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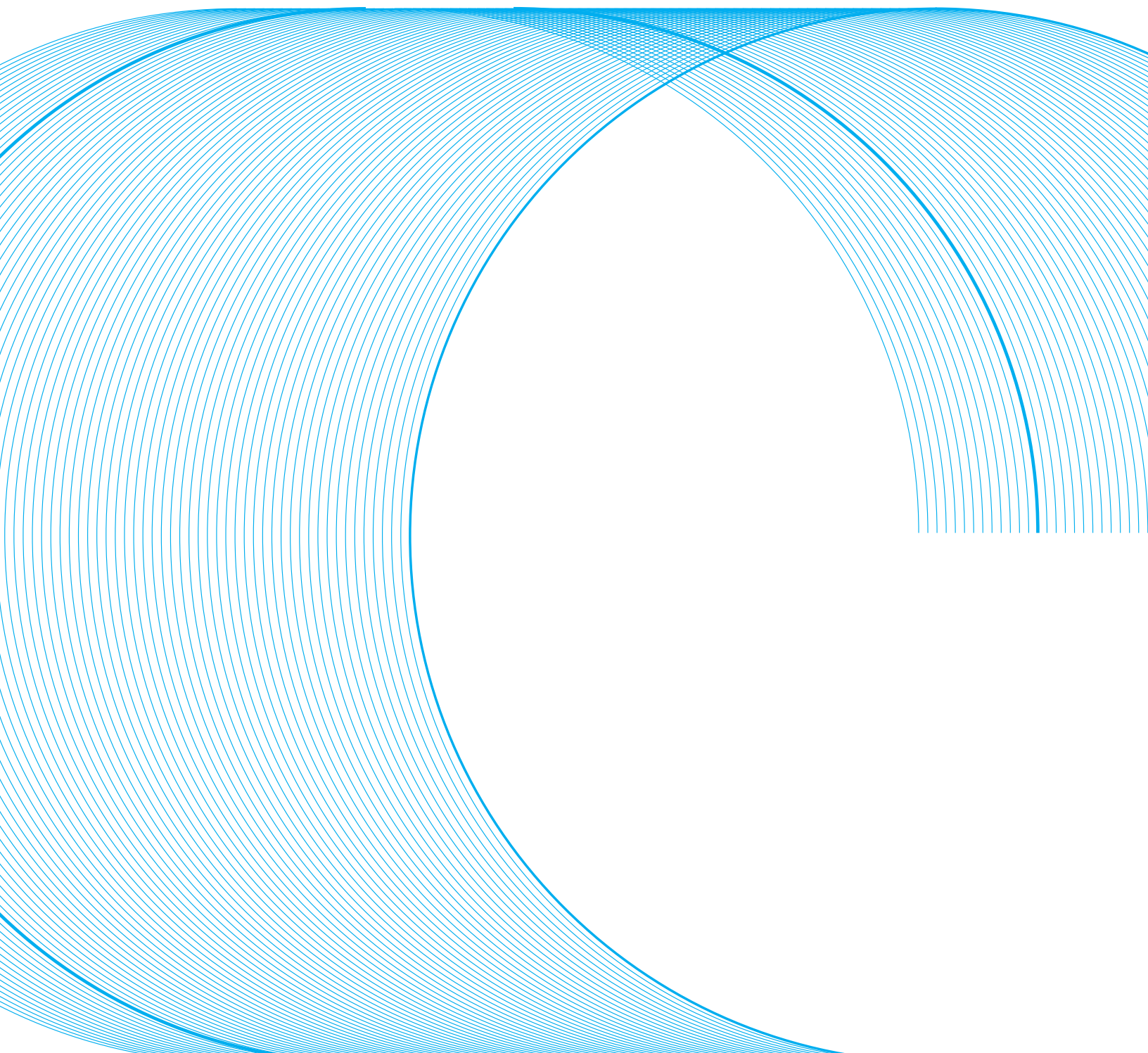
ADDRESS:

Scottish Recovery Network
Baltic Chambers
Suites 320-321
50 Wellington Street
Glasgow G2 6HJ
Scotland UK

Phone: 00 44 141 240 7790

Email: wendy.brown@scottishrecovery.net
info@scottishrecovery.net

Web: www.scottishrecovery.net



Methodology

The aim of this research is to better understand what factors help and hinder recovery from long-term mental health problems. This aim helped determine the decision to collect narrative accounts of recovery from mental health problems from 64 people across Scotland.

METHODOLOGY	10
Ethics and Data Protection	11
Research process	12
Language	12
Recruiting narrators	12
Preliminary telephone interview	12
Structured questionnaire	13
Interview topic guide	13
Interviewing	13
Data handling and analysis	13
Inclusive research	14
Limitations of the methods and research	14
Report structure	15

Methodology

Increasingly, studies have used narrative or qualitative methodologies as a route to uncovering factors that help individuals towards recovery from mental health problems and as a means to explore in some depth the nature and meaning of individual recovery (Barnett & Lapsley, 2006; Larry Davidson, 2003; L Davidson & Strauss, 1992; Jacobson, 2001; Lapsley *et al.*, 2002; M. A. Mancini *et al.*, 2005; Ridgway, 2001; Thornhill *et al.*, 2004). Using narrative or story collection as a research method allowed us to acknowledge that each person's experience of recovery is unique, that definitions of recovery vary and that the criteria people use to measure their progress are difficult to quantify or compare.

The use of narrative is compatible with the ideas of recovery. Narrative often emphasises things happening over time or a chronological sequence of events and recovery is often visualised as a journey over time and experience. Ageing and growing is emphasised in narrative literature as are the same processes and constructs in recovery literature. Of more importance, the use of narrative places the narrator, not the researcher or clinician, at the centre of the journey. Although the social context is critical, the emphasis within this report is on collective, individual journeys, personal experience and meaning. (Individual narratives from this research have been summarised and reproduced in a booklet; 'Journeys of Recovery' (2006), and podcasts and are available to hear online at the Scottish Recovery Network website: www.scottishrecovery.net).

It has been shown in other narrative studies (Kelley, 1995; Ridgway, 2001) that the process of narrating, re-framing, re-telling, re-storying, re-authoring, questioning and reformulating one's life story can provide a sense of meaning and possibility to individuals, and can have a positive and empowering impact on a recovery journey, allowing narrators to demystify and re-focus on the positives of their experience. Indeed, many participants within this research reported that giving their story was both a powerful and positive experience, offering them the opportunity to frame their experience in a more positive light.

To facilitate and help unfold the recovery narratives it was decided to use a semi-structured interview schedule because it would:

- Provide interviewer support to the 'narrator'.
- Provide a common framework for analysis whilst not prohibiting the narrator's self expression and thus deepen reflection.
- Allow the narrator to lead the pace and direction of the research.
- Reduce questions that lead to preconceived research outcomes.
- Generate data that could be used to illustrate personal experiences of recovery (e.g. Journeys of Recovery booklet).

Ethics and Data Protection

Initial ethical guidance and approval was drawn from the project's steering group. The dignity, rights and welfare of participants and interviewers were core criteria when establishing ethical guidelines for research. External training on ethical approaches to researching was provided to interviewers to ensure research was conducted within strict ethical guidelines.

Research purpose and the ways in which transcribed interviews were to be used was explained to all participants at each contact point in the research and participants were

asked to give informed consent for their involvement in the research. Anonymity and confidentiality was assured at all stages of participation and researchers have done their utmost to ensure confidentiality was upheld in story sharing and data handling. All personal contact details linking individual participants to this research have been erased from SRN databases to comply with data protection laws.

As researchers we have a moral responsibility to ensure that participants were not exposed to harm as a consequence of participation. A counsellor was made available to narrators and interviewers at each 'research event', and signposts to further sources of help were made available. In a bid to empower individuals and to ensure they were comfortable with their participation, individuals were given the opportunity to review and amend the transcription of their interview. This allowed them to clarify data and remove information that in retrospect they may wish they had not shared. A 'follow up call' post interview also served to ensure that narrators were not harmed as a consequence of their participation in this research.

Research process

The interview guide and questionnaire were piloted with two key informants prior to research commencement.

Language

Key informants – the individuals on whom this research is based will be referred to throughout this report as narrators, participants, individuals, people, activists and service users. All terms are used to refer to the individuals who have contributed their recovery story to this research. Similarly, in recognition of the various means by which our narrators and other authors have described the experience of having mental health issues, a variety of terms will be used throughout including; mental health, mental ill-health, mental illness, and mental health problems.

Recruiting narrators

The focus of the research was upon adults (over eighteen years of age) living in Scotland who defined themselves as recovering from or having recovered from long-term mental health problems. Notions of health and recovery are subjective, therefore allowing individuals to self define as 'in recovery from a long term mental health problem' was considered a reasonable approach to recruiting participants. To facilitate recruitment of a diverse range of individuals, an advert was placed in national and local press requesting individuals in recovery to contact SRN for information on participation. Individuals were also recruited through SRN mailings, existing contacts, other press and word of mouth.

Participants were purposively selected to achieve diversity in terms of geography, recovery stage, medical condition and demographics.

Preliminary telephone interview

All participants were informally interviewed by a trained counsellor (Niki Kandirikirira) to assess their suitability to take part in the project. Where the applicant was felt not ready to participate, the decision to withdraw was taken by that person. In such instances applicants were provided with information on how to access external sources of help if necessary.

Whilst we attempted to value all offers of participation, sample quotas were met quickly and research was over subscribed. The individuals who missed out on participating were asked to submit their recovery story to the SRN in writing allowing the SRN to recognise and use their contribution in other aspects of its work. Every individual's contribution was therefore valued.

Structured questionnaire

Individuals chosen for interview were asked to complete a structured questionnaire several weeks prior to interview. The questionnaire provided background and demographic information for interviewers and principal researchers. Interviewees were also given a preview of general interview topics at this time. It is hoped that prior disclosure of questions would help to minimise unease and eliminate fear of unexpected questions. It would also provide individuals with a chance to think about what they had experienced in relation to recovery.

Interview topic guide

The interview guide was adopted to initiate and generate discussions with narrators and to provide minimum consistency of research. Techniques were developed within this guide to move narrators' stories towards their recovery journey.

Narrators were asked to:

- Reflect upon factors that had helped or empowered them on their recovery journey.
- Comment upon factors that had been detrimental to their wellbeing and recovery journey.
- Discuss what factors have helped them sustain their wellbeing.
- Discuss any learning they had experienced from their journey.
- Describe what recovery felt like for them.

The results from these interviews provided a view of people's recovery journeys as they perceived them at the time of interviewing.

Interviewing

Each interview was prefaced by a brief discussion with the principal researcher (Wendy Brown) to ensure participants could give informed consent for their participation in this research.

The semi-structured narrative interviews were conducted face to face to increase rapport, confidence and sharing. Two interviewers and one participant attended each interview. One interviewer conducted the interview while the second observed, paying attention to the process and recording. Interviews were held in seven venues (hotels and business suites) throughout Scotland including locations in Aberdeen, Dumfries, Dundee, Edinburgh, Glasgow, Inverness and Kirriemuir. Interviews were conducted by a pool of seven interviewers who were supervised by two principal researchers (Brown & Kandirikirira).

Data handling and analysis

Interviews lasted between 40 and 90 minutes and were tape recorded digitally and transcribed verbatim. Additional field notes (observations and reflections) were added by

observers. Initial themes were checked with narrators after which interviewers and principal researchers collaboratively constructed broad interview themes across the interview population. Using NVivo data management software, whole transcripts were double coded by the two principal researchers using the broad themes. Themes were further refined through inductive thematic analysis of the data which identified anomalous, recurrent and contrasting features in the transcripts. Finally, themes were imported into Excel software for ease of data manipulation before final analysis and write-up.

Inclusive research

Scottish Recovery Network sought to involve people with experience of mental health problems in this research in several different ways. Participatory approaches within this research included:

- Encouraging participant involvement. All transcripts were returned to participants for final editing and approval prior to analysis and dissemination.
- Designing research processes that reflected inclusive practice. We held in-depth discussions with a range of active groups on the strategic direction and ethical implications of the research.
- SRN positively promoted the employment of individuals who have experienced mental health problems and recovery as interviewers.
- Research practice and methodological choice were inclusive and favoured empowerment of participants through allowing them to narrate the shape and flow of each interview.

Narrators, not the authors, the SRN or the mental health system, are the ‘champions’ of these stories and this research.

Limitations of the methods and research

According to Lucius-Hoene (2000, June) the narrative interview not only provides a method for constructing the life experience of the narrator, it can also be seen as an ongoing process of construction, motivated by the focus and interest in self-exploration at the time of the interview. The authors of this report share this belief. Narrators who participated in this study provided important insights and a fresh interpretation of the recovery journey, but the stories they told represent only a snapshot of their journey determined by the narrator and their interviewer’s attitudes at time of interview and analysis.

In a desire to better understand the recovery process the authors argue that qualitatively investigated experiences would best distinguish between positive and negative aspects of recovery. They would unveil the effects of the recovery process allowing researchers to appreciate the personal experience as well as the more commonly held experiences of recovery.

Narrators were self selecting; that is, they actively volunteered to participate in this research. They were also purposively selected for diversity of experience. Therefore the views and opinions captured within these findings represent only a small number of unique experiences that can not be statistically projected or generalised across a population as diverse as those in recovery from mental health problems. Throughout this research we have striven to value the contribution each individual narrator made and as such have reported upon unique as well

as common experiences. We have attempted to draw greater attention to more commonly experienced factors and have referenced other literature where they are found to be similar to other studies.

With every qualitative research project comes an element of subjectivity in analysis and interpretation. We are analysts using techniques to shape and retell stories translated with chance into research and as such face the possibility of being too reductionist. Storytellers may modify or withhold certain information either deliberately or subconsciously.

How to evaluate and validate a narrative analysis can present a problem. Traditional notions of reliability do not apply to narrative studies so validation is difficult and may need to be strengthened or supported by other research methods. Perceptions of validity need to be radically re-conceptualised to include persuasiveness of the accounts, correspondence (cross checking with the story teller), coherence of findings and their pragmatic use. Despite their limitations, narratives are emerging as a primary unit of analysis in social psychology, education and cultural anthropology (Bruner, 1987).

Many factors have helped and hindered narrators' recovery journeys. To add a more dynamic element to this research it might have been helpful (prior to deletion of contact details) to have arranged to revisit participating narrators in up to three years time to engage them in a further dialogue about what factors have affected their recovery journeys in the intervening period. Also, it may be pertinent to purposively investigate the individual topics presented in this report in order to identify their significance to recovery.

Report structure

The narrative research conducted by Brown and Kandirikirira for the SRN has produced very complex, rich data. In order to ensure that this data can be easily accessed and assimilated by readers, the authors have produced several chapters of evidence that will highlight the things that have helped individuals along their recovery journey. The chapters include: re-finding your self and your identity, re-engaging socially and finding meaning and purpose in life, building meaningful relationships, finding the right treatment and supports for you, recovering at your own pace, recognising opportunities for recovery and reframing your attitudes to be more recovery oriented.

Each chapter will contain a brief summary of contents, a review of relevant literature, findings and a brief discussion of the policy implications of findings. In order to fully engage our network in the dissemination of this research it is the intention of the authors to invite wider comment upon the policy implications of our findings. It is hoped that in doing so we can generate wider discussion and thought about what helps people recover from long term mental health problems.

Demographics

A synopsis of demographic figures relating to the narrators is presented here. Narrators derived from rural, urban and island environments throughout Scotland. Sixty seven individuals completed a telephone interview and demographic questionnaire and 64 completed an intensive narrative interview. Of the 67 initial participants, 84% described themselves as Scottish, the remaining individuals as English (5%, n:3), Irish (3%, n:2), Welsh (1%, n:1) and of other nationalities (7%, n:5). Only two individuals (3%) were of non-white ethnic origin. There was an even gender balance with 52% (n:35) female and 48% male (n:32). Individuals ranged in age from 28 years to 70 with a median age of 46 years at time of questionnaire completion. Eighty one per cent (n:54) of individuals were heterosexual, 9% (n:6) homosexual and 5% (n:3) bisexual (four individuals preferred not to indicate sexuality).

Demographics

Most individuals (n:52) voluntarily described some form of diagnosis ranging from various types of depression, anxiety, mania, and personality disorder, to various forms of psychosis (diagnostic terms were provided by narrators). Twelve per cent of narrators (n:8) had no 'official' diagnosis and 11% (n:7) were unsure of their 'official' diagnosis. Some individuals had previously contemplated suicide or self-harm. A number of individuals stated that their diagnosis (and subsequent treatments) had changed over the course of their ill-health and many narrators had been hospitalised. Seventy-nine per cent (n:53) of individuals were being prescribed medication for mental health problems and 25% (n:17) were receiving therapeutic non-drug treatments for mental health problems at the time of questionnaire completion. Twenty one per cent (n:14) of narrators had an additional physical disability.

Narrators held various types of housing tenancies. Thirty six per cent (n:24) lived alone without support, 27% (n:18) lived with a partner and 12% (n:8) lived with family members or dependents for whom they held responsibility. Twenty one per cent (n:14) of participants lived alone with support, and 6% (n:4) lived in supported accommodation.

Thirty-three per cent of participants (n:22) were in full or part-time work, including 6% (n:4) who were full or part-time self-employed. Another 34% (n:23) of individuals were in voluntary unpaid employment with the remainder of participants being retired, in education, on sickness benefits or employed in unpaid domestic capacities. Of those not in paid work, many aspired to be in paid employment (n:12), others wished to pursue voluntary work or further education whilst 14 individuals (21%) felt incapable of working full time in any capacity.

Eighty four per cent (n:56) of narrators received some form of state benefit with many receiving multiple sources of benefit income. Health related benefits ranged from various types of Disability Living Allowance (n:33) and Severe Disablement Allowance (n:4) to Short and Long Term Incapacity Benefits (n:25). Other benefits received included work, housing and family related benefits and tax credits. Sixteen per cent of participants (n:11) received no form of state benefits.

Educational attainment of participants varied widely with some individuals obtaining a basic high school education and others obtaining further and higher education qualifications. Several participants held university masters qualifications or a PhD. Others were vocationally well qualified having completed apprenticeships and having gained work experience.

The authors recognise that the high level of educational attainment found within this group could be considered atypical of individuals with long term mental health problems. Overall, a relatively heterogeneous population was represented. They were however, held together by their common experience of being in recovery or having recovered from long term mental health problems.