindful of the ethics of this and to ensure that I did not get drawn into more of a clinical interview.

During the interviews I sometimes found myself silenced because of my own urge to respond therapeutically and then my own inner supervisor closing down that line of enquiry. This was particularly evident with one of the participants, who was especially anxious. It is also worth noting that my role as a clinician meant that the information I was being given during the interviews was also being interpreted by me from a clinical perspective, even though the purpose of my role during the interviews was to gain an understanding within an IPA study. I found myself thinking about the interviews afterwards and considering what the interview had meant in relation to my role within the inpatient unit. My way of managing this was to be aware that this was happening and to allow myself space to do this but in a contained way. I found my reflective journal helpful to raise my awareness of this. By not suppressing this but giving it some space meant that during the interviews I was aware of my agenda as a clinician and that I should not veer off track and explore topics more related to clinical work (e.g. PSWs perspective of seclusion or restraint) but should keep the focus on experiences related to recovery.

In addition, I found that my knowledge of psychotherapeutic models would influence my thinking when analysing the data. For instance, when identifying the theme of “on the scrapheap”, I kept thinking of the idea of “creative hopelessness” within acceptance and commitment therapy (ACT) and I then started to consider similarities to other ACT concepts within the data.

6.4. Influence of the research on my clinical practice

During the research process, I also became aware of how I, as a researcher, was influenced by participants’ experiences. I recall that after seeing my first participant, I felt inspired and enthusiastic about peer support. I initially thought that this was a result of feeling that I was moving forward in the research process. However, I think that I perhaps identified strongly with this individual’s perspective. This participant was someone who worked in an inpatient unit. She spoke about her experience of having been restrained when she was unwell herself and then how distressing she found it to witness another person being restrained when she began working on a ward as a PSW. This resonated with the horror I felt when first seeing someone being restrained. I had not fully realised how much the participant’s experience had affected me until I found

myself in a situation at work (on an inpatient unit) where I was using words which I realised afterwards were similar to those I recalled the participant saying she had said to one of the service users she was working with.

I had not been fully prepared for how the interviews would affect me. The stories of the participants who were working within inpatient services resonated with me and influenced my role as a psychologist within an inpatient ward. Hearing PSWs talking about their experiences of having been in inpatient wards themselves and what it was like for them then working within those services had a profound effect on me. It reminded me to recognise how disempowered patients are likely to feel in this setting, and it reinforced the importance of “being with” rather than “doing to”. In an inpatient unit the level of distress can be so intense that it becomes easy to rely on medication, and after working in this setting a while and hearing the perspectives of doctors and nursing staff, it can be easy to be accepting of the medical model and see patients as ill and needing treatment.

This research, and the interviews particularly, have reminded me of the need to question and challenge. It has connected me again with the need to understand subjective experiences, and has encouraged me to be creative. In taking this back to the ward in which I work, I have found myself noticing more occasions when patients may be feeling disempowered and specifically check this out with them. For instance, checking that patients are aware of what certain words mean (such as “handover”), ensuring that patients are given sufficient support after restraints, encouraging service user involvement, and allowing time to simply be on the ward and available.

This came as a surprise to me as I had not expected to be affected this way. I then realised how the account of one participant can influence the research process, and I found that I was not only having to be aware of my own experience, but also my experience and interpretation of each participant’s experiences. This initially led me to feel anxious as to whether my analysis was an accurate representation of the participants’ experiences. However, I came to realise that this is an inevitable process of researching experience. This realisation helped me to be curious about the different

influences on the research process and to be open to them, rather than getting into a struggle and trying to find an unrealistic accuracy.

6.5. Heightened awareness of my own biases

When carrying out the interviews and when working through the data I became aware of my own biases and recognised that my expectations had perhaps been that the PSWs would have experienced difficulties similar to mine when working within mental health services. I began to recognise the differences between my story and the lived experience of the PSWs. It is through my professional training that I came to recognise that I had experienced social anxiety, and prior to working within services I had no contact with NHS mental health services. In my teenage years and early twenties, I felt that there was something wrong, but had no awareness of social anxiety. In trying to understand my difficulties, I sought private therapies, including complementary therapy and counselling. My experience of these interventions is that they were supportive and inclusive. I did not feel that my difficulties were pathologised and I was in control of the interventions in that I was choosing who I would work with and when, and if I did not find the person I was working with helpful I was able to go and work with someone else. This is a very different scenario to being referred to services, being assessed and placed on waiting lists, being given medication and told you have a disorder.

6.6. Roles and identities of the participants

Just as I was in a dual role of psychologist and researcher as well as having had my own experiences of anxiety, I was aware that the participants in this research were also in the position of having dual roles and identities and that this may also have influenced the research.

The participants were working within mental health services and knew that I, as a psychologist, would also be working within this setting, and this could have led participants to censor what they were saying about their role, perhaps wanting to show the role of PSW positively. They would also have had experiences of psychologists, perhaps both as a client and as a colleague. These prior experiences would have shaped how they then viewed me. As I had limited contact with the participants prior to the interview and then only met them once during the interview process, they knew very

little about me and this could perhaps have meant that their previous experiences of clinicians, particularly psychologists, could have filled the relational field within the interview encounter. Within this study participants were encouraged to reflect both on their position as people who have a lived experience of mental illness and on their experience of providing support and help to others.

In addition, IPA considers the hermeneutics involved within the research process and during the interviews. Thus, it would not only have been me as a researcher interpreting the experience of each participant's interpretation of events, but would also have involved the participant's interpretation of the questions I asked, and perhaps also their interpretation of my response to their answers. It is likely that the participants might have had an expectation in their mind of how I would perceive their responses even before they spoke.

Their interpretation of my questions together with their expectations and interpretation of my responses could also have been influenced by their perspective of not only having been a service user but also by their stance as helpers working within the NHS. Therefore, the accounts of the participants would have been influenced by their prior experiences and perceptions. Their perceptions of me as a psychologist may have either hindered or facilitated their disclosure. Therefore, the findings of this study should be considered in the context of PSWs (whose role encompasses both a service user and a helper perspective) speaking with a psychologist-researcher about their experiences.

6.7. Carrying out the analysis

After the interviews were completed, I felt excited and keen to make a start on transcribing the data. However, my excitement soon turned to apprehension as I began to realise how much time the analysis would take. I felt daunted by the amount of raw data and found myself sometimes being overly focused on listening to the recordings and reading the transcripts but not actually getting on with the analysis. There were also times when I was sitting in a room surrounded by themes and I really felt that making any sense of the data was impossible. Due to working full time, I found that I had to sometimes leave the analysis and come back to it later. Returning to it later meant that on occasion I would find that my ideas about the analysis were then different and I

would change and rework the themes many times. However, it was sometimes beneficial to have periods of time when I left the data and distanced myself from it. I found this helped me to be aware of how I was influencing the data.

During the time I was carrying out the analysis I came across an article which stated the following:

... your analysis will proceed unabated within your own head, whether you want it to or not, with insights often arriving in the middle of the night, or at the most inconvenient moment in the day. It is worth deliberately taking time away from the analysis, in order to give your thoughts time to crystallize. (Hale, Treharne & Kitas, 2008, p. 92).

When I read this I was struck by how accurate it was. I even dreamt about the analysis at times! It was helpful to hear that this happens to other people too!

During the analysis I found that I was also influenced by the reading I had carried out, and I began to see themes which fitted with the already established data. Rather than just going with the themes I was seeing, because I was aware they were already in the literature, my response to that was to do the opposite and avoid them. This was in part to do with my eagerness to give a voice to the PSWs within my study rather than fitting their experiences to established literature but also it was because of my need to find something different to the established literature. When I recognised that I was doing this I also realised that I was doing the opposite of what I intended – if I was avoiding any themes which were consistent with the literature then I was not allowing the PSWs their voice.

In managing this, I had to focus on bracketing my expectations, but this was very hard to do. I found that discussing the data with others, including my supervisor, and getting their perspective was helpful. However, the most helpful strategy seemed to be to stop reading, have a break from the analysis and then go back to it later. I found that this

enabled me to bracket my assumptions and to be willing to consider the themes as they were emerging from the data.

6.8. Final reflections

The remainder of the research journey was a pattern of ups and downs. There were points that felt completely satisfying and fulfilling, and other points of the journey which felt completely soul destroying and frustrating. At times, these feelings could come within minutes of each other, sometimes as a result of some intrapersonal process (usually me doubting myself), but sometimes triggered by other life circumstances.

There have been times in this research process when I really believed it was an impossibility and that the completion of my doctorate was something I would not be able to achieve. I had supervision sessions where I explained how impossible it was to do the doctorate, how I did not have enough time, how everything took me much longer than everyone else, how perhaps I am now too old or how perhaps I am just not clever enough. However, my supervisor did not join me in my drama. She did not take up the invitation of joining me in the drama triangle (Karpman, 1968), but remained calm and empathic, encouraging me to put it all in context, and reminded me of the realistic timescales. She seemed to be unwavering in her belief that I could do it, despite me sometimes firmly believing I couldn't.

Coming towards the end of this research has led me to reflect not only on the process of the research itself but also where I am at in my career and in my life. In reflecting on the journey I have taken through this research I feel that there has been something of a parallel process between the processes that occur within recovery, the themes identified within the analysis and my experience of completing this research. My life has changed considerably since beginning this journey. I feel in some ways that the journey of completing a professional doctorate is a non-linear process in a similar way to that of a recovery journey. However, I have moved forward, despite having ups and downs.

In summary, it is inevitable that my own experiences will have affected the focus and the outcome of this research. During the interview process, I may have non-verbally encouraged or discouraged certain perspectives, and the questions and prompts I used

will have been influenced by my own experiences. Therefore, the reflexivity within this thesis is important in order to give an understanding of my journey through the research and the influences that I have brought to this study, and I urge readers to recognise this and to consider their own interpretations of the quotes as they read my analysis.

References

- Aiyegbusi, A. (2009). The nurse-patient relationship with offenders: Containing the unthinkable to promote recovery. In A. Aiyegbusi and J. Clarke-Moore (Eds.) *Therapeutic relationships with offenders: An introduction to the psychodynamics of forensic mental health nursing* (pp. 15-31). London: Jessica Kingsley Publications.
- Andresen, R., Caputi, P. & Oades, L. G. (2006). The stages of recovery instrument: Development of a measure of recovery from serious mental illness. *Australian and New Zealand Journal of Psychiatry*, 40, 972-980.
- Andresen, R., Caputi, P. & Oades, L. G. (2010). Do clinical outcome measures assess consumer-defined recovery? *Psychiatry Research*, 177, 309-317.
- Andresen, R., Oades, L.G. & Caputi, P. (2003). The experience of recovery from schizophrenia: Towards an empirically validated stage model. *Australian and New Zealand Journal of Psychiatry*, 37(5), 586-594.
- Andresen, R., Oades, L. G. & Caputi, P. (2011). *Psychological recovery: Beyond mental illness*. Chichester, England: John Wiley & Sons.
- Anthony, W. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal*, 16(4), 11-23
- Araci, D. & Clarke, I. (2017). Investigating the efficacy of a whole team, psychologically informed, acute mental health service approach. *Journal of Mental Health*, 26(4), 307-311.
- Ashcraft, L. & Anthony, W. A. (2005). A story of transformation: An agency fully embraces recovery. *Behavioral Healthcare Tomorrow*, 14, 12-14.

- Aston, V. & Coffey, M., (2012) Recovery: what mental health nurses and service users say about the concept of recovery. *Journal of Psychiatric and Mental Health Nursing, 19*(3), 257-263
- Austin, E., Ramakrishnan, A. & Hopper, K. (2014). Embodying recovery: A qualitative study of peer work in a consumer-run service setting. *Community Mental Health Journal, 50*(8), 879-885.
- Bailie, H. A. & Tickle, A. (2015). Effects of employment as a peer support worker on personal recovery: A review of qualitative evidence. *Mental Health Review Journal, 20*(1), 48-64.
- Bassman, R. (2000). Agents, not objects: Our fights to be. *Journal of Clinical Psychology, 56*(11), 1395-1411.
- Basset, T., Faulkner, A., Repper, J. & Stamou, E. (2010). *Lived experience leading the way: Peer support in mental health*. London: Together for Mental Wellbeing.
- Bellamy, C., Schmutte, T. & Davidson, L. (2017). An update on the growing evidence base for peer support. *Mental Health and Social Inclusion, 21*(3), 161-167.
- Beresford, P. (2015). From 'recovery' to reclaiming madness. *Clinical Psychology Forum, 268*, 16-20.
- Bhaskar, R. (1978). On the possibility of social scientific knowledge and the limits of naturalism. *Journal for the Theory of Social Behaviour, 8*(1), 1-28.
- Bird, V., Leamy, M., Tew, J., Le Boutillier, C., Williams, J. & Slade, M. (2014). Fit for purpose? Validation of a conceptual framework for personal recovery with current mental health consumers. *Australian & New Zealand Journal of Psychiatry, 48*(7), 644-653.

- Blair, L. (2010). A critical review of the scientist-practitioner model for counselling psychology. *Counselling Psychology Review*, 25(4), 19-30.
- Blau, G., Tatum, D. S. & Ward Goldberg, C. (2013). Exploring correlates of burnout dimensions in a sample of psychiatric rehabilitation practitioners: A cross-sectional study. *Psychiatric Rehabilitation Journal*, 36(3), 166-172.
- Boardman, J. & Roberts, G. (2014). Risk, safety and recovery. *ImROC Briefing Paper*. London: Centre for Mental Health and Mental Health Network.
- Bonney, S. & Stickley, T. (2008). Recovery and mental health: a review of the British literature. *Journal of Psychiatric and Mental Health Nursing*, 15(2), 140-153.
- Bracke, P., Christiaens, W. & Verhaeghe, M. (2008). Self-esteem, self-efficacy, and the balance of peer support among persons with chronic mental health problems. *Journal of Applied Social Psychology*, 38(2), 436–459.
- Bradstreet, S. (2006). Harnessing the “lived experience”. Formalising peer support approaches to promote recovery. *The Mental Health Review*, 11(2), 33-37.
- Bradstreet, S. & Pratt, R. (2010). Developing peer support worker roles: reflecting on experiences in Scotland. *Mental Health and Social Inclusion*, 14(3), 36-41
- British Psychological Society (2006). Ethical principles for conducting research with human participants. In *Code of ethics and conduct*. Leicester, UK: British Psychological-Society. Retrieved 15th June 2016 from http://www.bps.org.uk/system/files/code_of_ethics_and_conduct.pdf
- British Psychological Society (2014). *Code of human research ethics*. Leicester, UK: British Psychological Society.
- Brophy, L. M., Roper, C. E., Hamilton, B. E., Tellez, J. J. & McSherry, B. M. (2016). Consumers’ and their supporters’ perspectives on barriers and strategies to

reducing seclusion and restraint in mental health settings. *Australian Health Review*, 40(6), 599-604.

Bury, D. & Strauss, S. M. (2006). The Scientist-Practitioner in a Counselling Psychology Setting. In: D. A. Lane & S. Corrie (Eds.), *The modern scientist-practitioner: A guide to practice in psychology*. (pp. 112-126). London, UK: Routledge.

Carter, K. (2016, 22 December). Is IAPT damaging clinical psychology? [Letter to the editor published online]. *The Psychologist*. Retrieved 20th January 2019 from <https://thepsychologist.bps.org.uk/iapt-damaging-clinical-psychology>

Chang, N. A., Grant, P. M., Luther, L. & Beck, A. T. (2014). Effects of a recovery-oriented cognitive therapy training program on inpatient staff attitudes and incidents of seclusion and restraint. *Community Mental Health Journal*, 50(4), 415-421.

Chang, B. H., Mueller, L., Resnick, S. G., Osatuke, K. & Eisen, S. V. (2016). Job satisfaction of Department of Veterans Affairs peer mental health providers. *Psychiatric Services*, 39, 47-54.

Chinman, M., George, P., Dougherty, R. H., Daniels, A. S., Ghose, S. S., Swift, A. & Delphin-Rittmon, M. E. (2014). Peer support services for individuals with serious mental illnesses: Assessing the evidence. *Psychiatric Services*, 65, 429-441.

Chinman, M., Young, A. S., Hassell, J. & Davidson, L. (2006). Toward the implementation of mental health consumer provider services. *The Journal of Behavioral Health Services & Research*, 33(2), 176-195.

Clarke, C. (2009) An introduction to interpretative phenomenological analysis: A useful approach for occupational therapy. *British Journal of Occupational Therapy*, 72(1), 37-39.

- Clifton, A., Repper, J., Banks, D. & Remnant, J. (2013). Co-producing social inclusion: The structure/agency conundrum. *Journal of Psychiatric and Mental Health Nursing*, 20(6), 514-524.
- Collins, R., Firth, L. & Shakespeare, T. (2016). "Very much evolving": A qualitative study of the views of psychiatrists about peer support workers. *Journal of Mental Health*, 25(3), 278-283.
- Cook, J.A., Steigman, P., Pickett, S., Diehl, S., Fox, A., Shipley, P., MacFarlane, R., Grey, D.D. & Burke-Miller, J. K. (2012). Randomized controlled trial of peer-led recovery education using Building Recovery of Individual Dreams and Goals through Education and Support (BRIDGES). *Schizophrenia Research*, 136(1), 36-42.
- Cooper, M. (2009). Welcoming the Other: Actualising the humanistic ethic at the core of counselling psychology practice. *Counselling Psychology Review*, 24(3 & 4), 119-129.
- Cooper, M. & McLeod, J. (2011). *Pluralistic counselling and psychotherapy*. London, England: Sage Publications.
- Cronise, R. (2016). Collaborative learning: A next step in the training of peer support providers. *Psychiatric Rehabilitation Journal*, 39(3), 292-294.
- Cronise, R., Teixeira, C., Rogers, E. S. & Harrington, S. (2016). The peer support workforce: Results of a national survey. *Psychiatric Rehabilitation Journal*, 39(3), 211-221.
- Crotty, M. (1998). *The foundations of social research: Meaning and perspective in the research process*. London, England: Sage Publications Ltd.

- Curtis, L. C. (1999). *Modelling recovery: Consumers as service providers in behavioral healthcare*. National Council News. Rockville, MD: National Council for Community Behavioral Healthcare.
- Cutts, L.A. (2013). Considering a social justice agenda for counselling psychology in the UK. *Counselling Psychology Review*, 28, 2. 8-16.
- Dallos, R. & Stedman, J. (2009). Flying over the swampy lowlands: Reflective and reflexive practice. In R. Dallos and J. Stedman (Eds.) *Reflective practice in psychotherapy and counselling* (pp. 1-22). Berkshire, England: Open University Press.
- Daniels, A. S., Tunner, T. P., Powell, I., Fricks, L. & Ashenden, P., (2014) *Pillars of peer support – VI: Peer specialist supervision*. Retrieved 16th June 2016 from <http://www.pillarsofpeersupport.org/POPS2014.pdf>
- Davidson L. (2005). More fundamentally human than otherwise. *Psychiatry*, 68(3), 243-249.
- Davidson, L., Bellamy, C., Guy, K. & Miller, R. (2012). Peer support among persons with severe mental illnesses: A review of evidence and experience. *World Psychiatry*, 11(2), 123-128.
- Davidson, L., Chinman, M., Sells, D. & Rowe, M. (2006). Peer support among adults with serious mental illness: A report from the field. *Schizophrenia Bulletin*, 32(3), 443-450.
- Davidson, L., Roe, D., Andres-Hyman, R. & Ridgway, P. (2010). Applying stages of change models to recovery in serious mental illness: Contributions and limitations. *Israel Journal of Psychiatry & Related Sciences*, 47(3), 213-221.
- Davidson, L. & Rowe, M. (2008) *Peer support within criminal justice settings: The role of forensic peer specialists*. The CMHS National Gains Centre. Retrieved

20th June 2016 from <http://www.prainc.com/wp-content/uploads/2015/10/peer-support-criminal-justice-settings-role-forensic-peer-specialists.pdf>

Davidson, L., Sells, D., Sangster, S. & O'Connell, M. (2005). Qualitative studies of recovery: What can we learn from the person? In R. O. Ralph & P.W. Corrigan (Eds.) *Recovery in mental illness: Broadening our understanding of wellness* (pp. 147-170). Washington, DC: American Psychological Association.

Deacon, B. J. (2013). The biomedical model of mental disorder: A critical analysis of its validity, utility, and effects on psychotherapy research. *Clinical Psychology Review, 33*(7), 846-861.

Deegan, P. E. (1993). Recovering our sense of value after being labelled: Mentally ill. *Journal of Psychosocial Nursing and Mental Health Services, 31*(4), 7-9.

Department of Health. (2007). *Putting people first: A shared vision and commitment to the transformation of adult social care services*. London, England: Crown Copyright.

Department of Health. (2011). *No health without mental health: A cross-government mental health outcomes strategy for people of all ages*. London, England: Crown Copyright.

Division of Clinical Psychology. (2013). *The classification of behaviour and experience in relation to functional psychiatric diagnoses: Time for a paradigm shift. Division of clinical psychology position statement*. Leicester, England: British Psychological Society.

Doherty, I., Craig, T., Attafua, G., Boocock, A. & Jamieson-Craig, R. (2004). The consumer-employee as a member of a mental health assertive outreach team. II. Impressions of consumer-employees and other team members. *Journal of Mental Health, 13*(1), 71-81.

- Doughty, C. & Tse, S. (2011). Can consumer-led mental health services be equally effective? An integrative review of CLMH services in high-income countries. *Community Mental Health Journal*, 47(3), 252-266.
- Draucker, C. B., Martsof, D. S. & Poole, C. (2009). Developing distress protocols for research on sensitive topics. *Archives of Psychiatric Nursing*, 23(5), 343-350.
- Duffy, M. (1990). Counselling Psychology USA: Patterns of continuity and change. *Counselling Psychology Review*, 5(2), 8-12.
- Durrant, C., Clarke, I., Tolland, A. & Wilson, H. (2007). Designing a CBT service for an acute inpatient setting: a pilot evaluation study. *Clinical Psychology & Psychotherapy: An International Journal of Theory & Practice*, 14(2), 117-125.
- Dyble, G. L. (2012). *Going through the transition from being an end user to sort of the provider: Making sense of becoming a mental health peer support worker using interpretative phenomenological analysis*. (Unpublished Doctoral Thesis). University of Lincoln, Lincoln, England. Retrieved 16 April 2016 from http://eprints.lincoln.ac.uk/18965/1/___network.uni_staff_S2_jpartridge_hard_bound_thesis_%283%29.pdf
- Dyble, G., Tickle, A. & Collinson, C. (2014) From end user to provider: Making sense of becoming a peer support worker using interpretative phenomenological analysis. *Journal of Public Mental Health*, 13(2), 83-92.
- Eatough, V. & Smith, J. A. (2007). Interpretative phenomenological analysis. In C. Willig & W. Stainton Rogers (Eds.) *Handbook of qualitative research methods in psychology* (pp. 179-194). London, England: Sage Publications Ltd.

- Ellison, M. L., Belanger, L. K., Niles, B. L., Evans, L. C. & Bauer, M. S. (2018). Explication and definition of mental health recovery: A systematic review. *Administration and Policy in Mental Health and Mental Health Services Research*, 45(1), 91-102.
- Etherington, K. (2004). *Becoming a reflexive researcher - Using ourselves in research*. London, England: Jessica Kingsley Publishers.
- Faulkner, A. & Bassett, T. (2010). "A helping hand": Consultations with service users about peer support. London, England: Together.
- Fealy, G. M. (2004). "The good nurse": visions and values in images of the nurse. *Journal of Advanced Nursing*, 46(6), 649-656.
- Feeney, L., Jordan, I. & McCarron, P. (2013). Teaching recovery to medical students. *Psychiatric Rehabilitation Journal*, 36(1), 35-41.
- Finlay, L. (2003). Through the looking glass: Intersubjectivity and hermeneutic reflection. In L. Finlay & B. Gough (Eds.) *Reflexivity: A practical guide for researchers in health and social sciences*. (pp. 106-119). Oxford, UK: Blackwell.
- Gates, L. & Akabas, S. (2007). Developing strategies to integrate peer providers into the staff of mental health agencies. *Administration and Policy in Mental Health and Mental Health Services Research*, 34(3), 293-306.
- Gazzillo, F., Schimmenti, A., Formica, I., Simonelli, A. & Salvatore, S. (2017). Effectiveness is the gold standard of clinical research. *Research in Psychotherapy: Psychopathology, Process and Outcome*, 20(2). doi: 10.4081/ripppo.2017.278

- Gazzola, N., De Stefano, J., Audet, C. & Theriault, A. (2011). Professional identity among counselling psychology doctoral students: A qualitative investigation. *Counselling Psychology Quarterly*, 24(4), 257-275.
- Gerry, L., Berry, C. & Hayward, M. (2011). Evaluation of a training scheme for peer support workers. *Mental Health Practice*, 14, 24-29.
- van Gestel-Timmermans, H., Brouwers, E. P., van Assen, M. A. & van Nieuwenhuizen, C. (2012). Effects of a peer-run course on recovery from serious mental illness: a randomized controlled trial. *Psychiatric Services*, 63(1), 54-60.
- Gianakis, M. & Carey, T. A. (2011). An interview study investigating experiences of psychological change without psychotherapy. *Psychology and Psychotherapy: Theory, Research and Practice*, 84, 442–457.
- Gidugu, V., Rogers, E. S., Harrington, S., Maru, M., Johnson, G., Cohee, J. & Hinkel, J. (2015). Individual peer support: A qualitative study of mechanisms of its effectiveness. *Community Mental Health Journal*, 51(4), 445-452.
- Gillard, S. G., Edwards, C., Gibson, S. L., Owen, K. & Wright, C. (2013). Introducing peer worker roles into UK mental health service teams: A qualitative analysis of the organisational benefits and challenges. *BioMed Central Health Services Research*, 13, 188. <http://biomedcentral.com/1462-6963/13/188>. doi: 10.1186/1472-6963-13-188.
- Gillard, S., Foster, R., Gibson, S., Goldsmith, L., Marks, M. & White, S. (2017). Describing a principles-based approach to developing and evaluating peer worker roles as peer support moves into mainstream mental health services. *Mental Health and Social Inclusion*, 21(3), 133-143.
- Gillies, F. (2010). Being with humans: An evolutionary framework for the therapeutic relationship. In Milton, M. (ed.) *Therapy and beyond: Counselling psychology*

contributions to therapeutic and social issues. (pp. 73-87). Oxford, UK: John Wiley & Sons.

Gkouskos, S. (2016). Becoming a trainer. In B. Douglas, R. Woolfe, S. Strawbridge, E. Kasket & V. Galbraith (Eds.), *The handbook of counselling psychology*. (5th ed., pp. 600-615). London, England: Sage Publications Ltd.

Glaser, B. G. & Strauss, A. (1967). *Discovery of grounded theory: Strategies for qualitative research*. Mill Valley, California: Sociology Press.

Hage, S. M. (2003). Reaffirming the unique identity of counseling psychology: Opting for the “Road Less Traveled By”. *The Counseling Psychologist*, 31(5), 555-563.

Haigh, C. & Witham, G. (n.d.). Distress protocol for qualitative data collection. Retrieved October 19 2014, from <http://www2.mmu.ac.uk/media/mmuacuk/content/documents/rke/Advisory%20Distress%20Protocol.pdf>

Hale, E. D., Treharne, G. J. & Kitas, G. D. (2008). Qualitative methodologies II: A brief guide to applying interpretative phenomenological analysis in musculoskeletal care. *Musculoskeletal Care*, 6(2), 86-96.

Hammersley, M. (2008). *Questioning qualitative inquiry: Critical essays*. London, England: Sage Publications Ltd.

Hancock, N., Smith-Merry, J., Jessup, G., Wayland, S. & Kokany, A. (2018). Understanding the ups and downs of living well: the voices of people experiencing early mental health recovery. *BMC psychiatry*, 18(1), 121. doi: 10.1186/s12888-018-1703-1

Hauser, M. J., Commons, M. L., Bursztajn, H. J. & Gutheil, T. G. (1991). Fear of malpractice liability and its role in clinical decision making. In T. G. Gutheil,

- H. J. Bursztajn, A. Brodsky & V. Alexander (Eds.) *Decision making in psychiatry and the law* (pp. 209-226). Baltimore, MD, US: Williams & Wilkins Co.
- Health and Care Professions Council (HCPC). (2015). *Standards of proficiency: Practitioner psychologists*. London, England: HCPC.
- Heidemann, G., Cederbaum, J. A., Martinez, S. & LeBel, T. P. (2016). Wounded healers: How formerly incarcerated women help themselves by helping others. *Punishment & Society*, 18(1), 3-26.
- Hemsley, C.M. (2013). An enquiry into how counselling psychology in the UK is constructed as a profession within discipline-orientated publications. *Counselling Psychology Review*, 28(1),8–23.
- Henderson, A. (1995). Abused women and peer-provided social support: The nature and dynamics of reciprocity in a crisis setting. *Issues in Mental Health Nursing*, 16(2), 117-128.
- Henton, I. (2012). Practice-based research and counselling psychology: A critical review and proposal. *Counselling Psychology Review*, 27(3), 11-28.
- Hesse-Biber, S. N. & Leavy, P. (2010). *The practice of qualitative research*. London, England: Sage Publications Ltd.
- Hurley, J., Cashin, A., Mills, J., Hutchinson, M., Kozlowski, D. & Graham, I. (2018). Qualitative study of peer workers within the “Partners in Recovery” programme in regional Australia. *International Journal of Mental Health Nursing*, 27(1), 187-195.
- James, P. (2011). The centrality and consistency of counselling psychology: Before, during and after 2008. *Hellenic Journal of Psychology*, 8, 374-387.

- James, P. & Bellamy, A. (2010). Counselling psychology in the NHS. In R. Woolfe, S. Strawbridge, B. Douglas & W. Dryden (Eds.) *Handbook of counselling psychology*. (3rd ed., pp. 397- 415). London, England: Sage Publications Ltd.
- Jenkins, P. (1997). False or recovered memories? Legal and ethical implications for therapists. *British Journal of Guidance and Counselling*, 25(2), 199-215.
- Johnson, R. & Haigh, R. (2011). Social psychiatry and social policy for the 21st century: new concepts for new needs-the 'enabling environments' initiative. *Mental Health and Social Inclusion*, 15(1), 17-23.
- Johnson, G., Magee, C., Maru, M., Furlong-Norman, K., Rogers, E. S. & Thompson, K. (2014). Personal and societal benefits of providing peer support: A survey of peer support specialists. *Psychiatric Services*, 65(5), 678-680.
- Johnston, J. & Paley, G. (2013). Mirror mirror on the ward: Who is the unfairest of them all? Reflections on reflective practice groups in acute psychiatric settings. *Psychoanalytic Psychotherapy*, 27(2), 170-186.
- Jones Nielsen, J. D. & Nicholas, H. (2016). Counselling psychology in the United Kingdom. *Counselling Psychology Quarterly*, 29(2), 206-215.
- Jose, D., Lalitha, K., Gandhi, S. & Desai, G. (2015). Consumer perspectives on the concept of recovery in schizophrenia: A systematic review. *Asian Journal of Psychiatry*, 14, 13-18.
- Joseph, S. & Patterson, T. (2016). A practical guide to positive functioning assessment in clinical psychology. In A. M. Wood & J. Johnson (Eds.) *The Wiley handbook of positive clinical psychology* (pp. 47-56). Chichester, England: Wiley.
- Karpman, S. (1968). Fairy tales and script drama analysis. *Transactional Analysis Bulletin*, 7(26), 39-43.

- Keats, H., Cockersell, P., Johnson, R. & Maguire, N. (2012). *Psychologically informed services for homeless people (good practice guide)*. Retrieved 15 April 2016 from www.rjaconsultancy.org.uk/PIEconcept.html
- Kemp, V. & Henderson, A.R. (2012). Challenges faced by mental health peer support workers: Peer support from the peer supporter's point of view. *Psychiatric Rehabilitation Journal*, 35(4), 337-340.
- Kido, Y. & Kayama, M. (2017). Consumer providers' experiences of recovery and concerns as members of a psychiatric multidisciplinary outreach team: A qualitative descriptive study from the Japan Outreach Model Project 2011-2014. *PloS one*, 12(3), e0173330. doi: 10.1371/journal.pone.0173330
- Kilpatrick, E., Keeney, S. & McCauley, C. O. (2017). Tokenistic or genuinely effective? Exploring the views of voluntary sector staff regarding the emerging peer support worker role in mental health. *Journal of Psychiatric and Mental Health Nursing*, 24(7), 503.
- Krause, N. (2016). Providing emotional support to others, self-esteem, and self-rated health. *Archives of Gerontology and Geriatrics*, 65, 183-191.
- Kroenke, K., Spitzer, R. & Williams, J. (2001). The PHQ-9: Validity of a brief depression severity measure. *Journal of General Internal Medicine*, 16, 606-613
- Lambert., M.J. & Norcross, J.C. (2017). Psychotherapy integration for counselling psychology. In D. Murphy (ed.) *Counselling psychology: A textbook for study and practice*. (pp. 152-167). West Sussex, UK: John Wiley & Sons.
- Lane, D.A. (2016). Counselling Psychology in organisations: From problem fixing to emergence and growth. In B. Douglas, R. Woolfe, S. Strawbridge, E. Kasket

& V. Galbraith (Eds.) *The handbook of counselling psychology*. (4th ed., pp. 447-463). London, England: Sage Publications Ltd.

- Larsson, P., Brooks, O. & Loewenthal, D. (2012). Counselling psychology and diagnostic categories: A critical literature review. *Counselling Psychology Review*, 27(3), 55-67.
- Lawn, S., Delany, T., Pulvirenti, M., Smith, A. & McMillan, J. (2015). A qualitative study examining the presence and consequences of moral framings in patients' and mental health workers' experiences of community treatment orders. *BMC Psychiatry*, 15(1), 274. doi: 10.1186/s12888-015-0653-0
- Lawton-Smith, S. (2013). Peer support in mental health: Where are we today? *The Journal of Mental Health Training, Education and Practice*, 8(3), 152-158
- Leamy, M., Bird, V., Le Boutillier, C., Williams, J. & Slade, M. (2011). Conceptual framework for personal recovery in mental health: Systematic review and narrative synthesis. *The British Journal of Psychiatry*, 199(6), 445-452.
- Lloyd, C., Williams, P. L., Vilic, G. & Tse, S. (2017). Progressing recovery-oriented care in psychiatric inpatient units: Occupational therapy's role in supporting a stronger peer workforce. *Irish Journal of Occupational Therapy*, 45(2), 92-99.
- Lloyd-Evans, B., Mayo-Wilson, E., Harrison, B., Istead, H., Brown, E., Pilling, S., Johnson, S. & Kendall, T. (2014). A systematic review and meta-analysis of randomised controlled trials of peer support for people with severe mental illness. *BMC Psychiatry*, 14(1), 39. doi: 10.1186/1471-244X-14-39
- London Metropolitan University. (2014). *Code of good research practice*. Retrieved 6 June 2016 from <http://student.londonmet.ac.uk/media/london-metropolitanuniversity/london-met-documents/professional-service-departments/researchoffice/course-documents/Code-of-Good-Research-Practice.pdf>

- Loveland, D., Weaver Randall, K. & Corrigan, P. W. (2005). Research methods for exploring and assessing recovery. In R. O. Ralph & P. W. Corrigan (Eds.) *Recovery in mental illness: Broadening our understanding of wellness*. (pp.19-59). Washington, DC: American Psychological Association.
- Lysaker, P. H. & France, C. M. (1999). Psychotherapy as an element in supported employment for persons with severe and persistent mental illness. *Psychiatry*, 62(3), 209-221.
- MacLellan, J., Surey, J., Abubakar, I. & Stagg, H. R. (2015). Peer support workers in health: A qualitative metasynthesis of their experiences. *PloS One*, 10(10), e0141122. doi: 10.1371/journal.pone.0141122
- MacNeil, C. & Mead, S. (2003). Discovering the fidelity standards of peer support in an ethnographic evaluation. Retrieved 12 April 2015 from www.intentionalpeersupport.org/wp-content/uploads/2014/02/Discovering-the-Fidelity-Standards-of-Peer-Support-in-an-Ethnographic-Evaluation.pdf
- Mahlke, C. I., Priebe, S., Heumann, K., Daubmann, A., Wegscheider, K. & Bock, T. (2017). Effectiveness of one-to-one peer support for patients with severe mental illness: A randomised controlled trial. *European Psychiatry*, 42, 103-110.
- Mancini, M. A. (2007). A qualitative analysis of turning points in the recovery process. *American Journal of Psychiatric Rehabilitation*, 10(3), 223-244.
- Mancini, M. A. (2018). An exploration of factors that effect the implementation of peer support services in community mental health settings. *Community Mental Health Journal*, 54, 127-137.

- Mancini, M. A. & Rogers, R. (2007). Narratives of recovery from serious psychiatric disabilities: A critical discourse analysis. *Critical Approaches to Discourse Analysis across Disciplines*, 1(2), 35-50.
- Mann, B., Matias, E. & Allen, J. (2014). Recovery in forensic services: facing the challenge. *Advances in Psychiatric Treatment*, 20(2), 125-131.
- Martin, P. (2010). Training and professional development. In R. Woolfe, S. Strawbridge, B. Douglas and W. Dryden (Eds.) *Handbook of counselling psychology*. (3rd ed., pp. 547-568). London, England: Sage Publications Ltd.
- Marwaha, S. & Johnson, S. (2004). Schizophrenia and employment. *Social Psychiatry and Psychiatric Epidemiology*, 39(5), 337-349.
- Matthias, M. S., Salyers, M. P., Rollins, A. L. & Frankel, R. M. (2012). Decision making in recovery-oriented mental health care. *Psychiatric Rehabilitation Journal*, 35(4), 305-314.
- McAdams, D. P. (1993). *The stories we live by: Personal myths and the making of the self*. New York, NY: Guilford Press.
- McAdams, D. P. (2001). The psychology of life stories. *Review of General Psychology*, 5(2), 100-122.
- McConnell-Henry, T., Chapman, Y. & Francis, K. (2011). Member checking and Heideggerian phenomenology: A redundant component. *Nurse Researcher*, 18(2), 28-37.
- McLean, J., Biggs, H., Whitehead, I., Pratt, R. & Maxwell, M. (2009). *Evaluation of the delivering for mental health peer support worker pilot scheme*. Edinburgh, Scotland: Scottish Government Social Research.

- McLeod, J. (2003). *Doing counselling research*. London, England: Sage Publications Ltd.
- McLeod, J. (2011). *Qualitative research in counselling and psychotherapy*. London, England: Sage Publications Ltd.
- Mead, S., Hilton, D. & Curtis, L. (2001). Peer support: A theoretical perspective. *Psychiatric Rehabilitation Journal*, 25(2), 134-141.
- Mead, S. & MacNeil, C. (2006). Peer support: What makes it unique? *International Journal of Psychosocial Rehabilitation*, 10, (2), 29-37.
- Meehan, T., Vermeer, C. & Windsor, C. (2000). Patients' perceptions of seclusion: a qualitative investigation. *Journal of Advanced Nursing*, 31(2), 370-377.
- Mercer-Quinn, C. & Wright, H. (2017). The Recovery Focused Care Transfer (ReFleCT) pathway: Fostering optimism and hope with clients prior to discharge from secondary care. *Counselling Psychology Review*, 32(3), 4-13.
- Milton, A. C. & Mullan, B. A. (2015). A qualitative exploration of service users' information needs and preferences when receiving a serious mental health diagnosis. *Community Mental Health Journal*, 51(4), 459-466.
- Miyamoto, Y. & Sono, T. (2012). Lessons from peer support among individuals with mental health difficulties: A review of the literature. *Clinical Practice and Epidemiology in Mental Health*, 8, 22-29.
- Modini, M., Joyce, S., Mykletun, A., Christensen, H., Bryant, R. A., Mitchell, P. B. & Harvey, S. B. (2016). The mental health benefits of employment: Results of a systematic meta-review. *Australasian Psychiatry*, 24(4), 331-336.

- Moleski, S.M. & Kiselica, M.S. (2005). Dual relationships: A continuum ranging from the destructive to the therapeutic. *Journal of Counselling and Development, 83*, 3-11.
- Mollon, P. (2009). The NICE guidelines are misleading, unscientific, and potentially impede good psychological care and help. *Psychodynamic Practice, 15*(1), 9-24.
- Moran, G., Russinova, Z., Gidugu, V., Yim, J. Y. & Sprague, C. (2012). Benefits and mechanisms of recovery among peer-providers with psychiatric illnesses. *Qualitative Health Research, 22*(3), 304-319.
- Morgan, A. (2010). Discourse analysis: An overview for the neophyte researcher. *Journal of Health and Social Care Improvement, 1*, 1-7.
- Mourra, S., Sledge, W., Sells, D., Lawless, M. & Davidson, L. (2014). Pushing, patience, and persistence: Peer providers' perspectives on supportive relationships. *American Journal of Psychiatric Rehabilitation, 17*(4), 307-328.
- Mowbray, C. T., Moxley, D. P. & Collins, M. E. (1998). Consumers as mental health providers: First-person accounts of benefits and limitations. *The Journal of Behavioral Health Services and Research, 25*(40), 397-411.
- Mowbray, C. T., Moxley, D. P., Thrasher, S., Bybee, D., McCrohan, N., Harris, S. & Clover, G. (1996). Consumers as community support providers: Issues created by role innovation. *Community Mental Health Journal, 32*(1), 47-67.
- Mrdjenovich, A.J. & Moore, B.A. (2004). The professional identity of counselling psychologists in health care: A review and call for research. *Counselling Psychology Quarterly, 17*, 69-79.

- National Mental Health Commission. (2014). *The national review of mental health programmes and services*. Sydney, Australia: National Mental Health Commission.
- Nelson, J. B. (2015). The Karpman drama triangle and diabetes. *American Association of Diabetes Educators in Practice*, 3(1), 38-42.
- Nelson, S. K., Layous, K., Cole, S. W. & Lyubomirsky, S. (2016). Do unto others or treat yourself? The effects of prosocial and self-focused behavior on psychological flourishing. *Emotion*, 16(6), 850-861.
- Nelson, G., Ochocka, J., Janzen, R. & Trainor, J. (2006). A longitudinal study of mental health consumer/survivor initiatives: Part 2 — A quantitative study of impacts of participation on new members. *Journal of Community Psychology*, 34(3), 261–72.
- Nolte, A. G., Downing, C., Temane, A. & Hastings-Tolsma, M. (2017). Compassion fatigue in nurses: A metasynthesis. *Journal of Clinical Nursing*, 26(23-24), 4364-4378.
- Nugent, A., Hancock, N. & Honey, A. (2017). Developing and sustaining recovery-orientation in mental health practice: Experiences of occupational therapists. *Occupational Therapy International*, vol. 2017, Article ID 5190901. doi: 10.1155/2017/5190901.
- Nursing & Midwifery Council. (2015). *The code: Professional standards of practice and behaviour for nurses and midwives*. London, England: NMC. Retrieved 20 June 2017 from <http://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/revise-new-nmc-code.pdf>
- Ochocka, J., Nelson, G., Janzen, R. & Trainor, J. (2006). A longitudinal study of mental health consumer/survivor initiatives: Part 3 – A qualitative study of

- impacts of participation on new members. *Journal of Community Psychology*, 34(3), 273-288.
- Onken, S. J., Craig, C. M., Ridgway, P., Ralph, R. O. & Cook, J. A. (2007). An analysis of the definitions and elements of recovery: A review of the literature. *Psychiatric Rehabilitation Journal*, 31(1), 9-22.
- Passmore, K. & Leung, W. C. (2002). Defensive practice among psychiatrists: a questionnaire survey. *Postgraduate Medical Journal*, 78(925), 671-673.
- Percy, W. H., Kostere, K. & Kostere, S. (2015). Generic qualitative research in psychology. *The Qualitative Report*, 20(2), 76-85.
- Perkins, R. & Repper, J. (2016). Recovery versus risk? From managing risk to the co-production of safety and opportunity. *Mental Health and Social Inclusion*, 20(2), 101-109.
- Piat, M., Seida, K. & Sabetti, J. (2017). Understanding everyday life and mental health recovery through CHIME. *Mental Health and Social Inclusion*, 21(5), 271-279.
- Pietkiewicz, I. & Smith, J. A. (2014). A practical guide to using interpretative phenomenological analysis in qualitative research psychology. *Psychological Journal*, 20(1), 7-14.
- Pitt, V., Lowe, D., Hill, S., Prictor, M., Hetrick, S. E. & Ryan, R. (2013). Consumer-providers of care for adult clients of statutory mental health services. *Cochrane Database of Systematic Reviews* (3), CD004807.
doi:10.1002/14651858.CD004807.pub2
- Pringle, J., Drummond, J., McLafferty E. & Hendry, C. (2011). Interpretative phenomenological analysis: A discussion and critique. *Nurse Researcher*, 18(3), 20-24.

- Prochaska, J. & DiClemente, C. (1983). Stages and processes of self-change of smoking: Toward an integrative model of change. *Journal of Consulting and Clinical Psychology, 51*(3), 390-395.
- Prochaska, J. O., DiClemente, C. C. & Norcross, J. C. (1992). In search of how people change: Applications to the addictive behaviors. *American Psychologist, 47*, 1102-1114.
- Proudfoot, J. G., Jayawant, A., Whitton, A. E., Parker, G., Manicavasagar, V., Smith, M. & Nicholas, J. (2012). Mechanisms underpinning effective peer support: A qualitative analysis of interactions between expert peers and patients newly diagnosed with bipolar disorder. *BMC Psychiatry, 12*:196 doi:10.1186/1471-244X-12-196
- Radohl, T. (2016). Living a meaningful life with serious mental illness: Defining and understanding personal medicine. *Journal of the Society for Social Work and Research, 7*(2), 345-369.
- Reissman, F. (1965). The “helper” therapy principle. *Social Work, 10*(2), 27-32.
- Repper, J. & Carter, T. (2011). A review of the literature on peer support in mental health services. *Journal of Mental Health, 20*(4), 392-411.
- Ribeiro, A. P., Mendes, I., Stiles, W. B., Angus, L., Sousa, I. & Gonçalves, M. M. (2014). Ambivalence in emotion-focused therapy for depression: The maintenance of problematically dominant self-narratives. *Psychotherapy Research, 24*(6), 702-710.
- Roberts, T. (2013). Understanding the research methodology of interpretative phenomenological analysis. *British Journal of Midwifery, 21*, 215-218.

- Roberts, G. & Boardman, J. (2013). Understanding “recovery”. *Advances in Psychiatric Treatment*, 19, 400-409.
- Rooney, K. (Ed.). (1999). *Encarta world English dictionary*. London: Bloomsbury Publishing.
- Rooney, J. M., Miles, N. & Barker, T. (2016). Patients’ views: Peer support worker on inpatient wards. *Mental Health and Social Inclusion*, 20(3), 160-166.
- Rose, D. (2014). The mainstreaming of recovery. *Journal of Mental Health* 23(5), 217-218.
- Saavedra, J., López, M., Gonzáles, S. & Cubero, R. (2016). Does employment promote recovery? Meanings from work experience in people diagnosed with serious mental illness. *Culture, Medicine, and Psychiatry*, 40(3), 507-532.
- Sabin J. E. & Daniels N. (2003). Managed care: Strengthening the consumer voice in managed care: VII. The Georgia Peer Specialist Program. *Psychiatric Services*, 54, 497-498.
- Salvatore, G., Dimaggio, G. & Semerari, A. (2004). A model of narrative development: Implications for understanding psychopathology and guiding therapy. *Psychology and Psychotherapy: Theory, Research and Practice*, 77, 231–254.
- Salyers, M. P. & Macy, V. R. (2005). Recovery-oriented evidence-based practices: A commentary. *Community Mental Health Journal*, 41(1), 101-103.
- Schaufeli, W. & Buunk, B. P. (2003). Burnout: An overview of 25 years of research and theorizing. In M. J. Schabracq, J. A. M. Winnubst & C. L. Cooper (Eds.), *Handbook of work and health psychology* (pp. 383– 425). Chichester, England: Wiley.

- Schutz, A. (1967). *The phenomenology of the social world*. Illinois, IL: Northwestern University Press.
- Schwartz, C. E. & Sendor, R. M. (1999). Helping others helps oneself: Response shift effects in peer support. *Social Science & Medicine*, 48(11), 1563-1575.
- Secker, J. & Membrey, H. (2003). Promoting mental health through employment and developing healthy workplaces: The potential of natural supports at work. *Health Education Research*, 18(2), 207-215.
- Sequeira, H. & Van Scoyoc, S. (2004). Discussion paper on psychological testing. *Counselling Psychology Review*, 19(2), 37 - 40.
- Shaw, R. (2001). Why use interpretative phenomenological analysis in health psychology? *Health Psychology Update*, 10(4), 48-52.
- Shepherd, C., Reynolds, F. A. & Moran, J. (2010). "They're battle scars, I wear them well": A phenomenological exploration of young women's experiences of building resilience following adversity in adolescence. *Journal of Youth Studies*, 13(3), 273-290.
- Shinebourne, P. (2011). The theoretical underpinnings of interpretative phenomenological analysis (IPA). *Existential Analysis*, 22(1), 16-31.
- Silverman, D. (2000). *Doing qualitative research*. London, England: Sage Publications Ltd.
- Silverman, D. (2006). *Interpreting qualitative data: Methods for analysing talk, text and interaction*. London, England: Sage Publications Ltd.
- Sims, C. (2010). Counselling psychology in forensic settings. In R. Woolfe, S. Strawbridge, B. Douglas & W. Dryden (Eds.) *Handbook of counselling psychology*. (3rd ed., pp. 454-465). London, England: Sage Publications Ltd.

- Skills for Health (2011). *Peer support roles in the mental health workforce - Examples of current practice: Recognising the benefits of “lived” experience*. Bristol, England: Skills for Health. Retrieved 15 April 2015 from http://www.skillsforhealth.org.uk/component/docman/doc_view/1845-peer-support-report09-2011.html
- Slade, M. (2009). *Personal Recovery and Mental Illness: A Guide for Professionals*. Cambridge, England: Cambridge University Press.
- Slade, M. (2017). Implementing shared decision making in routine mental health care. *World Psychiatry, 16*, 146-153.
- Slade, M., Amering, M., Farkas, M., Hamilton, B., O'Hagan, M., Panther, G., Perkins, R., Shepherd, G., Tse, S. & Whitley, R. (2014). Uses and abuses of recovery: Implementing recovery-oriented practices in mental health systems. *World Psychiatry, 13*(1), 12-20.
- Slade, M., Bird, V., Le Boutillier, C., Farkas, M., Grey, B., Larsen, J., Leamy, M., Oades, L. & Williams, J. (2015). Development of the REFOCUS intervention to increase mental health team support for personal recovery. *The British Journal of Psychiatry, 207*(6), 544-550.
- Slade, M., Leamy, M., Bacon, F., Janosik, M., Le Boutillier, C., Williams, J. & Bird, V. (2012). International differences in understanding recovery: Systematic review. *Epidemiology and Psychiatric Sciences, 21*(4), 353-364.
- Slade, M. & Longden, E. (2015). Empirical evidence about recovery and mental health. *BMC Psychiatry, 15*(1), 285. doi: 10.1186/s12888-015-0678-4
- Slade, M. & Wallace, G. (2017). Recovery and Mental Health. In M. Slade, L. Oades & A. Jarden (Eds.) *Wellbeing, recovery and mental health* (pp. 24-34). Cambridge, England: Cambridge University Press.

- Slade, M., Williams, J., Bird, V., Leamy, M. & Le Boutillier, C. (2012). Recovery grows up. *Journal of Mental Health, 21*(2), 99-103.
- Smith, J. A. (1984). The problem of criteria for judging interpretive inquiry. *Educational Evaluation and Policy Analysis, 6*(4), 379–91.
- Smith, J. A. (1996). Beyond the divide between cognition and discourse: Using interpretative phenomenological analysis in health psychology. *Psychology and Health, 11*, 261-271.
- Smith, J. A. (2011). Evaluating the contribution of interpretative phenomenological analysis. *Health Psychology Review, 5*(1), 9-27
- Smith, J. A., Flowers, P. & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. London, England: Sage Publications Ltd.
- Smith, J. A., Harré, R. & Van Langenhove, L. (1995). Idiography and the case study. In J. A. Smith, R. Harré & L. Van Langenhove (Eds.) *Rethinking psychology* (pp. 59-69). London, England: Sage Publications Ltd.
- Smith, J. A., Jarman, M. & Osborn, M. (1999). Doing interpretative phenomenological analysis. In D. M. Murray & K. Chamberlain (Eds.) *Qualitative health psychology: Theories and methods* (pp. 218-240). London, England: Sage Publications Ltd.
- Smith, J. & Osborn, M. (2008). Interpretative phenomenological analysis. In J. Smith, (Ed.) *Qualitative psychology: A practical guide to research methods*. (pp. 53-80). London, England: Sage Publications Ltd.

- Smith-Merry, J., Sturdy, S. & Freeman, R. (2010). *Recovering mental health in Scotland. "Recovery" from social movement to policy goal*. Louvain-la-Neuve, Belgium: Universite Catholique de Louvain.
- Sodeke-Gregson, E. A., Holttum, S. & Billings, J. (2013). Compassion satisfaction, burnout, and secondary traumatic stress in UK therapists who work with adult trauma clients. *European Journal of Psychotraumatology*, 4(1), 21869. doi: 10.3402/ejpt.v4i0.21869
- Solomon, P. (2004). Peer support/peer provided services underlying processes, benefits, and critical ingredients. *Psychiatric Rehabilitation Journal*, 4, 392-401.
- Spitzer, R., Kroenke, K., Williams, J. & Lowe, B. (2006). A brief measure for assessing generalized anxiety disorder. *Archives of Internal Medicine*, 166, 1092-1097.
- Steger, M. F. (2017). Meaning in life and wellbeing. In M. Slade, L. Oades & A. Jarden (Eds.) *Wellbeing recovery and mental health*. (pp. 75-85). Cambridge, England: Cambridge University Press.
- Stickley, T. & Wright, N. (2011). The British research evidence for recovery, papers published between 2006 and 2009 (inclusive). Part One: A review of the peer-reviewed literature using a systematic approach. *Journal of Psychiatric and Mental Health Nursing*, 18(3), 247-256.
- Strawbridge, S. & Woolfe, R. (2003). Counselling psychology in context. In R. Woolfe, W. Dryden & S. Strawbridge (Eds.) *Handbook of counselling psychology*. (2nd ed., pp 3-21). London, England: Sage Publications Ltd.
- Strawbridge, S. & Woolfe, R. (2010). Counselling psychology: Origins, developments and challenges. In R. Woolfe, S. Strawbridge, B. Douglas & W. Dryden, (Eds)

Handbook of counselling psychology. (3rd ed., pp 3-22). London, England: Sage Publications Ltd.

Stuart, S.R., Tansey, L. & Quayle, E. (2017). What we talk about when we talk about recovery: A systematic review and best-fit framework synthesis of qualitative literature. *Journal of Mental Health*, 26(3), 291-304.

Suzy Lamplugh Trust. (2014). Personal safety at work: Lone working. [Leaflet]. Retrieved 12 April 2015 from <https://www.suzylamplugh.org/forms/leaflets/>

Taylor, R. R. (2008). *The intentional relationship: Occupational therapy and use of self*. Philadelphia, PA: F. A. Davis Company.

Thorne, A. (2000). Personal memory telling and personality development. *Personality and Social Psychology Review*, 4(1), 45-56.

Tickle, A., Brown, D. & Hayward, M. (2014). Can we risk recovery? A grounded theory of clinical psychologists' perceptions of risk and recovery-oriented mental health services. *Psychology and Psychotherapy: Theory, Research and Practice*, 87(1), 96-110.

Torrissen, W. & Stickley, T. (2018). Participatory theatre and mental health recovery: A narrative inquiry. *Perspectives in Public Health*, 138(1), 47-54.

Urquhart, C. (2013). *Grounded theory for qualitative research*. London, England: Sage Publications Ltd.

Vandewalle, J., Debyser, B., Beeckman, D., Vandecasteele, T., Deproost, E., Van Hecke, A. & Verhaeghe, S. (2018). Constructing a positive identity: A qualitative study of the driving forces of peer workers in mental health-care systems. *International Journal of Mental Health Nursing*, 27(1), 378-389.

- Vandewalle, J., Debyser, B., Beeckman, D., Vandecasteele, T., Van Hecke, A. & Verhaeghe, S. (2016). Peer workers' perceptions and experiences of barriers to implementation of peer worker roles in mental health services: A literature review. *International Journal of Nursing Studies*, 60, 234-250.
- Varpio, L., Ajjawi, R., Monrouxe, L. V., O'Brien, B. C. & Rees, C. E. (2017). Shedding the cobra effect: Problematizing thematic emergence, triangulation, saturation and member checking. *Medical Education*, 51(1), 40-50.
- Vassilev, I. & Pilgrim, D. (2007). Risk, trust and the myth of mental health services. *Journal of Mental Health*, 16(3), 347-357.
- Vayshenker, B., Mulay, A. L., Gonzales, L., West, M. L., Brown, I. & Yanos, P. T. (2016). Participation in peer support services and outcomes related to recovery. *Psychiatric Rehabilitation Journal*, 39(3), 274-281.
- Waldemar, A. K., Esbensen, B. A., Korsbek, L., Petersen, L. & Arnfred, S. (2018). Recovery orientation in mental health inpatient settings: Inpatient experiences? *International Journal of Mental Health Nursing*, 27(3), 1177-1187.
- Walker, G. & Bryant, W. (2013). Peer support in adult mental health services: A metasynthesis of qualitative findings. *Psychiatric Rehabilitation Journal*, 36(1), 28-34.
- Walsh, F. & Tickle, A. (2013). Working towards recovery: The role of employment in recovery from serious mental health problems: A qualitative metasynthesis. *International Journal of Psychosocial Rehabilitation*, 17(2), 35-49.
- Warner, S. (2004). Contingent morality and psychotherapy research: Developing applicable frameworks for ethical processes of enquiry. *British Psychological Society Psychotherapy Section Newsletter*, 36, 11-21.

- Watson, E. (2014). A day in the life of a Peer Support Worker: training day. *Mental Health and Social Inclusion*, 18(3), 116-119.
- Webb, C. & Kevern, J. (2001). Focus groups as a research method: a critique of some aspects of their use in nursing research. *Journal of Advanced Nursing*, 33(6), 798-805.
- White, H., Whelan, C., Barnes, J. D. & Baskerville, B. (2003). Survey of consumer and non-consumer mental health service providers on assertive community treatment teams in Ontario. *Community Mental Health Journal*, 39(3), 265 - 276. doi:10.1023/A:1023398525070
- Whitwell, D. (1999). The myth of recovery from mental illness. *Psychiatric Bulletin*, 23, 621-622.
- Willig, C. (2008). *Introducing qualitative research in psychology*. Buckingham, England: Open University Press.
- Woolfe, R. (1990). Counselling psychology in Britain: An idea whose time has come. *The Psychologist*, 3(12), 531-535.
- Woolfe, R. (2016). Mapping the world of helping: The place of counselling psychology. In B. Douglas, R. Woolfe, S. Strawbridge, E. Kasket & V. Galbraith (Eds.) *The handbook of counselling psychology*. (4th ed., pp. 5-19). London, England: Sage Publications Ltd.
- Wroblewski, T., Walker, G., Jarus-Hakak, A. & Suto, M. J. (2015). Peer support as a catalyst for recovery: A mixed-methods study/Le soutien par les pairs comme catalyseur du rétablissement : Une étude à méthodologie mixte. *The Canadian Journal of Occupational Therapy*, 82(1), 64-73.

Wykes, T., Csipke, E., Williams, P., Koeser, L., Nash, S., Rose, D., Craig, T. & McCrone, P. (2018). Improving patient experiences of mental health inpatient care: a randomised controlled trial. *Psychological Medicine*, 48(3), 488-497.

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology & Health*, 15(2), 215-228.

Zerubavel, N. & O'Dougherty Wright, M. (2012). The dilemma of the wounded healer. *Psychotherapy*, 49(4), 482-491.

Appendices

Appendix A	Research flyer	page 142
Appendix B	Letter to participants	page 143
Appendix C	Consent form	page 146
Appendix D	Demographic form	page 147
Appendix E	Interview guide	page 148
Appendix F	GAD-7 and PHQ-9	page 150
Appendix G	Distress protocol	page 153
Appendix H	Ethics	page 154
	Email from Health Research Committee	page 155
Appendix I	Quality assurance	page 157
Appendix J	Example of transcripts with themes	page 158
	Themes identified for one participant	page 164
Appendix K	Advice from participants	page 171

Appendix A – Research flyer

Research Investigating the Experiences of Peer Support Workers Employed in Mental Health Services

My name is Michelle Mackin and I am looking for participants for my study into the experiences of peer support workers employed in mental health services. In particular I am interested in understanding the experience of providing help after receiving help, and what the role means in terms of the individual's recovery.

The research will involve an interview of approximately 1 hour.

The research is to be carried out as part of my counselling psychology doctorate. The idea for this research developed out of my interest in service user involvement and my experience working in the Health Service.

If you are interested in participating, you may contact me either by email or phone.

Many thanks

Michelle Mackin

Email: [REDACTED]

Tel: [REDACTED]

Appendix B – Letter to participants

Dear

Re: Study into the experiences of Peer Support Workers employed in mental health service.

Thank you for your interest in this study. Before you decide whether to participate, it is important that you fully understand what the research involves. This letter is intended to provide the relevant information, but if you require any clarification please do not hesitate to contact me. I have also enclosed a copy of the consent form which you will be required to sign.

Aims of the research:

I am currently attending London Metropolitan University, studying towards a Professional Doctorate in Counselling Psychology. This study will be submitted to London Metropolitan University in September 2016 as the doctoral thesis component of the course. My academic supervisor is Dr Angela I. Loulopoulou (Principal Lecturer and Course Leader, Professional Doctorate in Counselling Psychology).

The aims of the study are:

- To explore peer support workers' experiences in relation to the work they do and the service they work within (How do they experience mental health services from within?)
- To explore what the work means in terms of their own recovery.
- To consider whether they felt prepared and supported in carrying out the role?
- To gain insight into how this research can then inform the level of support, training and supervision needed by those employed in this role?

What is expected if you participate?

It is entirely your decision whether or not you participate. If you do decide to participate, it is important to remember that you can withdraw from the study any time prior to the interview, any time during the interview, and up to four weeks after the interview. If at any time following your decision to participate you have any concerns, you are welcome to contact me for further discussion.

If you go ahead with the study then I will contact you to arrange a suitable and convenient time for the interview (within office hours). Before commencing the interview I will clarify any questions you have and will go through the consent form with you.

The interview will take approximately 1 hour and will be audio recorded. After the interview the recording will be transferred to an encrypted computer and will be password protected. In addition, codes will be used for filenames (rather than your name). The recording will then be transcribed. Codes will be used for the transcriptions, and the transcriptions themselves will be stored in a locked filing cabinet. Personal information and any details which may identify you will be changed within the transcriptions.

Confidentiality

The procedures followed in relation to the recordings and transcriptions are intended to protect your confidentiality. Information that you tell me will only be used for the purposes of this research. Your personal details will be kept confidential and no-one will be aware of what information you have told me.

It is important to remember though that there are limits to the confidentiality offered. That is, if there is evidence that your safety, or another person's safety is at risk, then I would need to act on this information. Where possible I will discuss this with you first.

Direct quotations will be included within the thesis. However, these quotes will be anonymised so that you will not be able to be identified from the quotes used.

The data obtained from the interview will be archived for the purpose of further evaluation and research as required by the publishers of the study. After the agreed retention period expires, the data will be securely destroyed.

Should you wish to withdraw from the study then the data and information obtained will be immediately destroyed.

Potential risks and benefits of participating

It is unlikely that there will be any risk in participating in this study. However, it is possible that exploring and discussing your experiences may result in you feeling upset or distressed. If you do feel upset at any point we will be able to have a break and/or suspend the interview. Remember that you do not have to continue, and so if you feel upset and do not wish to continue you can easily withdraw your consent to participate.

In terms of benefits, you may find it interesting and helpful to discuss your experiences. In addition, your experiences will contribute to the knowledge base and understanding of peer support workers experiences.

Suitability for taking part in the study

In order to take part in this study you need to have been employed as a peer support worker for at least 3 months.

The role of peer support worker means that you will have had your own experience of mental health problems. However, participating in the study may not be helpful to you if you have any current difficulties. Therefore, prior to starting the interview I will ask you to complete a GAD-7 and PHQ-9

screening questionnaire in order to see whether you have any current problems which might mean that participating in the study will not be helpful to you.

If the screening questionnaires reveal any current problems it may be that I advise you to discuss this with either your GP or another service which can be of help to you. We will have time to discuss this.

Hopefully this letter will have given you an overview of the research and what will be expected of you if you do decide to participate.

If you are interested in participating in the study, or if you just want to discuss this letter in more detail, then please contact me either by email or telephone.

Yours sincerely

Michelle Mackin

Encs consent form

PHQ-9

GAD-7

Appendix C – Consent form

Consent to Participate in Research Study

- I confirm that I have read and understood the information letter and have had the opportunity to ask questions
- I understand that my participation is voluntary and I am able to withdraw at any time up until the submission date (September 2016)
- I agree to the interview being audio-recorded
- I agree to the inclusion of direct quotes (these will be anonymised)
- I consent to the processing of my personal information for the purposes of this research project. I understand that such information will be treated in accordance with the terms of the Data Protection Act (1998)
- I understand that data will be archived to enable further investigation by other researchers e.g. for the purposes of meta-analysis. Data will be destroyed when retention periods required by publishers for this purpose are completed.
- I understand that it will be possible to withdraw consent up to four weeks following the interview.
- If I decide to withdraw my consent, and request to be omitted from the data analysis, then all data and forms will be immediately destroyed in a secure manner.
- I have read this consent form. My questions have been answered. My signature on this form indicates that I understand the information and I consent to participate in this study

Signature of participant/Date

Signature of researcher/Date

Name of participant

Name of researcher

Appendix D – Demographic form

Demographic Details:

Participant number:

Gender	Female <input type="checkbox"/>	Male <input type="checkbox"/>	Do not wish to disclose <input type="checkbox"/>

Age	Do not wish to disclose <input type="checkbox"/>
------------	--

Ethnicity:				
White	White British <input type="checkbox"/>	White Irish <input type="checkbox"/>	White other <input type="checkbox"/>	
Mixed race	White & Black Caribbean <input type="checkbox"/>	White & Black African <input type="checkbox"/>	White & Asian <input type="checkbox"/>	Other mixed background <input type="checkbox"/>
Asian or Asian British	Indian <input type="checkbox"/>	Bangladeshi <input type="checkbox"/>	Pakistani <input type="checkbox"/>	Other Asian background <input type="checkbox"/>
Black or Black British	Caribbean <input type="checkbox"/>	African <input type="checkbox"/>	Black Other <input type="checkbox"/>	
Chinese or other ethnicity	Chinese <input type="checkbox"/>	Other <input type="checkbox"/> (please specify)		
I do not wish to disclose <input type="checkbox"/>				

What setting have you worked in as a PSW?		Do not wish to disclose <input type="checkbox"/>
--	--	--

How long have you worked as a PSW?		Do not wish to disclose <input type="checkbox"/>
---	--	--

Appendix E – Interview guide

Interview procedure

- Researcher introduces self.
- The aims of the study are explained and discussed.
- Information on the consent form is explained and discussed. Researcher will give ample time for any questions or clarification in order to ensure that the participant has a full understanding of each section of the form.
- Signed consent is obtained.
- The voluntary nature of the participation will be reiterated and it will be made clear that they can withdraw their consent at any time.
- Proceed with recorded interview.
- Participants will be encouraged to talk about what is important to them in relation to their experiences. Prompts to be used from the interview guide if necessary.

Possible Questions & Prompts

Can you tell me how you became a Peer Support Worker?

Prompts - How long have you been working in this role?

What was your journey to becoming a Peer Support Worker?

Can you tell me about your experience of being a peer support worker working in mental health services?

Prompts - Can you describe what your work involves?

What aspects of this work are particularly meaningful to you?

What aspects of this work are particularly challenging?

What is your understanding of “recovery”?

Prompts - How do your views now compare to your understanding prior to working as a Peer Support Worker?

What do you think is a useful way of understanding mental health and some of the problems people have?

What has been unhelpful?

What does this work mean in terms of your own recovery?

Prompts - What changes (if any) have you noticed within yourself as a consequence of this work?

Have you learned anything about yourself since you began this work?

Is there anything you do differently because of your work?

How do you feel this work has affected you personally?

What has your experience been regarding the training and support provided during your work?

Prompts - What support do you feel you need to perform this role effectively?

Do you feel that you get that support?

What would you tell someone who was considering working as a Peer Support Worker?

Is there anything else you feel important to add?

Appendix F – GAD-7 & PHQ-9
GAD-7 Anxiety

Over the <u>last 2 weeks</u>, how often have you been bothered by the following problems? <i>(Use “✓” to indicate your answer”)</i>	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

Column totals: ___ + ___ + ___ + ___

= Total Score _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all

Somewhat difficult

Very difficult

Extremely difficult

From the Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD PHQ). The PHQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues. For research information, contact Dr. Spitzer at rls8@columbia.edu. PRIME-MD® is a trademark of Pfizer Inc. Copyright© 1999 Pfizer Inc. All rights reserved. Reproduced with permission

PHQ-9 Depression

Over the last 2 weeks, how often have you been bothered by any of the following problems?

(Please circle your answer).

	Not all	at Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things.....	0	1	2	3
2. Feeling down, depressed, or hopeless.....	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.....	0	1	2	3
4. Feeling tired or having little energy.....	0	1	2	3
5. Poor appetite or overeating.....	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down.....	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.....	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual.....	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way.....	0	1	2	3

Column totals ___ + ___ + ___ + ___

= Total Score _____

From the Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD PHQ). The PHQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues. For research information, contact Dr. Spitzer at rls8@columbia.edu. PRIME-MD® is a trademark of Pfizer Inc. Copyright© 1999 Pfizer Inc. All rights reserved. Reproduced with permission

Scoring notes.

- **PHQ-9 Depression Severity**

Scores represent: **0-5 = mild 6-10 = moderate 11-15 = moderately severe
16-20 = severe depression**

- **GAD-7 Anxiety Severity.**

This is calculated by assigning scores of 0, 1, 2, and 3, to the response categories of “not at all,” “several days,” “more than half the days,” and “nearly every day,” respectively. GAD-7 total score for the seven items ranges from 0 to 21.

Scores represent: **0-5 mild 6-10 moderate 11-15 moderately severe anxiety
15-21 severe anxiety.**

Appendix G: Distress protocol

Distress protocol	
Distress	<p>Participants states that the interview is too stressful or voices that it is difficult for them.</p> <p>Behaviours can be observed which indicate distress e.g. becoming tearful, speech becoming incoherent, looking fearful, becoming quiet etc.</p>
Stage 1 Response	<ol style="list-style-type: none"> 1. Stop the interview 2. Offer support and allow the participant to become calmer 3. Assess mental state – <ul style="list-style-type: none"> • What are their thoughts and feelings? • Do they feel able to continue with their day? • What strategies can they use to look after themselves?
Review	<p>Does the participant wish to continue?</p> <p>If so resume the interview reminding the participant they can stop at any time they wish and/or have a break.</p> <p>If the participant does not wish to continue, or if they continue to be distressed so that they are unable to carry on then move to stage 2 response.</p>
High distress/ continued distress.	<p>If the participant experiences high levels of distress which continue – (for instance panic attack, hyperventilating, and continued crying) beyond which would be expected, then move to Stage 2 response.</p>
Stage 2 Response	<ol style="list-style-type: none"> 1. Stop the interview/do not resume the interview. 2. Offer support and reassurance. 3. Encourage the participant to participate in grounding techniques e.g. focusing on objects in the room, describing what they can see in the room, trying to remember their phone number backwards (to move their attention away from distressing content of thoughts). 4. Discuss with the participant what support they have available to them. 5. Ask if they need to phone someone e.g. family member, friend. 6. Assess any risks – e.g. is participant voicing thoughts of harming self and act as appropriate (encouraging them to contact GP or other care provider for further assessment). 7. If there are concerns of an imminent nature, then offer (with participant consent) to contact GP or other health care provider for advice.
Follow up	<p>Offer a follow up phone call if participant wishes and/or</p> <p>Encourage the participant to contact the researcher if they have any further questions or concerns relating to the interview.</p>
<p>Distress protocol modified from: Drauker, C.B., Martsof, D.S. & Poole, C. (2009) Developing distress protocols for research on sensitive topics. <i>Archives of Psychiatric Nursing</i>, 23 (5): 343-350. Haigh, C. & Witham, G. (nd) Distress Protocol for Qualitative Data Collection. Retrieved 19th October 2014, from: http://www2.mmu.ac.uk/media/mmuacuk/content/documents/rke/Advisory%20Distress%20Protocol.pdf</p>	

Appendix H: Ethics LMU Research Ethics Confirmation



London Metropolitan University,
School of Psychology,
Research Ethics Review Panel

I can confirm that the following project has received ethical approval by one anonymous Reviewer, the Head of School of Psychology and the Dean of the FLSC to proceed with the following research study (Professional doctorate):

Title: Mental Health and Recovery - Experiences of Peer Support Workers Employed in Mental Health Services

Student: **Ms Michelle Mackin**

Supervisor: *Dr. Angela Loulopoulou*

Ethical clearance to proceed has been granted providing that the study follows the most recent Ethical guidelines to dated used by the School of Psychology and British Psychological Society, and follows the above proposal in detail.

The researcher and her supervisor are responsible for conducting the research and should inform the Ethics panel if there are any substantive changes to the project that could affect its ethical dimensions, and re-submit the proposal if it is deemed necessary.

Signed:

A handwritten signature in black ink, appearing to read "Lange-Küttner".

Date: 5 January 2015

Prof Dr Chris Lange-Küttner
(Chair - School of Psychology Research Ethics Review Panel)

Email c.langekuettner@londonmet.ac.uk

Contact with NHS Ethics Committee:

From: [REDACTED] - (HEALTH RESEARCH AUTHORITY)
Sent: 24 March 2015 09:18
To: Mackin Michelle
Subject: RE: Advice regarding ethics approval

Dear Michelle

Thank you for your email. Research involving NHS staff is exempt from REC review, regardless of the staff's medical experiences.

Best wishes,
Rachel.



[REDACTED] | REC Manager

Health Research Authority

[REDACTED]
E: [REDACTED] | T: 0161 625 7827

HRA NRES Centre [REDACTED] | www.hra.nhs.uk

IMPORTANT – [Click here](#) for details of significant changes to the REC booking and submission process

The HRA is keen to know your views on the service you received – our short feedback form is available [here](#)

From: Mackin Michelle [REDACTED]
Sent: 23 March 2015 12:45
To: [REDACTED] - (HEALTH RESEARCH AUTHORITY)
Subject: Advice regarding ethics approval

Dear Ethics Committee

I have recently spoken with Dr [REDACTED], (Research Manager [REDACTED]) regarding some research I am planning. He suggested I contact the coordinator of a local ethics committee to seek advice.

I have recently started working for [REDACTED] so I am new to the Trust. I am a qualified Counselling Psychologist and I am enrolled on a "Top up" Doctorate at the London Metropolitan University. The research I want to carry out is a qualitative study exploring the experiences of Peer Support Workers employed in the NHS. Peer Support Workers will have past experience of mental health problems. I will be excluding any participants who have current mental health problems.

When I spoke with [REDACTED], he said that I do not have to submit a Research Ethics Committee request via IRAs because the research is with members of NHS staff and research involving staff doesn't need to go via an Ethics Committee. However, he said to check with an Ethics Committee informally first because of the fact that to be a Peer Support Worker the

participants will have had some personal experience of mental health problems and past involvement of services.

Any advice or guidance would be helpful.

Regards

Michelle

Michelle Mackin
Counselling Psychologist

Appendix I: Quality assurance

<i>Qualities</i>	<i>Examples</i>	<i>This study</i>
<i>Sensitivity to context</i>	Theoretical; relevant literature; empirical data; sociocultural setting; participants' perspectives; ethical issues	Carried out literature review situating this study within the context of previous research Made own position clear through reflexive comments Attended to and acknowledged power dynamics within the researcher-participant relationship Ethics considered – detailed in methodology Used verbatim extracts to support identified themes
<i>Commitment and rigour</i>	In-depth engagement with topic; methodological competence/skill; thorough data collection; depth/breadth of analysis	Detailed process of recruitment, interviews and analysis Engaged in in-depth analysis of the data and developed themes detailed in the results section Checked themes with colleagues Engaging in supervision Using quotes to highlight themes
<i>Transparency and coherence</i>	Clarity and power of description/argument; transparent methods and data presentation; fit between theory and method: reflexivity.	Explanation of why I chose topic in introduction Being clear within the methodology section as to why I chose IPA and qualitative method Maintaining a reflective journal and using this to include reflexive comments within the written study The written study demonstrates a coherent account of the research undertaken – each section demonstrates relevance
<i>Impact and importance</i>	Theoretical (enriching understanding); sociocultural; practical (for community, policy makers, health workers).	Topic is of relevance to psychology within NHS services Will help to raise awareness of recovery for counselling psychologists Discussion section highlights implications to services and the field of counselling psychology.

Characteristics of good research (adapted from Yardley, 2000, p. 219)

Appendix J: Examples of transcripts with themes

	VN680126	
Other patients were a huge support to me 98	97 shortages and ... it was a dreadful dreadful experience. And I actually found the patients in there were a huge support to me, and me to them ... and I think that's how I survived my time in there with the other patients, even though they were in bad places themselves ... but I found there was somebody actually understood me and listened to me. So then after I left I had made a decision to leave my job which I'd worked in for 28 years – I was medically retired actually out of it. Then I got involved with service user involvement work and I was told that the trust were considering employing peer support workers, and I thought mm, that's something I'd really like to do. My family were very much against me doing it, cos I had gone from strength to strength with my own recovery and really became a new person, and discharged and everything from the services. But they were really really concerned that this would set me back.	Repetition of words for emphasis. The other patients helped her to "survive" the experience of being on the ward. This talk about the ward is relevant to me as I currently work on a ward. The participant is not aware of this. She found the experience of being understood and listened to by the other patients significant.
The power of being understood by another 101	101	
Family fearful the role would be a set back 105	102	
	103	
	104	
	105	
	106	
	107	
	108	
	109	
	110	
	111	
Doing what I wanted rather than what was expected 112	112 I Okay.	
	113 R But for the first time in my life I went against them and did something that I really wanted to do, so that's how I got involved.	Almost like an emancipation. Presenting self as passive before – "going against them"
	114	
	115 I Yeah, that's a really clear ... you made it sound really clear about how kind of your journey really, how you got to the point of your own sort of recovery, and how important this role kind of felt to you, that it was ...	
	116	
	117	
	118	
Not fitting in 119	119 R Yeah. Cos I did a job for 28 years where I was a square peg in a round hole, but yet afraid to leave it because – good pension, very good conditions ... secure. And it was drilled into me as a child you know if you get a secure job ... civil service, HMRC ... you don't leave it you know. But I wish I'd left it years ago because I think my job was part of my problem.	Didn't fit into previous job but felt fearful to leave. The job itself was causing stress. Drilled, forced, being forced to do what she did not want to do.
Previous job part of the problem 122	120	
	121	
	122	
	123	
	124	
	125 I Right I see, okay. So when you ... at the beginning before you'd actually started in the role of a peer support worker, what was your understanding of what that role would be?	
	126	
	127	
	128	

4

	VN680126	
Wanting to help people and give them hope 129.	129 R Um ... my understanding of it was that I would be there for people in despair really and that I could give them hope. And that we would have you know a shared, a truly shared understanding - it would be something I would enjoy sharing mutual sort of experiences.	This is how she had felt. The sharing of experiences seems to be significant for her, as she has repeated it. Perhaps what had been useful to helping her to feel understood when she was in hospital.
Sharing mutual experiences 132	130	
	131	
	132	
	133	
Professionals don't truly understand 137	134 I Mm, cos it sounds like that was what was helpful when you was in that inpatient unit – one of the most important bits was that sharing with ...	As she had been given hope.
	135	
	136	
	137 R That's right. And being in the company of someone that really truly understood you know. Sometimes professionals, as good as they are, they don't really get it, you know. You know sometimes I find myself going down the track now that I'm well maybe thinking 'Oh for God's sake, just do it!' I'm thinking with a patient you know 'Why can't you just do it? – it will help you'. But I have to stop and think 'No [redacted], you've been there, it is not just a matter of just doing it' - getting up and going to Mindfulness or something like that – it's not as easy as that when you're in that place ... but I have to keep reminding myself that.	Truly understood. Professionals "don't get it". How can someone "really understand if they haven't experienced it themselves? Frustration with patients.
Impatience - this will help – just do it! 140	138	
	139	
	140	
	141	
	142	
Own experience as a reminder that it's not that easy 144	143	
	144	
	145	
	146 I Mm okay. And has your understanding of the role changed while you've been doing the role?	Sometimes positioning herself with professionals, but her experience reminds her to recognise the difficulties.
	147	
	148	
	149 R Yes.	?Leading question?
	150	
	151 I You know is there a difference between what you thought it would be and what your understanding was then to how it is now?	"They"
Barriers to doing the role to the best 154	152	Them and us.
	153	
	154 R Unfortunately I can't do the role to the best ... to the way I want it, because the only way they would employ us due to the lack of funds was by giving us health care support worker duties as well. Cos they believe you can do peer support ... and to a certain extent I agree ... no matter what you're doing. When I went into it first I envisaged myself running all these groups, like recovery groups, groups about hope, gratitude groups ... Mindfulness groups ... I have achieved	My way= the best way - But "they" won't let me?
Additional duties get in the way 156	155	
	156	
	157	
	158	
	159	

5

<p>Lack of time to do my best 160</p> <p>Insufficient resources 167</p> <p>Focus on keeping the ward safe 169.</p> <p>Need to redesign new model of working 174.</p> <p>Recovery focused environment needed 177.</p> <p>Differing views of recovery 182.</p> <p>Fix them up, get them out (not recovery)179</p> <p>Surprised how I've coped with the role 190.</p>	<p>160 that, I do run that. Drop in sessions, all that, but there is <u>no time for that</u> unfortunately.</p> <p>161</p> <p>162</p> <p>163 I Right. So your role gets taken up with these other sort of perhaps more practical things.</p> <p>164</p> <p>165</p> <p>166 R Yeah. And it's okay if you have enough staff on the ward, you can have plenty of time to you know have one to ones with people. But like this week for instance there was only four staff on a shift for 25 patients. It's just <u>keeping the ward safe at times.</u></p> <p>167</p> <p>168</p> <p>169</p> <p>170</p> <p>171 I Mm, yeah yeah.</p> <p>172</p> <p>173 R But now they've decided the model isn't working, that <u>they're going to ... it's going on at the moment, (they're going to have a look and redesign a new model ... whether that will happen or not I don't know ... and we've given our input on what we think the role should look like. Also I think peer support doesn't work unless it's in a setting where they're truly recovery focussed. Unfortunately, even though they say on paper we're all about recovery, it's more of a tick box. The attitudes of the staff there is to fix them up, get them out of hospital – they'll be back in in no time. You know they're not truly following a recovery model. And to them recovery is getting them out of hospital – that to me isn't recovery at all. (They) have a very different view of recovery to what I have.</u></p> <p>174</p> <p>175</p> <p>176</p> <p>177</p> <p>178</p> <p>179</p> <p>180</p> <p>181</p> <p>182</p> <p>183</p> <p>184</p> <p>185 I Okay okay. So ... and I've got some other questions later about kind of recovery itself, so that would be really interesting to ask a bit more about that. Can you tell me more about your experience, of your actual own experience of being a peer support worker?</p> <p>186</p> <p>187</p> <p>188</p> <p>189</p> <p>190 R I mean actually that's the thing that has shocked me. Because my family were so against me ... I started to believe them and worry maybe ... you know you</p> <p>191</p>	<p>Role gets taken up</p> <p>"just" keeping the ward safe.</p> <p>Keeping the ward safe gets in the way of listening /being understood.</p> <p>Not enough staff/not enough time</p> <p>Us and them</p> <ul style="list-style-type: none"> - Other ? powerful entity, nameless. <p>Importance of recovery focus.</p> <p>The staff – fix them up, get them out.</p> <p>Different views of recovery.</p>
--	--	--

<p>Feels good relating to service users</p> <p>Able to see the positive effects of my words</p> <p>Sharing stories</p> <p>Telling stories of hope</p> <p>Recognition of own achievement</p> <p>Positive role model of change.</p>	<p>318</p> <p>319 R Made me feel good. Repeats</p> <p>320</p> <p>321 I Yeah.</p> <p>322</p> <p>323</p> <p>324 R Cos like people share things in the group and I know I've had that experience, or a very similar experience, and I can relate to them when I talk to them and ... and a lot of them calm down as well when I start talking to them.</p> <p>326</p> <p>327</p> <p>328 I Yeah yeah. So do you sort of share ... if somebody says that they've been through a certain thing, do you share actually that's something that I've been through too, or how do you ...</p> <p>329</p> <p>330</p> <p>331</p> <p>332 R Yeah I share that. I tell them <u>how</u> I've overcome all the barriers ... obstacles, barriers.</p> <p>333</p> <p>334</p> <p>335 I Yeah yeah.</p> <p>336</p> <p>337 R What I've done like. I would never go on a bus on my own. And there are racing thoughts in my head 'What if I ain't got the right change, the bus driver will shout at me' 'What if I fall over and make a fool of myself?' I'd like tell people ... so when somebody tells me this, so I tell the people now. So what if a bus driver's grumpy, just think 'You're having a bad day, you're not going to spoil mine'.</p> <p>338</p> <p>339</p> <p>340</p> <p>341</p> <p>342</p> <p>343</p> <p>344 I Uhuh, uhuh.</p> <p>345</p> <p>346 R And things like that.</p> <p>347</p>	<p>Transforming experiences into something positive – her experience helps her to relate to others and this is helpful to them.</p> <p>Guiding their way</p> <p>Sharing experiences and giving hope – you too can overcome these barriers.</p> <p>Recognition of change, going from a position of worry and "what if" to a position of "so what".</p> <p>She is able to explain this to people from a place of really knowing what it's like to worry, and then being a role model of change – I can do it so it's possible.</p>
---	---	--

<p>You're not alone</p> <p>You're not the only one that feels that way</p> <p>Recovery has its ups and downs</p> <p>Keep going</p> <p>Recovery takes perseverance</p>	<p>348 I Yeah. So I suppose you giving your experience helps people to feel less alone, so they don't feel like they're the only one, it sort of normalises it a bit I suppose and tells them you know it's okay, you're okay. And also it gives them hope.</p> <p>349</p> <p>350</p> <p>351</p> <p>352 R Mm, you're not the only one that's feeling that way.</p> <p>353</p> <p>354</p> <p>355 I Yeah. And I guess it gives them hope as well for things. You know as you're saying how you deal with it, they can see that they can deal with it differently.</p> <p>356</p> <p>357</p> <p>358 R Yeah. I say to people it's a lot of steps forward and a lot back, but eventually ... you can do it, cos I managed it.</p> <p>359</p> <p>360</p> <p>361 I Yeah.</p> <p>362</p> <p>363 R After 16 years nearly.</p> <p>364</p> <p>365 I Yeah yeah. So you do get there, yeah. Okay. So how ... what has the work meant in terms of your own recovery? You know how has it affected your view or how has it ... just how do you think about recovery and what does the role bring to that? Does that question make sense? Waffly</p> <p>366</p> <p>367</p> <p>368</p> <p>369</p> <p>370 R No, sorry.</p> <p>371</p> <p>372 I (laughs) I suppose I'm just interested in the idea of recovery and what it means for people, you know personally, and how much the role has influenced your view of your own recovery and recovery more generally. So what do you think about recovery? Cos it's used a lot, that phrase is used quite a lot, the term's used quite a lot nowadays.</p> <p>373</p> <p>374</p> <p>375</p> <p>376</p> <p>377</p> <p>378 R Yeah recovery.</p> <p>379</p>	<p>Implies that she continues to feel that way now. Demonstrating a coping model. It's human to feel this way, but we can cope with these worries, Life continues despite the worry.</p> <p>That recognition that recovery does not run smooth, sometimes it may feel that you are taking backward steps.</p> <p>A positive perspective of "keep going you will get there". – it took her a long time.</p> <p>I think I waffled cos she looked confused.</p> <p>I think that this interviewee felt somewhat intimidated by me, and knowing my role as a psychologist. I wonder what her experience of psychology has been before?</p> <p>Perhaps assuming I know the answers and feeling inhibited to give her opinion?</p>
---	--	---

VN680142

The role gives me a purpose	380	I	Yeah I mean what do you think of that, what does it mean to you?	Gives life meaning and a reason for living
Having a purpose helps my recovery	381			
	382			
	383	R	Um ... like I said before it's like ... helps my recovery because I've got a purpose.	
	384			
	385			
	386	I	Yeah yeah.	
	387			
The role gives me a reason for being	388	R	Something to get out of bed in the morning for. Something to go out the door for.	
	389			
	390			
The role increases my confidence	391		Yeah.	Perhaps gives validation and a sense "I can do it" e.g. in 325 she sais she can help people to feel calmer
	392			
	393	R	It's just boosting my self confidence.	
	394			
	395	I	Yeah. Would you say ... but by working with other people, has it helped you to feel more hopeful? Or has it sometimes made it more difficult to feel hopeful or ... you know how has it ...	
Feeling hopeful	396			I did put words in her mouth here
	397			
	398	R	It's made me feel more hopeful.	
	399			Associate seems an interesting choice pf words. "to join, keep company", also to meet or "have dealings with someone regarded with disapproval"
	400			
	401	I	Uhuh.	
The role encourages me to speak with people outside of work	402			
	403	R	It's made me want to associate with people in the general public as well.	
	404			Interesting – "associate" and "general public"
	405	I	How come?	
	406			?signalling her dislike for other people (the general public) ?feeling threatened, intimidated.
	407	R	I just feel more confident in myself. If I was walking down the street or getting on the bus or anything I'd like have my head down and ... scowling.	
Before, not confident, head down	408			
	409			
	410	I	Yeah yeah.	?expects others to be critical
	411			Now more likely to speak to people

VN680143

	412	I	Yeah yeah okay. So what's the work meant in terms of your own recovery? So have you noticed changes within yourself? And has it changed your view of your recovery or anything?	
	413			
	414			
	415			
Personal changes	416	R	It's changed me a lot, it's changed me an awful lot. Again I suppose it comes down to the understanding, having empathy now and understanding for what we can sometimes go through and where our mind can take us off with the illnesses and things like that it's ... it's previously something that I never ever thought I would see myself working in. I always thought I would be in that sort of very ... and it's not to sound chauvinistic or anything like that, but very male orientated engineering, on the oil refineries or ... either that or before that it was in the military and ... and I always saw my life going that way. I never for one minute thought I'd be in a caring or supportive role as it were.	He reflects on his own changes and how the work has contributed to that.
Becoming a different person	417			
	418			
Changing roles	419			Going from a very male focused role to a more caring role.
	420			
Finding my hidden self	421			
	422			
	423			Learning and understanding is very important to him
	424			
	425			
Personal development	426	I	Yeah yeah.	
	427			
Gaining insight into self	428	R	So to develop the illness as it were, and then to develop in through recovery and into the peer support role – it's been huge, it's been huge. It's something I'd like to do more of and keep going and (earn more) I just wish I'd had this experience earlier. I know that sounds quite bizarre to say, but I really wish I'd had insight to some of these thoughts, emotions, at a much earlier stage.	Peer support worker role has been part of his recovery and has enabled personal development and increased self-awareness. Recognition that this is different from how he was before.
Increased awareness	429			
	430			
	431			
	432			
	433			
	434	I	Yeah. Well it sounds like a big change then is your own sort of personal insight and self awareness, it's sort of really grown through doing the role.	
	435			
	436			
Walking a tightrope – fear falling	437	R	Yeah yeah yeah. I wish I could say I was always going to feel stronger and more empowered by it. Sometimes it does make me feel quite fragile or it does make me feel quite scared, but I feel I'm better equipped now to cope with it as well in the same vein. I don't know, it's a bit of a tightrope I suppose in that sense in that there's the fear of falling back into the severe depression and the psychosis and things like that, as well as ... I feel so fortunate to have been on this journey and to know what I know now as well.	
	438			
	439			
	440			
	441			
	442			
	443			

14

VN680143

	444	I	Yeah yeah.	
	445			
	446	R	It's brilliant. So ...	
	447			
	448			
PSW – a key to recovery	449	I	Okay. So I mean you've kind of answered this question really, but just I'll ask it again – is there anything else you want to add ... but how has the role contributed to your understanding of your own wellbeing and your own mental health?	A repetition, demonstrating how important this has been to him.
	450			
Finding my purpose again	451			
	452			
Aware of my own limits – increased self awareness.	453			
	454	R	Yeah I think probably with the things like I've said, it's ... the peer support role has been vital for me, absolutely vital. It's been key I think to ... or it's been one of the major factors in my recovery. Obviously I suppose if we were to look at recovery and my mental health in general, there'd be lots of things in there, the support networks I would consider would be my family, you know my wife, my children, things like that. But also with me losing all of my sort of work role and my purpose sort of in that, to then have it replaced over a period of time with the peer role – it was a huge huge part to my recovery and my wellbeing as it were. I don't know, I'm more aware of my limits mentally now than I would have been before. I know when it's time to sort of say I need to step away or ... rather than always trying to keep battling or finding an answer or finding ways to fix things or make them better. Sometimes I have to sort of say it's okay to ask others and it's okay to step back a little bit myself and things like that.	He describes the role as a vital part of his recovery.
Developing a new work role	455			
	456			
	457			He does not consider it to be the only thing, as he also acknowledges the role of his social networks. But he does see the loss of his role as a worker, and then developing a new working role as significant.
	458			
	459			
	460			
	461			
	462			
	463			
	464			
	465			
	466			
	467			
To let go of the battle – I don't always need to know the answer	468	I	Yeah yeah.	
	469			
	470	R	I suppose to a certain extent that would be boundaries and things like that, but for me it's more about understanding my limits really .	
	471			
	472			
	473	I	Yeah yeah, cos it sounds like you've always been very driven and sort of any sort of vulnerability or any kind of ... anything difficult, you'd just sort of keep	
	474			

15

Before I just kept going, wanting to be the best.

My life unravelled

475 going and drive forward with it. But actually, that came at a cost really... at a
 476 cost... so ...
 477
 478 R Uhuh, yeah.
 479
 480 I ... you've become more aware of that, and you're kinder to yourself, that's how
 481 it sounds.
 482
 483 R I try to be, yeah I try to be. Um ... yeah, I didn't even realise though that I was
 484 that sort of driven person.
 485
 486 I I mean would you say that you were? That's my sense, it might not be accurate
 487 but ...
 488
 489 R It probably is, it probably is like that. When I was [redacted] I always wanted
 490 to be stronger, fitter, faster, better at my job than anybody. And it served me
 491 well because I went [redacted], I was fortunate enough I used to do
 492 [redacted] and things like that, I'd be up in [redacted] and things. You
 493 know in places and doing all these different things that people would never ever
 494 experience in their life. It just kept me motivated to keep going and keep
 495 moving forward as well as being a better [redacted], being a better [redacted] as it
 496 were and things like that ... [redacted]. That pushed on, and then
 497 I moved on and was assigned to [redacted] and things like that. Which was
 498 ... although I wasn't [redacted], my role meant that I then worked alongside
 499 [redacted]. It just kept me drive, and I was really really motivated to keep
 500 doing the best at everything I could. Left the [redacted] for a high paid job, which I
 501 thought oh great ... going going going going >. and then uh ... all of a sudden it
 502 started to (unrave) in front of me. Once the physical health started to deteriorate
 503 with the ... I keep going like that, well I suppose it's my heart really ... but I've
 504 got a pacemaker and things like that ... the other stuff started to come up from
 505 my past, like [redacted] and all things like that. And ... I suppose
 506 the depression then started to really sink in and ... it made me ... for probably a

Always wanted to be the best at what he did. He kept going, pushing himself forward, until his physical health got in the way of him continuing. Then became depressed (depression = sense of loss of self as physical fit and strong/experiences of trauma)

Themes identified for one participant:

PSWs offering something different/differing perspectives

The different roles are needed 919
Differences between nursing staff and PSWs 836
Fix them up, get them out (not recovery)179
Differing views of recovery 182.
Identifying strengths rather than what's wrong with them 829
Medical perspective of recovery is different from the PSW perspective 816
Recovery in the hospital setting is about ticking boxes 819
Professionals don't truly understand 137
Staff's views are challenging 434
PSWs trained to focus on strengths 831
Being employed by another organisation is helpful 884
The dilemma of wanting to fit in 865

Giving and receiving feedback

Giving positive feedback to other staff 543
"Banking" the positives 577
Other staff valuing feedback 545
Positive feedback from patients 556
Making suggestions to other staff 510
Banking positive comments 425
Being honest with others 503

Changing the culture of the NHS

Influencing services and making changes 317
Making a difference 238.
Changing the culture of the ward 281
Stigmatising remarks – wanting to change the culture 271

Staff concerns

Having to work to prove themselves 890
Staff concerned by the effect of patient negativity on the PSW 718

Being watched by staff 258
Staff worries 260
Needing to gain staff's trust 254
To trust someone who had been so unwell must be difficult 252.
Gaining the trust of staff 286
Staff revealing their own mental health problems 894

Unwanted

Not fitting in 119
Other staff did not want us 893
Peer support not always accepted by patients 711
Feeling unwanted 249.
Preference for a professional rather than a PSW 707
Training didn't prepare for problems with staff 927

A quick fix to recovery

Belief that professionals will "fix" mental health problems 637
Painful realisation that the "quick fix" doesn't exist" 650
Before PSW role thought recovery had a start and finish 793
Learning about recovery from the role 788
View of recovery has changed 613
Recovery is more than taking medication 618
More than professional help 624

Improved mental wellbeing

Training didn't mention that you could feel well 1055
Didn't know it would help my wellbeing 1037
The job has helped my wellbeing 1064
Mental health best it has ever been 590
Improved mental health 588
Ways to keep self feeling OK 579
Own mental health going from strength to strength 193
Valuing own wellness 264
Keeps the focus on own recovery 426
Helping me to focus on my recovery 446

Better communication in relationships

Easier to live with 473
Improved relationships 471
More understanding towards others 480
Focusing on others rather than living in my head 456
Increased ability to be diplomatic 492
Responding to others more effectively 518
Thoughtful responses 504
Improved relationships with other staff 514
An ability to contain emotional responses 503
Able to not take negativity personally 721
Challenging to not challenge 275
Using validation to get point across 506

Personal development and self-awareness

Need to be aware of own wellbeing 983
Doing what I wanted rather than what was expected 112
Being the real me 905
Importance of self-awareness and seeking support 199.
Developed as a person 520
Personal growth 482
No need to please others anymore 908
The work builds self-esteem 227
Being worthwhile and having something to offer 455
The role brings out the best in me 196.

Inner turmoil

Having been close to death 897
Told I would be unable to work 220
On the scrap heap -written off by psychiatry 217
Previous job part of the problem 122
Extreme distress and turmoil 86
On the outside the perfect life, but on the inside "turmoil" 83
Believed she couldn't survive on her own 665
Addressing buried issues through psychological therapy 94

Use of self and experiences

Own experience as a reminder that it's not that easy 144
Learned to use self and own experience to influence 348
Using own experience to improve services 315
Being an inspiration to others 415

Mutual support

Other patients were a huge support to me 98
Sharing mutual experiences 132
The power of being understood by another 101
Development goes both ways 1026
Picking up skills from patients 1015
Being inspired by patients 849

Rewards of the role

A rewarding role with some caveats 985
Gaining so much from the role 554
Reward of being part of the patient's journey 402
Not in it for the money 391
Rewards other than money 392
Not doing the job for money 263
Being valued by patients 561
Validation – that the role is valued 291
Feeling needed 751

Problems with the system

Mental health hospitals are not a place to recover 772
Medical treatment did not address the problem 89
System creates dependency 667

Stretched resources

Additional tasks to justify the role 368
Barriers to doing the role to the best 154
Lack of time to do my best 160
Additional duties get in the way 156

Insufficient resources 167
Focus on keeping the ward safe 169.
Idealised view of what could be achieved at the start 158

Recognition of own strengths

Strengths highlighted by the challenges 563
Family fearful the role would be a setback 105
Recognising own resilience 564
Not affected negatively by the work 602
More able to deal with disagreements 484
Having the confidence to challenge others 494
Surprised how I've coped with the role 190

Being there for service users

Helping patients to feel heard 744
Only there to support the patients 887
Doing anything to help 333
Wanting to help people and give them hope 129.
Trying to be there for everybody (all pts) 704
Needing to give a lot of time 384
Giving equal time 386
Being equals 337
Influencing patient's recovery 559

New ideas

PSWs have great ideas 308
PSWs need to be in recovery focused services 1000
Recovery focused environment needed 177.
Need to redesign new model of working 174.
Role would benefit from being extended out of the hospital setting 939

Working at recovery is essential

Having to "work" on recovery 644
Recovery takes practice 652
Having to work at my recovery 447
Own recovery has to be worked at 953

Recovery sometimes goes backwards 956

Recovery has “blips” 968

Never take recovery for granted 428

Doubts

Is it possible to help without the professional training 208.

Needing reassurance that I’m doing the right thing 207.

Uncertainty and fear about the role ending

Uncertainty in how the role will continue 296

Fear of the role ending 591

Uncertainty – what will happen when it ends 597

Recovery is an ongoing process

Recovery isn’t about going back to how you were 612

Recovery is about growing 784

Realisation that recovery is ongoing 805

Recovery never stops 789

Finding meaning for recovery

Importance of meaning in keeping well 779

Importance of finding meaning for recovery 767

Recovery is about finding meaning 609

Recovery is individual

Involving self in own recovery 638

The power is within the individual 668

Recovery is individual 766

Relationships important to recovery 619

Sometimes people aren’t ready to take their power 672

Many things contribute to recovery 777

Recovery is being your own therapist 795

Support and training

Being assertive to seek support 1010

Would have liked more support 933

Need for supervision and training 1001

Training didn't prepare me fully 72

A life worth living

I wasn't meant to die 900

Life is worth living again 410

The right person for the job

Have people the "right" experience to do the role 379

Have they been a "proper patient" – different types of experience (some more valued than others) 381

Need to be at a certain place in your recovery 989

Identification and re-enactments

Sees similarity of self with patients 450

Getting too attached to patients 681

Difficulty ending the relationship 685

Patients fulfilling own needs 689

Increased awareness of becoming over involved 697

Telling patients what to do 336

Impatience - this will help – just do it! 140

Appendix K – Advice from participants for those considering working as a PSW

What would you say to somebody who's considering working as a peer support worker?

In this study participants were asked what they would tell someone who was interested in becoming a peer support worker. Some aspects of these responses were incorporated into the themes identified within the analysis. However, I thought that it may be of interest to anyone considering becoming a peer support worker to see these answers in full.

Richard: For me I would ... obviously I would say go for it, give it a try. I would just also say make sure you're up to it, make sure you feel like you can take what's coming as it were and things like that. I'd just give words of caution around what you're potentially exposing yourself to, and make sure you've got the resilience and the support networks around you to make sure you can cope with that. Somewhere to turn to should you need it ... or lots of places to turn to should you need it and things like that. Not to keep things to yourself, not to bottle things up, not to think that you've got to take on everybody's problems and worries and things like that as well. Just um ... yeah definitely best thing that probably ever happened to me I would say by a long stretch. And that goes with everything that I've done career-wise and things like that - this has been probably the far best experience I've had, as it were. So yeah give it a go. But I would also say it's not for everybody is it I suppose, it's the same as anything. Depends where you are in your recovery and what you want in life as well.

Sarah: I'd say it's a lot of hard work. Um ... at the beginning it seems daunting and it's hard work doing the courses... but once you do it it's worth ... it's really worth it. And just don't ... if people don't speak or don't listen to you, don't take it to heart, just carry on.

Fran: Um ... I'd say try and be as well as you can be, like really look after your own wellness. Cos you always get told to but you think ... I don't think you necessarily believe it. But I'd say to them sort of don't underestimate how important it is to look after your own wellness. Find out a lot more about it, find out as much as you can about it ... but you can't ever really be prepared for what it would be like. If you think you're going to like it you probably would

Sandra: It's a very very rewarding job, but you must must always be aware of your own wellbeing, you know, it can trigger things for you ... and seek some sort of support immediately if it does. It's an amazing role and it can have a huge benefit to your own mental wellbeing, as long as you have that self-awareness about triggers and looking after yourself, and being that independent person as well and not to get sucked into the system. But I would highly recommend it, I really would. But you need to be a certain place in your recovery. And it's not necessarily how long you've

been discharged from the services or anything like that, it's where you really are yourself in your recovery.

Tom: I'd say make sure they have enough self-insight first, make sure they have a bit of a routine going, a little bit of discipline. Exercise helps, having a bit of a better diet. And make sure that you're in a good enough place that you're not going to latch onto somebody else's problems and live it with them, rather than experiencing just sharing. It's about sharing – shared experiencing but not kind of getting stuck in each other's lives. If people aren't far enough in their recovery that will happen.

Interviewer: Yeah. Okay. So I guess there's something about if you're looking after yourself it helps you to be more resilient and ...

Tom: Yeah yeah. You have to have a certain amount of self-reliance to be able to do it. Not completely cos you know part of the journey in the recovery journey of being a peer support worker is getting better. So you don't have to be perfect, but you do have to be like you know a little further on than some of the people you'll be supporting. I mean sometimes you'll find people who you're supporting who in some ways are more advanced than you, but at the same time that's good cos you learn from that. Cos nobody ... I mean the recovery perspective is so broad that nobody is going to be like ahead ... there's no one line for it. It's really like you know ... it's a spectrum or a matrix of matrices almost. So ... you know I mean it's all about just learning, you just have to make sure you're in the right mindset to learn and help lead a little bit.

Celia: I'd say they should go for it, I think that it's an extremely enjoyable and rewarding role. I think just be aware that it can get tiring as the role progresses, but it's an extremely enjoyable role, and it will hopefully open opportunities for the individual in terms of where they want to specialise or where they want to work, so I'd definitely encourage anyone to go for it