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USING THE TREE OF LIFE GROUP IN UK MENTAL HEALTH CONTEXTS.

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MRP portfolio summary

Section A is a literature review exploring the potential utility of the Tree of Life group in UK mental health contexts. Thirteen studies were included in the review and the findings were synthesised and critically evaluated. It could be suggested that the Tree of life group could be useful in UK mental health contexts due to its alignment with the concept of 'recovery', its inclusiveness and some of the processes of the group that are relevant in mental health contexts. Clinical implications and directions for future research are identified.

Section B presents a Thematic Narrative Analysis of the stories that people tell of inpatient admission and the Tree of Life group. Several shared narrative themes were identified that suggest the recovery orientation of inpatient wards is limited, and that the meaning attributed to preadmission experiences mediates inpatient experience. The Tree of Life group was shown to promote recovery values in inpatient settings although its impact on the scope of wider admission was limited, possibly due to the impact of context. Clinical implications, limitations, and directions for future research are discussed.

 Section C is an appendix of supporting materials.

Contents

List of figures

List of tables

Major research project

Sophie Parham

Section A literature review:

Could the Tree of Life model be a useful approach for UK mental health contexts? A review of the literature.

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Abstract

The Tree of Life (ToL) group, a Collective Narrative Practice, has become increasingly popular over recent years and is now used in a wide range of contexts. Some have suggested that the ToL model aligns with some elements of personal recovery, so could be helpful for mental health contexts within the UK. This review collated fourteen papers written on the Tree of Life group to explore whether the model could be a useful model in UK mental health contexts, according to the research and descriptive literature. The literature was synthesised using the thematic analysis method and three broad themes were identified that help to answer the review question. These were recovery aligned themes, the inclusivity of the ToL model and ToL group processes relevant to mental health contexts. The literature is critically appraised and key concerns regarding the wider literature and research papers are discussed. Future clinical and research implications are summarised.

Introduction

Narratives regarding mental illness have changed in recent years from 'disorder narratives' centred around prolonged, lifelong disability, decline and the need for lifelong care (Harding, Zubin & Straus, 1987; Ridgway, 2001) to narratives that acknowledge 'personal recovery'; where individuals can live meaningful lives in the presence of ongoing mental health difficulties (Slade et al, 2012). Concepts of personal recovery have come to dominate mental health legislation and policy with services emphasising the importance of meaning making, personal choice, agency and hope as key elements of recovery from mental ill-health (Slade et al, 2014). However, it has been acknowledged that this transformation in policy has been difficult to translate into practice. Some have highlighted the lack of recovery-focused care in mental health services and have criticised the 'tokenistic' approach to recovery that often exists in inpatient wards (Slade et al, 2014). Consequently the Five Year Forward View for Mental Health (2016) recommended that services should increase recovery focused activity in mental health settings (Mental Health Taskforce, 2016; NHS England, 2014.).

 The Narrative Approach

The word 'narrative' refers to the emphasis placed upon the stories of people's lives and the differences that can be made through telling and retelling of these stories (White & Epston, 1990). Narrative therapists believe that people tell stories to give meaning to their experiences and these stories, or narratives, are influenced by dominant social, cultural or political context (White & Denborough, 1998). When a context is problem or deficit focused, as some suggest mental health services are, the stories people tell about themselves come to reflect these discourses and become problem saturated (Payne, 2006). Narrative approaches intend to 'thicken' the problem saturated accounts of people's lives by reconnecting the

person with parts of their life that are not dominated by the problem; such as listening out for the skills, abilities, values and hopes that people have used to resist the influence of a problem on their life. These stories of resistance facilitate the development of an 'alternative story' filled with strength and resilience rather than problems and deficits (Morgan, 2000).

Collective Narrative Practice

The phrase Collective Narrative Practice (CNP) describes a collection of group methodologies developed to respond to communities who have experienced significant distress, and for contexts where traditional therapy may not be culturally resonant, or possible (Denborough, 2012). CNPs are based on the premise of narrative therapy and aim to allow people to address experiences of distress 'without speaking directly about them' (Denborough, 2012). The first CNP (The Tree of Life) was developed in response to concerns that the Western notion of catharsis (that talking about strong emotions provides relief) was not culturally universal, could be re-traumatising for children and did not leave space for culturally diverse responses to distress (Collins English Dictionary, n.d; Ncube, 2006).

Since the ToL there have been a number of CNPs developed that are structured in ways that make sense to different cultures and communities, often based on traditional folklore. Each CNP uses a different metaphor to structure the group (a tree, a recipe, a river) but consists of similar elements (Abu-Rayyan, 2009; Hegarty, Smith & Hammersley, 2010; Wood, 2012; Denborough, 2010a; Rüsch et al, 2014). This includes helping people to find a safe place to stand by identifying the rich mix of skills and strengths within a community alongside hopes and dreams for the future, and then exploring the rich ways that communities have responded individually, and collectively, to hardship to create an alternative story of coping and resilience (Denborough, 2012). A summary of the ToL group and the narrative intentions of the group can be found in table 1 below. A general overview of the history of CNPs can be found in Denborough's article (2012).

Table 1: *Table to show the Tree of Life group protocol and narrative intentions of the group.*

Tree of Life group protocol		Narrative intentions (Ncube, 2006)
Session 1: Drawing the tree	Participants are asked to draw a tree where each element of the tree represents part of their life including strengths, supportive people and hopes and dreams for the future.	Drawing the tree helps to thicken 'thin' stories such as stories of 'illness' that identify problems but ignore other parts of a person's life. Once the person has reconnected with their identity and who they are outside of the problems they have experienced, also known as a 'safe place to stand', then it is deemed safe to think about problems (Ncube, 2006).
Session 2: The forest	This part of group involves participants observing each other's' trees and having the chance to tell a story about their own tree whilst the rest of the group listen. The group act as witnesses to the story and then have the chance to comment on what they have noticed or appreciated about that person's story.	When someone has authored an alternative story about their life, witnesses can be used to help validate these new stories (White, 2000). Members of the group such as facilitators and other participants can be used as outsider witnesses who bear witness to the new stories that have been authored by participants.
Session 3: Storms	The storms element of the ToL group is a chance for participants to come together and talk about the challenges they face from a position of solidarity. Particular attention is paid to how participants have been able to respond to challenges in their lives and there is also time to think about how they can use these knowledges to tackle future challenges.	The storms element highlights how people have responded to the traumas in their lives andhelps people to think about how they can use this knowledge to overcome future storms they may face (White, 2006, p. 28). Participants are helped to see that the problems they face are not their fault and are influenced by other factors such as history, culture and politics (Denborough, 2012).
Session 4: Celebration & certificates	In the final part of the group participants are awarded certificates detailing important parts of their tree story and paying attention to the contribution they have been able to make to the group.	Narrative therapists use documents to recognise and honour the steps that people have taken to tackle problems and make preferred changes in their lives (Ncube, 2018; Payne, 2006). The ToL uses certificates which are presented to participants at the end of the group in a ceremony. Others are invited to bear witness to their alternative story through the presentation of the certificate.

Recovery focus

Why study the ToL group in UK mental health contexts?

Recovery focus

Some have suggested that the strength and re-storying focus of the ToL model, aligns with the mental health recovery movement (Fraser,Williams, Hayes, Akpan, & Bowerman, 2018). Others have highlighted how the ToL group's focus on personal understandings and responses to mental health difficulties, above those offered by 'experts', further echoes the recovery movement (Nurser, 2017; Fraser, 2018). To this end, the British Psychological Society (BPS) has recommended further investigation of the Collective Narrative Practices in UK mental health contexts, particularly inpatient settings, to improve recovery aligned activities (DoH, 2001; BPS, 2012).

Cultural applicability

Black and Minority Ethnic (BME) communities are underrepresented in access to mental health services across Western countries and research with BME communities have described that Western mental health services can be experienced as strange, foreign and unhelpful (Memon et al, 2016). It has been highlighted that Western psychological services are insensitive to cultural traditions which is likely to act as a further barrier to accessing psychological support due to the lack of culturally responsive psychological interventions and understanding of cultural differences by mental health services (Clement et al, 2015; Nobles, 1980; Sue, & Zane, 1987). The ToL group could be a model of psychological therapy that helps respond to some of these concerns within UK mental health services.

Cost

It is well documented that in the current NHS climate there is a shortfall in psychological therapy provision (Hellider, 2009; Paturel, 2012). Groups are an effective way to increase access to psychological therapies in a cost-effective manner whilst providing additional therapeutic benefits of social cohesion and universality (Yalom & Leszcz, 2005). In addition, by running a group that engenders many concepts that service users themselves have described as important in the recovery process, and with an ethos that moves away from the idea of 'cure' (as in clinical recovery), services may be able to redirect resources into what is important to service users; this includes creating a meaningful life in the presence of ongoing psychological distress. With this in mind service users could be discharged earlier from services, with support focusing on managing, rather than removing symptoms. This change of focus in mental health care could ultimately reduce inpatient admissions and in turn lower costs.

Past review on the ToL group

A review of the literature was carried out on the Tree of Life group in 2016, however this review did not employ a systematic search strategy (Lock, 2016). Further limitations of the review were that it did not distinguish between formal research articles and descriptive papers and it excluded a large number of papers that have reported on the ToL group (6); either because they have been written since the previous review, or because the authors search strategy did not identify the papers. The aim of the review was to 'inform practitioners of the key elements of the approach' and therefore does not discuss outcomes or critically appraise studies, which this review sets out to do.

The current review

The narrative approach is grounded in post structuralism and social constructionism (White, 1997). Thus, narrative literature often moves away from structuralist research

paradigms towards a rich network of 'non-research' (Greenhalgh, 2014 p30, p170) practice-based evidence. However, due to dominant discourses in health care of evidenced based practice being the gold standard, this is often not seen as 'credible knowledge' of the utility of narrative approaches and may often be left out of empirical reviews (Neimeyer, 1993; Roy-Chowdhury, 2003; Nolte, Brown, Ferguson & Sole, 2016). To exclude this rich descriptive information on account of what is deemed acceptable knowledge by dominant power structures (Smith, 1997) would create a 'thin' story of the ToL group. It may risk excluding many helpful stories about the identity of the ToL model that may be too complex to fit within traditional research paradigms or may not align with traditional empirical measures (Roy-Chowdhury, 2003; Greenhalgh, 2014, p235; Wellman, Lepori & Szlachcic 2016). Clinicians have acknowledged the benefits of including practice-based evidence within reviews, as it helps to bridge the research–practice gap that often exists in healthcare settings (Dixon-Woods et al, 2018; Greenhalgh, Thorne & Malterud, 2018). Therefore, this review synthesises research and non-research literature; including papers that are not described as research papers, do not present aims, a method or clearly report research outcomes, but instead describe an application of the ToL group (the term descriptive papers is adopted for the purpose of this review).

Aims

To the authors knowledge this is the first time that a broad selection of literature on the ToL group has been brought together and synthesised whilst critically appraising the available evidence and exploring whether it could be a useful model for UK mental health contexts. Descriptive articles are included in the review to explore the stories told about the ToL group in a 'rich' way.

This review employed a systematic search strategy to answer the following question:

1. Could the ToL model be a useful intervention for UK mental health contexts (referred to as mental health contexts hereafter)?

Method

Literature search

Three electronic databases were searched on the 15th February 2019. As the Ncube's (2006) ToL methodology was first published in 2006, the date range used was limited from January 2006. Searches were conducted using PsychINFO, SAGE (both searched using "Tree of Life" and (group or collective) and Wiley online library (searched using "Tree of Life" AND (group OR "Collective Narrative Practice"). As this review does not exclude descriptive papers, literature searches had to continue beyond standard database searches. The International Journal of Narrative Therapy and Community Work was later searched using the term "Tree of Life" and then "Collective Narrative Practice" as this database holds a lot of accounts written about narrative work. Similarly a wider search was conducted using Google, Google Scholar and publications such as 'Context' and 'The Clinical Psychology Forum' to ensure as many descriptive articles as possible were included. Several clinicians who are embedded within ToL networks including a key figure in creating the ToL group were approached for any additional papers that may have missed and the author posted a question on a specific ToL social media page regarding additional papers. A further 6 papers were found and examination of the reference section of all papers revealed four more relevant papers. Please see table 2 for inclusion criteria for papers identified in the literature search.

Table 2: *Inclusion criteria for the systematic search*

Inclusion criteria
Published in English
Published in peer reviewed journals

Researched or described work using the TOL methodology

Specifically used the Tree of Life methodology as described by Ncube (2006) and Denborough (2008) and not a different CNP (e.g. 'Team of life' and 'Beads of life' were excluded.

Search Strategy flow diagram

Figure 1: *PRISMA (Moher et al, 2009) Flow Diagram*

Literature review

Structure of the review

The review is a narrative literature review and will be structured according to themes drawn out from the literature using a thematic analysis method (Ferrari, 2015; Thomas & Harden, 2008). Individual papers were analysed using thematic analysis (Braun & Clarke, 2006). Firstly, the descriptive papers were read in full and then content from the articles were organised into codes so that themes could be explored across papers, forming part of the synthesis. Overarching patterns or divergences between themes were identified so that initial codes could be organised into grand themes.

Due to the range of study designs (see table 5 for a summary of the literature found in the review) found in research studies in the literature several critical appraisal frameworks were employed for the review (See appendix 1 for a table detailing the research studies and their quality appraisal). The Critical Appraisal Skills Program (CASP) frameworks were used to review qualitative and quantitative papers (CASP, 2018). For mixed methods papers, each element (quantitative or quantitative) was assessed using the appropriate CASP framework then the Mixed Methods Appraisal Tool (MMAT; Hong, 2018) was applied to the study overall (MMAT, 2018). The case study was assessed using the Evidence Based Medicine and Practice (EBMP) 'critical appraisal of a case report' framework (Roever & Reiss, 2015).

Summary of the literature

The literature search revealed fourteen relevant papers of which seven were research articles and seven were descriptive articles. Of the research articles four used qualitative

methods including thematic analysis and case study. Three studies employed mixed methods. All of the papers could be broadly divided into two contexts; health services including mental health services, and marginalised populations including refuges and people with learning disabilities. It is not known exactly how many participants were included in the review overall as some studies did not include participant numbers; 70 is the amount reported. Groups were run in the UK, Greece, South Africa, Australia and America with people from the UK, Bangladesh, Afghanistan, Libya, Zimbabwe and Mexico.

Table 3: *Table to show all papers found in the review*

Author	N	Context	Design	Measures	Analysis	Outcomes (Research papers only) or main themes	Adaptation	Contextual challenges
Ncube 2006	22	Original ToL group Bereavement camps (HIV/AIDS) in South Africa with children One day workshop	n/a	Facilitator descriptions and some quotes	none	Different perspective on identity Hope Connecting with others Inclusive model Removed shame Positive experience /engaging model	None	Concerned that existing models of therapy trap people in problem saturated accounts of their lives, can be re-traumatising and not culturally relevant.
McFalane & Howes 2012	Not reported but multiple groups have been run	Parenting intervention for 'hard to reach families' form low SES backgrounds. London	Descriptive	Facilitator description	none	Personal reflection Connect with others Improved relationships to services Removed shame Challenge dominant discourses & stigma Engaging	Combined with behavioural parenting intervention to aide engagement by giving space for parent's experience whilst retaining 'helpful' behavioural elements.	Limited evidence base for client group. Families who previously didn't engage with services. Existing interventions gave little space for parent's own experience.
German 2013	29	School setting. To learn about culture. Eight 90-minute sessions. London	Mixed methods Repeated measures	Beck youth inventory of self-concept (Beck, Steer, Epstein & Brown, 1990). Post-evaluation interviews	Statistical analysis (t-test, ANCOVA,) Content analysis and frequency counts	Significant improvement in self-concept post ToL compared to pre ToL. Positive experience of the group Improvements in cultural knowledge of themselves and others.	Added extra exercises relating to understanding culture or cultural differences. Also added deconstruction exercises about elements of the group such as 'what is appreciation?'	Limited appropriate interventions that explore strength and nurture what works well, rather than just focusing on weakness and damage.

Butera-Prinzi, Charles & Story 2014	Four families	Traumatic brain injury service Family to family link up therapy Australia	Descriptive	Therapist description	None	Connecting with others Positive personal & family identities	Combined with Family therapy to connect multiple families together	Worried about individualising what is a collective experience – inadvertently increasing vulnerability
Schweitzer, Vromans, Ranke & Griffin 2014	1	Libyan Refugees settled in Australia	Case study	Observations (of therapeutic processes that enabled the participant to adopt a preferred self-narrative).	None	Exploration of alternative stories of self Group cohesion Corrective emotional experience Outsider witnessing Instillation of hope.	Sessions included at the beginning to develop a richer understanding of home and belonging.	Few successful interventions to support child refugee mental health.
Mendez & Cole 2014	Not reported	Wrap-around service. Family therapy with Latino families living in the America	Descriptive	Therapist description	None	Improved relationships to services Acknowledges wider context of the 'problem', reduces shame. Enables therapist to better understand client's cultural values.	Combined with family therapy to explore each family members values and acculturation strategy.	Cultural beliefs as barriers to therapy. Need or an approach that address family values, acculturation and self-disclosure levels.
Hughes 2014	Not reported	Parenting intervention for Afghani refuges living London	Descriptive	Therapist description	None	Reinforcing of identity & personal resources (strengths). Social support Improved Engagement in further support Empowerment from 'Takwal' (no direct translation but linked to faith). Culturally appropriate	Talked about 'Tashwish' – depression before drawing the tree. Externalised Tashwish. Used interpreters.	Cultural barriers to accessing 'traditional mental health support'. Concerned about disempowering participants.

							Removed sense of shame (strengths & context)		
Wellman, Lepori & szlachcic 2016	9 but 8 completed measures	Adult inpatient mental health London 7 Weekly sessions	Qualitative	Most important event questionnaire (Bloch, Reibstein, Crouch, Holroyd, & Themen,1979).	Thematic analysis	**Personal refection** -Re-discovering Identity -Reflection on strengths **Creating community** -Relationships -Sharing **Usefulness of metaphor** -Challenging dominant discourse -Group development	Added 'damaged roots' when drawing the tree. This was included instead of the later 'storms' element. Peer support	Limited recovery focused interventions for inpatient settings.	
Randle-Phillips, Farquhar, & Thomas 2016	4	Learning disabilities service 6 one-hour sessions England	Mixed methods,	CORE LD Marshall & Willoughby-Booth (2007). Rosenberg self-esteem Inventory (Rosenberg, 1965) Semi structure interviews	Descriptive statistics Thematic analysis	Scores not analysed but 'generally remained the same'. Main themes: Positive emotional response Social interaction	Adapted communication style, using pictures.	Limited suitable therapies for people with communication difficulties.	
Casdagli, Christie, Ali, Girling & Fredman 2017	93 have attended groups, not clear how many were included in research	Paediatric diabetes service London One day workshops	Qualitative	Evaluation interviews Followed up with telephone interviews	Thematic analysis	**Building a positive view of the self.** -Focusing on my qualities -Separating myself from diabetes -Empowerment **Connecting with others** -A feeling of togetherness -A space to share experiences	Included peer trainers to support the running of the group.	Traditional psychological models locate problems within young people and their families, rather than as a legitimate expression of distress.	

						- Learning from each other **Responding to negative attitudes about diabetes** -Improving diabetes management		
Ibrahim & Tchanturia 2017	5	Eating disorder service London 6 one-hour sessions	Qualitative	Focus group Semi-structured interview	Thematic analysis	Offering an alternative perspective (focus on something other than the eating disorder/ new perspectives/ identity). Creating community (Supportive of each other, not in competition). Hope An image to remember, share and change (valued the metaphor)	Extra sessions such as 'externalise the eating disorder', 'our optimal self' (what resources does a tree need to flourish), becoming a witness (creative writing exercise), consolidating (how to use trees in the future), reflecting on our journey (reflect on experience of the group).	Finding engaging group therapy formats for people with eating disorders (addressed challenges that can arise with this client group).
Fraser, Williams, Hayes, Akpan & Bowerman 2018	16 (staff)	Inpatient psychiatric ward London Two-hour workshops	Research	Themes from **staff** focus groups	Thematic analysis	Relating to each other (staff & service users) – outside of group Challenges (boundaries & staffing) Accessibility of model Culture	Included peer trainers, removed storms element.	Response to lack of activities on the ward, to provide a recovery focus away from 'custodial values' and to provide support to BAME service users.
Ibrahim & Allen 2018	6	Adult bipolar disorder service London 5 sessions (1.5 hours)	Mixed methods	Semi Structured interview (focus group) CORE (Evans et al, 2000). Mental Health	Thematic Statistical analysis	Social support & Hope Understanding & coping (empowerment) The Tree of Life model (experience) Group processes (Challenges) Scores on the CORE remained the same pre and post the ToL group.	Combined with CBT for bipolar disorder to improve social support of intervention and to help participants construct personal understanding of their experiences.	CBT does not influence relapse rates, does not address social support aspect of recovery.

				Recovery Measure (Young & Ensing, 1999).		Scores on the Mental Health Recovery Measure remained the same.		
Jacobs 2018	Not reported	Unaccompanied refugee minors Greece Two-day workshop	Descriptive	Therapist observations	None	New perspective of difficulties Learning from and appreciating others New conversations about the future (hope) Cultural applicability.	Used translators to adapt communication style.	Western approaches to mental health may not be suitable for refugees. Language barrier. Limited time. Risk of re-traumatising & disempowering.

Thematic Summary

Three overarching themes were derived from the literature that applied to the utility of the ToL group in mental health contexts and are summarised in table 4 below.

Table 4: *Table to show the themes derived from the literature*

Grand themes	*Sub themes*
Themes that align with the concept of 'Recovery'	Alternative stories of self
	Connecting with others
	Hope
	Empowerment
	Psychological distress
Inclusivity of the ToL model	Overcoming barriers to psychological support
	Cultural applicability
	Challenging stigma & reducing shame
Processes of the ToL group relevant for mental health contexts	Experience of the model
	Flexibility of the model

Themes that align with 'CHIME' stages of personal recovery (Leamy et al, 2011)

Thirteen papers were identified as belonging to at least one theme that aligns with the concept of personal recovery from mental health difficulties (Leamy et al, 2011). This framework was used to guide the reporting of the themes, after the initial analysis had been completed. Bracketing measures were taken to reduce chances of bias in 'moulding' themes to fit with the model.

Alternative stories of self. A dominant theme across six research and five descriptive papers was the idea that the ToL group creates an alternative narrative for individuals away from problem saturated descriptions of their lives (Ncube, 2006; German, 2013; Butera-Prinzi, 2014; Schweitzer et al, 2014; Hughes, 2014; Wellman, 2016; Randle-Philips et al, 2016; Ibrahim & Tchanturia, 2017; Casdagli, Christie, Girling, Ali, & Fredman, 2017; Jacobs, 2018; Fraser et al, 2018).

In the papers that used the ToL in health contexts, the model helped participants look beyond seeing themselves solely in terms of their illness (Cadagli et al, 2016; Wellman et al, 2016; Ibrahim & Tchanturia, 2017; Fraser et al, 2018). For example, in Casdagli et al's (2017) group for young people with diabetes, the participants felt that the ToL model helped to see diabetes as part of themselves rather than their full identity.

*"I often feel like I am just a diabetic…, but this has helped me realise that there is much more to me" (*Casdagli et al, 2017, p. 13).

The participants in Casdagli et al's (2017) group as well as two other papers (Ibrahim & Tchanturia's; 2017; Schweitzer et al, 2014) specifically mentioned the process of outsider witnessing as an important element of the group that facilitated the development of an alternative, more positive view of the self, such as:

"Having the group act as witnesses… helped… strengthen a [positive] *self-narrative"* (Schweitzer et al, 2014, p. 14)

In Schweitzer et al's (2014) paper the relevance of outsider witnessing was the view of the author rather than the participant themselves. Concerningly the process of 'outsider witnessing' was considered especially relevant in the introduction to the paper, which raises questions as to whether the observer may have been biased in looking for this process to be important. Moreover, Casdagli et al. (2017) gave little information on how the data from

focus groups was analysed and how main themes were selected so it is possible that there was some bias in the selection of positive responses to the group as the researchers were also facilitators of the group.

Two papers used questionnaires to quantitatively explore the effect of the ToL group on participants' self-esteem and self-concept; the results revealed a split in the data (Randle-Philips et al, 2016; German, 2013). In the context of a ToL school-based group German (2013) reported a statistically significant increase in post compared to pre-scores on the Beck Self Concept Inventory (Beck et al, 1990). The study reported a large effect size and controlled for extraneous variables such as gender, ethnicity and age showing a robust improvement in self-concept after the ToL group. In contrast, in the context of a group for people with learning disabilities, Randle-Philips et al. (2016) found that participants' self-esteem decreased between pre and post measures. However, the author did not employ statistical analysis of these scores, so it is not clear whether this was a significant decrease. Moreover, the self-esteem measure (Rosenberg Self-esteem scale; Rosenberg, 1965) was administered to individuals with a learning disability despite not being validated for this population which could have caused issues in the validity of the findings from this measure.

It is also important to note here the difference in the measures here of looking at the 'who am I/ identity' element of self (self-concept; German 2013) including future goals, strengths, beliefs and values; compared to the 'how confident am I in myself' element of self (self –esteem; Randle-Philips, 2016). As mentioned above, it was developing an alternative identity or self-concept that the ToL model aligned with and intends to develop (who am I). It is not denied that they are inextricably linked but when someone has been exposed to an alternative version of themselves or their identity, it may take some while to develop confidence in this new-found story. Thus, the self-esteem scale may not have been a valid

measure even if it had been used correctly due to the mismatch between what it intends to measure versus what the ToL intends to do.

Connecting with others. A key theme reported in seven research papers was the idea of being able to connect with others or find social support and emotional containment from others: (Ibrahim & Tchanturia, 2017; Wellman et al, 2016; Casdagli et al, 2017; German 2013; Schweitzer et al, 2014; Ibrahim & Allen, 2018; Randle-Philips et al, 2016)

*"I like the way it brought everyone together to actually work with each other… I learned a lot" (*German, 2013, p. 86)

This theme was also present across five descriptive papers and connecting with others in the group enabled members to have their experiences heard and put into context of others' experiences (Butera-Prinzi et al, 2014; McFarlane & Howes, 2012 & Hughes, 2014; Jacobs, 2018; Ncube, 2006).

'I know I'm not alone' (Hughes, 2014, p. 149)

In Ncube's (2006) group for bereaved children reference was made specifically to the ToL facilitating participants to 're-member' (see table 1 for definition) and purposely re-connect with people, past and present, who have been important in the person's life; for example:

'there are many people who have done a lot for us in our lives but sometimes we forget this and rarely acknowledge them'. (Ncube, 2006, p. 18)

Three papers reported that this feeling of connecting with others, or community transferred to the context outside of the group (Wellman, 2016; German, 2013; Fraser, 2018; Butera-Prinzi, 2014). For example, in the paper that explored staff perceptions of the ToL group in an inpatient psychiatric ward, connecting with others in the group was said to have

helped to improve the ward environment as staff begun to see service users in terms of their identity and not just as patients (Fraser et al, 2018).

*'It gives me a good starting point for me to build rapport with them to find out about their life.' (*Fraser et al, 2018, p. 10).

However, the results from Fraser et al. (2018) should be interpreted with caution as the paper did very little to describe the method of the research including how participants were chosen, what questions were asked to participants, who held the interviews and how the themes were derived. It is noted that the author of the paper is heavily involved in the running of the ToL groups and therefore participants may have felt compelled to respond positively, or the questions asked may have influenced the responses; particularly as attending the group was part of paid employment for ward staff. Furthermore, there was no longer term follow up after the group, so it is not known whether these gains were maintained over time.

Engendering hope. The theme of hope was particularly well represented in groups run in mental health contexts and was identified in three research papers (Wellman, 2016; Ibrahim & Tchanturia, 2017; Ibrahim & Allen, 2018). Identifying a renewed attitude towards the future was reflected metaphorically with the idea of moving away *'doom and gloom'* or darkness towards light (Wellman et al, 2016).

"...rather than it all being about a dark path" (Ibrahim & Tchanturia, 2017, p. 8),

"I can see a light at the end of the tunnel" (Ibrahim & Allen, 2018, p. 17).

This was also replicated in descriptive papers with group run to support mental health reflecting the strongest representation of installing 'hope' where participants reported having renewed hope or faith that could help them to survive the storms they were facing and *'look forward to living each day'* (Ncube, 2006; Hughes, 2014; Jacobs, 2018; Butera-Prinzi et al,

2014). However, in the descriptive papers no reference is given to how themes or quotes are chosen to be included in papers. It is possible that there could have been bias from authors who did not employ formal analysis of feedback as to which feedback was paid attention to; especially given that one of the key intentions of the ToL group is to install a sense of hope.

Empowerment. The theme of empowerment was present in two descriptive papers and one research paper but although not as commonly reported as 'hope', was closely linked to the concept of hope in other papers. Participants reported feeling able to overcome future challenges. In the context of parenting support for 'hard to reach' or refugee mothers, parents reported having new ideas or a feeling of strength within themselves (Hughes, 2014; McFalrane & Howes, 2012)

"I feel stronger now as a parent" (McFarlane & Howes, 2012, p. 24)

Some papers also reported that participants had specifically learnt new ideas, from themselves or from others, to help them feel able to tackle and overcome problems in their lives (Casdagli et al, 2017).

Tree of Life and Psychological distress. Two quantitative papers explicitly explored the impact of the ToL group on psychological distress using the Clinical Outcomes in Routine Evaluation (Randle-Philips et al, 2016; Ibrahim & Allen, 2018). The studies found that the scores remained the same with no statistically significant reductions in distress. However, both studies had a very small number of participants to be employing statistical analyses (four and six respectively) and no consideration was given to issues of power which is likely to have rendered the data invalid.

In the context of a group for people with bipolar disorder, Ibrahim & Allen (2018) used the Mental Health Recovery Measure to explore if the ToL group had any impact on recovery from psychological distress. Similarly, the measure showed that participants' feelings of

'recovery' remained the same in all domains on pre and post measures. The recovery measure was administered in the final group session and was not followed up thus it is not clear whether the measure may have been impacted by negative, or positive feelings at the ending of the group. Additionally, any impact of the group on recovery may need time to develop and thicken through other processes. Once again there was a very small number of participants therefore any results, even non-significant results should be interpreted with caution.

Despite the methodological concerns the non-significant findings are supported by the absence of an explicit theme relating to reductions in psychological distress in any of the descriptive or qualitative papers. Other factors such as social connectedness, self-identity and hope may contribute to longer term reductions in psychological distress, but similarly this is likely to take time to emerge or have any effect so using the quantitative measures at a longer follow up may provide more valid results.

Inclusiveness of the ToL model

A theme evident across all fourteen papers was authors' description of the inclusiveness of the Tree of Life model in some way.

Overcoming barriers to psychological support. Every paper found in the literature referred to the ability of the ToL model to overcome barriers to providing psychological support either related to the participants' demographics or the setting the therapy was delivered in. Many papers identified participants that may be deemed 'difficult to engage' in other types of psychological therapy including those from non-Western cultures, those in mental health crises, or individuals with a learning disability (Jacobs, 2018; Fraser et al, 2018; Randle-Philips et al, 2016).

"This approach may be helpful for people who had found it difficult to engage in psychological therapy in the past" (Randle-Philips et al, 2016, p. 3).

An example of this was the four papers in the literature that referred to using the ToL model with refuges (Jacobs, 2018; Hughes, 2014; Schweitzer et al, 2014; McFarlane & Howes, 2012). In the context of running a ToL group in a refugee camp in Greece, Jacobs (2018) explained that traditional models of psychological support may disempower refuges by their focus on problems and that the ToL model was one way to overcome this. Jacobs (2018) also highlighted how Western models of therapy are unusual, or stigmatising, to refugees which may stop them accessing traditional types of mental health support.

"Connecting with refugees is quite a challenge, as they usually come from countries that do not facilitate mental health support" (Jacobs, 2018, p. 281)

Despite all authors referring to the ToL group as an inclusive model, none of the papers investigated this from the perspective of group participants of the group. It is possible that this observation about the inclusive nature of the ToL model may be a biased opinion that may be evidenced through those who have chosen to participate in the group, rather than those who declined to be involved.

All other authors acknowledged that the ToL group could help overcome contextual challenges to providing traditional models of psychological support (detailed in table 6). For Jacobs (2018) this included working with *'limited time'* and resources (Jacobs, 2018, p. 282), but for others included concerns about "*the potential to disempower and silence people [with]… psychological interventions*" (Hughes, 2014, p. 140) by focusing on problems saturated descriptions of people's lives (Hughes 2014; Wellman et al, 2016; Fraser et al, 2018) or, recognising the limited evidence base for parenting interventions (McFarlane & Howes, 2012).

Cultural applicability. All papers that used the ToL with refugees or with any participants from a non-Western culture referred to the cultural applicability as a key reason for using the ToL model (Mendez & Cole, 2014; Jacobs, 2018; Hughes, 2014; Schweitzer et al, 2014; German, 2013; Hughes, 2012). There was emphasis on the ToL model being able to incorporate different understandings of psychological distress that may not fit within other models of mental health care due to their Western values.

"...Western mental health service impose models of mental health care that do not fit [with non-Western cultures]" (Hughes, 2012, p. 141)

Mendez and Cole (2014) also found that using the ToL to learn about culture between therapist and client helped to improve relationships in the therapy but also noticed that it improved engagement in other services, as families felt they were better understood by therapists. The ability of the ToL group to improve engagement in services was also noted in two other papers (Hughes, 2014; McFarlane & Howes, 2012)

"The Tree of Life activity can be used as an important tool in gathering cultural values ... to provide culturally sensible services" (Mendez & Cole, 2014, p. 219)

German (2013) specifically focused on the ability of the ToL model to help others learn about different cultures in the context of reducing racism in school children. German (2013) used quantitative measures to explore the effect of the ToL group on cultural understanding and awareness (German, 2013). Statistical analysis of the scores revealed that there were significant increases in cultural understanding after attending the ToL group compared to cultural understanding before the ToL group. However, it must be noted that the ToL model was used among other exercises to help the children understand their own and other cultures, such as conversations with parents and show and tell exercises in the classroom; therefore, it

is not clear how much the increase in cultural understanding was due to the ToL model or the other classroom exercises.

Reducing stigma and shame. Four research and four descriptive papers highlighted the ability of the ToL model to 'deconstruct', challenge or acknowledge wider societal discourses that contributed to 'problem' narratives; such as the stigma and labels applied to people with learning disabilities or the wider systemic issues parents faced including poverty, deprivation and past abuse or negative attitudes surrounding diabetes (Randle-Philips et al, 2016; McFarlane & Howes, 2012; Hughes, 2014; Jacobs 2018; Schweitzer et al, 2014; German, 2013; Mendez & Cole, 2014; Casdagli et al, 2017).

"It helped me challenge some of the misconceptions" (Ibrahim & Allen, 2018, p. 7)

Interestingly in four descriptive papers authors reported that participants seemed able to talk about their problems *"with seemingly no shame"* (Ncube, 2006, p. 13) because the wider context of their difficulties had been acknowledged. For example, in the context of a parenting intervention, the authors stated that parents were able to speak about the challenges of parenting and were receptive to some of the ways to overcome them as *"... they felt less blamed"* (McFarlane & Howes, 2012, p. 23). Others attributed this reduction in shame to the focus of the group in speaking with solidarity rather than from an individualistic perspective (Ncube, 2006).

"It proved not to be difficult to talk collectively" ... *"the solidarity in their responses was even bigger"* (Jacobs, 2018, p. 289)

Processes of the ToL group that are relevant to mental health contexts

Flexibility of the ToL model. There was a theme across all papers, apart from the original paper describing the Tol methodology (Ncube, 2006), that the ToL model could be adapted in

some way, to suit the context or the need of the client group. The adaptations (detailed in table 6) were either superficial, where Ncube's (2006) original methodology was maintained or profound, where adaptations meant the methodology was changed in some way.

The superficial adaptations involved adapting communication styles to suit the needs of participants (Randle-Phillips et al, 2016; Hughes, 2014; Jacobs, 2018), the addition of extra sessions to consolidate learning (Ibrahim & Tchanturia, 2017) or the addition of service user peer trainers to either run, or support the running of ToL groups (Fraser et al, 2018; Casdagli et al, 2017). The profound adaptations included three papers that removed the storms element of the group (Wellman, 2016; German, 2013, Fraser 2018) and four papers that made an adaptation to the group which meant 'a safe place to stand' was not reached before moving on to talk about problems (Wellman et al, 2016; German, 2013; Hughes, 2014; Schweitzer et al, 2014). Moving away from the original protocol of the group means that the researchers are not investigating 'The Tree of life model' but rather an adaptation of it which may question the validity of the data from these studies in reference to the utility of the full Tree of life model. Moreover, Ncube (2018) advises against these kinds of adaptations as they reinforce a problem saturated story over the subjugated alternative story of strength and resilience that the group intends to bring forward (Ncube, 2018). This is supported by earlier results that highlight developing an alternative sense of self as an important part of the group. Removing the storms element may also reinforce dominant ideas that 'expert knowledge' in mental health settings is more powerful, or important, than participants' own experience which is not the intention of the group.

The ToL was also combined with other models of therapy to provide a 'holistic' intervention (McFarlane & Howes, 2012; Ibrahim & Allen, 2018; Butera-Prinzi, 2014; Mendez & Cole, 2014). For example, in the context of a parenting intervention, the ToL was combined with traditional behavioural parenting interventions to "*maintain parents' interest*"

and to *"give an alternative voice to those who have been oppressed by dominant narratives such as stigma or other marginalising discourses"*. It also *"created an atmosphere of reflectiveness and personal enquiry…missing in traditional behavioural approaches"* as well as *"recognition or acceptance of many of the dire situations parents were experiencing"* (McFarlane & Howes, 2012, p. 22-23).

Experience of the model. Six research papers referred to participants' enjoyment of the model. Two quantitative analyses revealed that participants reported enjoying or experiencing positive emotions in the ToL group (Randle-Philips et al, 2016; German, 2013). In the context of a school intervention, all participants rated the group five out of ten or above (ten being enjoyable), with the more than half of participants rating the group ten out of ten (German, 2013).

 "I really enjoyed it...I liked creating the tree and that you could do it in your own way." (German, 2013, p. 86)

Three qualitative papers referred specifically to the usefulness of the tree metaphor to either contain emotion (Wellman et al, 2016); make the group easy to remember (Ibrahim & Tchanturia, 2017) or a good structure (Ibrahim & Allen, 2018).

"I will definitely remember the Tree of life because it is so visual" (Ibrahim & Tchanturia, 2017, p. 7).

Four of the qualitative papers identified themes that highlighted challenges noted by participants or facilitators; specifically, challenges with attendees of the group; either participants not attending, loud participants, wanting to swap partners (Ibrahim & Allen, 2018; Randle-Philips et al, 2016; German, 2013) or not wanting ward staff to attend (Wellman et al, 2016). In the descriptive paper that explored staff perceptions of the ToL

group, staff reported finding it challenging to know how much personal information to share with participants (Fraser et al, 2018).

The theme of experience was represented in descriptive papers through facilitator reports of participants enjoyment of the model, reflected by authors reporting on the 'engaging' nature of the model and describing how much participants were talking in or getting involved with the group activities (McFarlane & Howes, 2012; Ncube, 2006; Mendez & Cole, 2014; Hughes, 2014; Jacobs, 2018).

"All boys agreed to come back" (Jacobs, 2018, p. 289)

"The enthusiasm the children were demonstrating" (Ncube, 2006, p. 9)

In the descriptive papers, challenges were often not reported which raises questions as to whether there is a positive publication bias to the running of groups that were successful, or whether authors are leaving out challenges from reflective accounts which once again would mean a positive bias in reporting on the ToL group. Even in research papers there tended to be a positive publication bias where challenges or limitations of the model were often left out of reports. Additionally, where participants were asked for their opinions on limitations of the group, it was often in interviews with facilitators of the groups which may have reduced the likelihood of being honest about any negative parts of the group.

Discussion

This review aimed to explore whether the ToL group could be a useful model for mental health contexts. Three key themes were identified in the literature that helped to answer this question; Themes that align with the concept of 'Recovery', the inclusivity of the ToL model and processes of the ToL group relevant for mental health contexts.

The literature showed that many of the key intentions of the group such as; to be
culturally resonant, to reduce shame in talking about problems, to address dominant
stigmatising narratives, to create alternative stories for people, to reduce shame in talking
about problems, to be useful in contexts where traditional therapy may not be resonant, or
possible and to be a non-traumatising experience (see table 8 below; Denborough, 2012),
were well represented within the themes found. Once again, bracketing was used to reduce
bias in 'looking' for certain processes to be prevalent in the literature related to the ToL
group's intentions including a bracketing interview and use of a second analyser of the data.
Themes found in the analysis were mapped onto ToL intentions after analysis had been
completed.

Table 5: *The intentions of CNP and themes found from the literature*

Intentions of the ToL group (Denborough, 2012; Ncube 2006)	Themes from ToL literature
To be culturally resonant	Culturally applicable
To be non-traumatising	Positive experience (absence of negative experiences)
To provide different narratives for people- To externalise problems (the problem is the problem not the person)	Alternative stories of self
To reduce shame in talking about problems and to address stigmatising narratives	Reducing shame and challenging stigma
To not individualise what are collective, social, experiences.	Connecting with others
For use in contexts where traditional therapies are not culturally resonant or possible	Inclusivity of the model

Additionally, this review supports claims made by professionals who have used the ToL model that the model aligns with the concept of personal recovery from mental health difficulties. (Fraser, 2018, Wellman, 2016; Ibrahim & Allen, 2018). Although recovery from mental health difficulties is defined as a unique and personal experience, Leamy et al. (2011) found by reviewing over a thousand studies that many processes were common between people. These processes created the "CHIME" model of recovery and include Connectedness, Hope, Identity, Meaning and Empowerment (Leamy et al, 2011). Many of these processes were featured heavily in the ToL literature (see table 9 below) with thirteen papers identifying at least one process as an important outcome of the ToL group. A limitation of the present review is that the review intended to apply the ToL group to mental health contexts, of which recovery ideas have become ingrained. There was danger of biasing the analysis of the wider literature by having the conceptual model of recovery in mind when thinking about the suitability of the ToL group to mental health contexts. However, bracketing measures were used in an attempt to reduce this bias such as a bracketing interview and the use of a second researcher to independently identify themes. Moreover, the specific 'CHIME' model of recovery was not explored until after the analysis of the literature had been completed and it is hoped that themes outside of this model have also been represented within the results.

Table 6: *The CHIME processes of Recovery (Leamy et al, 2011) and themes from ToL literature*

CHIME model of Recovery taken from Leamy et al. (2011)		Themes from ToL literature that map onto CHIME model of recovery (Leamy et al, 2011)
Connectedness	Identifying support from different areas including peer support, relationships, community support	Connecting with others
Hope	Belief in recovery, motivation to change, Positive thinking and valuing successes, having dreams and aspirations.	Hope
Identity	Overcoming stigma	Alternative stories of self

Redefining a positive sense of identity

Meaning	Meaning in life, meaning of illness, spirituality, meaningful life and social roles, rebuilding life.	
Empowerment	Focusing on strengths, personal responsibility, control over life	Empowerment
	Acknowledgement of spiritual and collectivist notions of recovery may be an important recovery process for those from BME backgrounds	Cultural applicability

One area that was not identified as a relevant theme throughout the ToL literature but is identified as important in the recovery process is finding meaning and purpose in life through the development of new social roles; including returning to employment (Leamy et al, 2011; Tew et al, 2011). Two papers that reported using peer trainers or service user facilitators referred to this process in supporting the development new roles such as *'getting me back into employment after mental ill health'* or *'I came out of the system and service user and returned as a professional'* (Fraser et al, 2018; Casdagli et al, 2017). The use of service user facilitators is one way to further promote and utilise its alignment with the recovery model and fit with health policies which promote peer support in mental health contexts (NHS England, n.d.).

Perhaps of particular relevance is that the review highlighted the ability of the ToL model to connect people together and create a supportive environment. The finding that this connectivity transferred to contexts outside of the group, particularly in the study exploring the ToL group in an inpatient ward,, is important as it has been shown that better inpatient experiences are linked to faster recovery rates and reduced subsequent admissions (Mullen, 2009). On a wider note, it appeared that the ToL model was able to challenge longstanding

institutional 'disorder' narratives by helping staff to see service users through their identity, rather than their diagnosis.

Despite the ToL model's alignment with the concept of recovery it cannot be avoided there were no significant changes observed on measures of psychological distress. At first glance this may indicate that it may not be a useful model for mental health context, as the focus of these contexts traditionally is to reduce psychological distress. However, as earlier mentioned personal recovery moves away from 'curing' distress towards understanding difficulties and living a meaningful life in the presence of ongoing symptoms. Not finding any significant changes in psychological distress may reflect the measures' focus on observing a reduction of symptoms (RC Psych; 2016) which is not the intention of the ToL group. Rather the ToL group could be said to focus on changing the relationship with the problem through re-storying (Hughes, 2014).

Alternatively, the ToL model's recovery focus may mean that its utility may be impacted by the stage of recovery that the participants are in (Leamy et al, 2011). In two of the papers that used the psychological distress measures participants were in acute services including inpatient settings, signifying they were experiencing high levels of distress. Leamy et al, (2011) identified different stages of the recovery process including pre-contemplation (hopelessness, despair), contemplation, action and maintenance of progress. It may be that the ToL is more or less useful at different stages of the recovery journey; a concept that would benefit from further exploration.

This review highlighted the inclusivity of the ToL model which was described in every paper as one of the main motivations for using the ToL model. This is of relevance due to the increasingly diverse contexts in which psychological interventions are being sought and delivered, combined with the increasingly diverse populations requiring psychological

support in the UK. A recent report revealed that many people, especially marginalised populations, feel excluded from mental health services due to their lack of focus on diversity (London Assembly, 2018).

The non-specificity of the model in relation to a problem or diagnosis also fits with recovery approaches due to its focus away from problems and diagnosis and towards strengths and resources (Shepheard, Boardman & Slade, 2008). The group can be utilised with populations where some have questioned what traditional problem focused or Westernised approaches to psychosocial support have to offer; such as with children or those from a non-Western background (Thabet, Vostanis & Karim, 2005; Ncube, 2006).

This review also highlighted that ToL also appears a useful model to begin to challenge and acknowledge some of the wider influences and discourses that contribute to people's experiences of problems, something which many feel is often ignored in some models of therapy that focus on the individual (McGrath, Griffin, & Mundy, 2015) .; White, 1997). This is important in mental health contexts as some authors felt that this acknowledgement of wider contextual factors and stigma helped to reduce shame around addressing different problems (McFarlane & Howes, 2012; Ncube, 2006; Jacobs, 2018). It is widely acknowledged that shame is an emotion linked to many different mental health problems, but also an emotion that can contribute to further difficulties and that can prevent help seeking (Rüsch et al, 2014; Miller, 1996).

Overall critique of the literature for the ToL group

There were some general concerns regarding the literature of the ToL group which will be discussed first and some specific concerns relating to research articles which will be later discussed.

The first issue was the general paucity of published articles on the ToL group considering it has been used in clinical contexts since 2006. In addition, there was a tendency of clinicians writing about their experiences to not use any formal research structures. Although some possible reasons for this have been considered, there are many methods that would be more aligned with the narrative approach including case study designs or narrative analysis which would help increase the number of research papers written on the ToL group, helping to secure its use in evidence-based mental health contexts.

There were several issues of bias in the literature. Firstly, there tended to be a largely positive reporting of experiences of the ToL group with less attention paid to challenges of running the group. There was largely a lack of reflexivity in the reporting of descriptive articles which meant that bias in the reporting of running groups was not considered.

Secondly, the issue of researcher bias was not fully considered by all authors. Of particular concern was that all qualitative interviews were carried out by facilitators of the groups which as previously mentioned may have made it difficult for participants to speak honestly about their experiences of the groups (Collins, Shattell, & Thomas, 2005). Additionally, not all participants consented to attending the research interviews which meant in some studies only a small number of original participants provided qualitative feedback (Ibrahim & Tchanturia, 2017; Wellman et al, 2016).

The use of mixed methods was a particular area of downfall as these papers often had a very small number of participants which may be acceptable in collecting qualitative data but is not sufficient for quantitative analysis. Often, significant results were interpreted without consideration of power issues and often non-significant results were reported as relevant results which risks conclusions being drawn about the ToL group without adequate representation from data of any kind.

The measures used in the quantitative analyses were varied and therefore made it difficult to compare across studies. All mixed methods studies used a mixture of validated measures, adapted versions of valid measures or non-validated measures (Randle-Philips et al, 2016) which may reduce the validity of the findings. Only one group completed follow up measures after some time had passed (2 weeks) but no groups involved a longer follow up.

Clinical implications

Mental health services may benefit from using the ToL model for several reasons. Firstly, to facilitate engagement in services by improving the cultural relativity and strengths focused approaches within available care. Secondly, there is an increasing call for approaches that are recovery based. The emerging positive impact of using service user facilitators to run the ToL group would suggest that more services should explore the use of peer support when considering running a ToL group. This fits with global policies that suggest the use of experts by experience in all different areas relating to psycho-social wellbeing. It appears to have benefits for both the service users and the peer trainers.

It is recommended that clinicians, where possible, follow the original methodology and intentions of the group and avoid making profound adaptations that may displace the group from its original narrative intentions, until more is known about removing key elements of the group. Ncube (2018) acknowledges that the ToL group can be run by anyone from any profession but highlights the importance of receiving the relevant training to ensure that facilitators are aware of the theoretical intentions of the group. It is recommended that clinicians hoping to run a ToL group for the first time attend training on the ToL group (PHOLA offer a certified Tree of Life training but other trainings are available through different mental health trusts; PHOLA, n.d.).

Research implications

Authors wishing to share their stories of using the ToL model should consider employing more formal structures to do so which would continue to build the evidence base for the ToL model to secure its future acceptance within the UK and further afield. Wider acceptance of a number of research methods including practice-based evidence, which incorporates case studies, means that clinicians have a range of methods to choose from that would allow them to display the idiosyncrasies of their work whilst acknowledging the wider discourses of outcome focus in many contexts. Additionally, authors of future research papers may benefit from methodologies that align more closely with the epistemological position of the group, such as narrative analysis. A less restrictive qualitative method may allow for new stories to emerge other than those that are created by the questions formed by researchers.

It is recommended that more research should be carried out on ToL groups run in inpatient wards investigating the ToL group from the perspective of the participants rather than staff. A new area of research would be to explore participant experience of the group on inpatient wards that use peer trainers as this has not yet been completed. Such research may also benefit from a passing of time between attending the group and engaging in the research regarding the group to allow for any benefits of the group to develop over time.

Researchers may also want to compare experiences of participants who experience the full group protocol to those who experience an adapted group to explore whether this has an impact on any outcomes of the group. Alternatively, it may be useful for future research to focus on the utility of the ToL group at different stages of the recovery process.

Conclusions

This is the first review to consider a wide range of literature on the ToL group. Both research and descriptive papers (n=14) were reviewed to answer the question: could the ToL group be useful in mental health contexts. Findings were organised under 3 broad themes;

Recovery aligned outcomes, inclusivity of the ToL model and processes of the ToL group relevant to mental health contexts. A key finding of the review was that the ToL model is helpful for those where other models may not be applicable either due to their Westernised or problem focused approach to distress. Thus, it is a model that can be utilised in the ever-expanding contexts requiring formal psychosocial support and is relevant in today's mental health contexts due to its alignment with elements of recovery models. It is suggested that clinicians should err on the side of caution when making adaptations to the group to avoid distancing it from the theoretical intentions and that the use of peer trainers could provide benefits to the participants of the group and service user experts themselves. Future literature on the ToL group should encompass a broader range of research methodologies, explore the utility of the ToL group using peer trainers from the participants' point of view in mental health contexts and consider the utility of the ToL in other fields such as wellbeing promotion or professional contexts.

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Major research project

Section B empirical paper:

Exploring how 'recovery' is reflected in narratives of inpatient admission after participation in the Tree of Life group.

Word count: 7987 (120)

Abstract

Despite a shift towards recovery focused practice in mental health policy, some have highlighted this does not always translate into practice on inpatient psychiatric wards. This study explores the stories people tell about their psychiatric admission, and their experience of the Tree of Life group, to identify how each aligns with the idea of recovery focused care. Seven people were interviewed, the interview data were analysed using Thematic Narrative Analysis; chosen due to its unstructured interview approach and focus on wider context. Narratives varied in structure and subjective content, but some themes were replicated across participants. Firstly, themes of powerlessness and problem-focused relationships with others were present throughout all narratives, supporting the wider literature that suggests the recovery orientation of inpatient wards is limited. Secondly, the meaning people attributed to their experience's pre-admission appeared important in setting the scene for the rest of their story. Generally, those who agreed with 'mental illness' discourses spoke of positive experiences of inpatient admission and those who disagreed with mental illness discourses spoke of negative experiences of inpatient care. Finally, the Tree of Life group was storied as a positive experience for most participants, offering experiences that link with processes of recovery; although its ability to influence a recovery focus in the context of inpatient admission was limited.

Introduction

Historically, narratives regarding psychiatric 'disorders' centred around lifelong disability and need for lifelong care (Ridgway, 2001; Harding, Zubin & Straus, 1987). Traditionally recovery was, and often still is, seen as return to a symptom free normality; therefore, viewed by some as unobtainable for mental health service users (Slade et al, 2014). Institutions designed to treat those with the label of a psychiatric disorder, such as psychiatric inpatient wards, reflected these dominant narratives; promoting passive acceptance of a lifelong disability without hope for recovery (Ridgway, 2001).

Recently, a new depiction of recovery that has evolved from service user movements, separates clinical recovery (subsidence of symptoms), from personal recovery (living a meaningful life in the presence of ongoing symptoms; referred to as 'recovery' hereafter; Anthony, 1993). The recovery movement emphasises the importance of hope, empowerment, social connectedness, positive identity and personal meaning in mental health care; rejecting a purely medical approach (Christoforou, Clarke, & Bell, 2018). The policy surrounding mental health has begun to reflect some recovery values such as emphasising the importance of recovery-principles and pinpointing recovery-oriented interventions as an important aspect of service-development (Department of Health, 2011).

However, some say that this policy does not translate into practice on inpatient wards where research into recovery-orientated practice is limited (Waldemar, Esbensen, Korsbek, Petersen, & Arnfred , 2018; Slade, Amering, Farkas, Hamilton, O'Hagan, Panther, & Whitley, 2014). Often narratives exist where patients are 'too ill' to adopt a recovery focus or that 'recovery' is only made possible by following the plan set by professionals (Slade et al, 2014). This is exacerbated under the Mental Health Act where treatment and detention are compulsory, thus reducing agency over treatment (Quirk & Lelliot, 2001). Some suggest a problem-risk culture exists on inpatient wards, where greater emphasis is placed on the

problems an individual has, rather than the strengths and resources service users draw upon to respond to their difficulties (Watkins 2009; Mullen, 2009).

Ridgway (2001) explored narratives from inpatient settings and found service users felt defined by their diagnosis, losing a sense of their strengths and a deep loss of self-esteem (Ridgway, 2001). Some have called for a radical move away from the medicalised discourses of inpatient settings towards holistic models of care that acknowledge the whole person, rather than just the illness (Barker, 2001). Subsequently, service users have partly attributed achieving and maintaining recovery to the development of a more integrated sense of self (Mancini & Rogers 2007).

Collective Narrative Practices

Collective Narrative Practices (CNPs) are groups based on the concepts of narrative therapy and aim to help participants connect with stories of strength and resilience (Denborough, 2012). They do not ignore the problems of people's lives but instead pay attention to how communities respond to collective problems, acknowledging personal resources and personal agency; thus, promoting possibilities for new action based on these stories (Denborough, 2012; Mehl-Madrona, 2007). Some suggest CNPs may be helpful on inpatient wards where problem focused psychiatric discourses and illness narratives may organise patients' self-narratives and limit their scope for current or future actions (British Psychological Society, 2012; Mehl-Madrona, 2007). Moreover, some have linked what happens in self-reported accounts of recovery to processes of narrative therapy, suggesting that the opportunity to re-story experiences away from stigmatising discourses can provide transformative therapeutic experiences (Mehl-Madrona, 2007; Hunter, 2010).

Two studies have shown that one CNP, The Tree of Life (ToL) group (see table 1 for a description of the ToL group), helps build social connections and engender hope on

inpatient wards (Wellman et al, 2016); but also in helps staff to understand service users

beyond their psychiatric diagnosis, indicating the ToL may help to promote a recovery focus

(Fraser et al, 2018). However, the previous studies did not explore the role of the group

through the wider context of participants admission narratives and nor did they involve a

follow up; participants were interviewed directly after the groups had finished and by

facilitators.

Table 7: *Table to show the Tree of Life group protocol and narrative intentions of the group.*

Tree of Life group protocol		*Narrative intentions (Ncube, 2006)*
Session 1: Drawing the tree	Participants are asked to draw a tree where each element of the tree represents part of their life including strengths, supportive people and hopes and dreams for the future.	Drawing the tree helps to thicken 'thin' stories such as stories of 'illness' that identify problems but ignore other parts of a person's life. Once the person has reconnected with their identity and who they are outside of the problems they have experienced, also known as a 'safe place to stand', then it is deemed safe to think about problems (Ncube, 2006).
Session 2: The forest	This part of group involves participants observing each other's trees and having the chance to tell a story about their own tree whilst the rest of the group listen. The group act as witnesses to the story and then have the chance to comment on what they have noticed or appreciated about that person's story.	When someone has authored an alternative story about their life, witnesses can be used to help validate these new stories (White, 2000). Members of the group such as facilitators and other participants can be used as outsider witnesses who bear witness to the new stories that have been authored by participants.
Session 3: Storms	The storms element of the ToL group is a chance for participants to come together and talk about the challenges they face from a position of solidarity. Particular attention is paid to how participants have been able to respond to challenges in their lives and there is also time to think about how they can use these knowledges to tackle future challenges.	The storms element highlights how people have responded to the traumas in their lives, and helps people to think about how they can use this knowledge to overcome future storms they may face (White, 2006, p. 28). Participants are helped to see that the problems they face are not their fault and are influenced by other factors such as history, culture and politics (Denborough, 2012).
Session 4: Celebration & certificates	In the final part of the group participants are awarded certificates detailing important parts of their tree story and paying attention to the contribution they have been able to make to the group.	Narrative therapists use documents to recognise and honour the steps that people have taken to tackle problems and make preferred changes in their lives (Ncube, 2018; Payne, 2006). The ToL uses certificates which are presented to participants at the end of the group in a ceremony. Others are invited to bear witness to their alternative story through the presentation of the certificate.

This paper explores a unique ToL group run by a peer worker. The use of peer workers in ToL groups on inpatient wards has not yet been researched from the perspective of service users in the literature, although the benefits of peer support in mental health have been well reported. Such benefits have included improved satisfaction with services, positive influences on other mental health staff and some service users have gone so far as to say that recovery can come from others' powerful stories of surviving the mental health system (Thomas, & Salzer, 2018; Hornik-Lurie et al, 2018).

Aims of the research

This research project aimed to explore the use of the ToL group on a psychiatric ward. This projectexplored the narratives of service users to ask:

1) What stories do people tell about their experiences of inpatient admission?

   a) To what extent are recovery processes reflected in narratives of inpatient admissions?

2) What stories do individuals tell about their experience of the Tree of Life group?

   a) To what extent is the ToL group reflected as promoting recovery processes?

3) Are any connections made between the ToL group and developing narratives that voice recovery processes?

Method

This was a qualitative study that used narrative interviewing to capture admission stories of participants and analysed the accounts using thematic narrative analysis (TNA).

Ethical considerations

Ethical approval for this project was gained in January 2019 and was reviewed by HRA ethics as well as a university panel (Appendix 2). A protocol was created so if

participants became upset, they could speak to their named nurse and they were reminded they could terminate the interview at any time. The researcher received a verbal handover when entering the ward and carried an alarm as per ward protocol. Participants were reminded that participation was voluntary as many individuals were detained against their will and exposed to coercive treatment.

Group protocol

A 'peer facilitator' who had previously been a service user and attended the ToL group was responsible for running the ToL groups with the assistance of a trainee psychologist, an assistant psychologist and an occupational therapist, depending on the number of participants. The facilitators had all received ToL training and were well versed in the narrative theory behind the group. The workshops ran for two hours but did not include the 'storms' element. The service felt addressing 'storms' whilst on an inpatient ward may serve to weaken participants rather than empower them as their personal agency to use their own responses were reduced at this time (Fraser et al, 2018). Any service user was able to attend the group, but participation was voluntary. The aims of the ToL project within the trust were:

1) To improve engagement with service users from BME communities; to improve the cultural sensitivity of the service

2) To promote the recovery approach to mental health on all wards

3) To build more collaborative relationships between staff and service users by getting to know the person behind the job or behind the diagnosis (Fraser, n.d.)

The aims of this project are in line with the second aim of the trust's ToL project.

The full group protocol can be found in table 1 above.

Service user involvement

A service user representative from a service user advisory group was consulted on plans for the research project, participant information sheets, consent forms and the interview schedule. A peer worker ran the groups and offered consultation and support in recruiting participants for the research.

Participants

Seven participants were recruited from five inpatient wards in London. Narrative approaches do not stipulate a set number of participants, but a literature review found studies varied from two to 200 participants (Riessman & Speedy, 2007); two similar studies using narrative analysis to explore group interventions in a doctoral theses, one of which also explored 'recovery', both used seven participants suggesting that this number of participants fits the scope of the study (Slator, 2012; O'Brien, 2014). Each participant attended the full ToL workshop and the demographics can be seen in table 2 below. The inclusion criteria were that participants will have been admitted to a psychiatric inpatient ward, attended one or more ToL groups during that admission and be able to consent to the research.

Table 8: *Table to show participant demographics*

Pseudonym	Age	Admission length	Gender	Previous admissions	Section	Ethnicity	Time since attending ToL group
Shola	57	2 months	F	1	3	Afro-German	1 month
Leonard	53	6 months	M	1	3	Afro-Guyanese	3 months
Mariam	40	2 months	F	0	Discharged	Latin-American	3 months
Anton	35	3 months	M	1	2	Black African	2 weeks
Marcus	58	2 months	M	2	Voluntary	Caribbean	4 weeks

| Warren | 26 | 1 month | M | 0 | 2 | Black British | 1 week |
| Bilal | 65 | 3 months | M | 5 | 3 | Indian | 2 months |

Research setting

The wards were acute mental health wards that accepted crisis admissions. The number of people on each ward varied from 15 to 20 and the wards were a mix of male, female or mixed gender wards. The wards were led by a ward manager, often a nurse and key decisions were made by consultant psychiatrists although other medics were available for day to day decisions. Service users had access to occupational therapy groups, the ToL groups and some service users were able to access section 17 leave from the ward. The majority of people on the ward had been sectioned and detained against their will.

Procedure

Information sheets (appendix 4) were given prior to the interview and service users could ask questions to the researcher or peer worker regarding the research. The consent forms were signed prior to the interviews which were completed face-to-face in private rooms (Appendix 5). Initial impressions were recorded in a research diary after each interview (Appendix 6). Interviews were recorded on a digital recorder and then transcribed verbatim by the researcher (Appendix 7). Following completion of the study, a summary was provided for the ethics committee (Appendix 8), participants, and the wards (Appendix 9). Interviews ranged from twenty to sixty-five minutes with a mean time of thirty-eight minutes.

Interview

A two-stage narrative interview was used (Kim, 2015). In the narration phase the participant is given space to talk uninterrupted while the interviewer pays attention to the way the interviewee talks (Kim, 2015). The conversation phase, allows the researcher to ask

questions to clarify and expand on earlier parts of the participants' story or ask questions related to the research (Kim, 2015). The questions in the conversation phase were largely based on the two-sentence format technique of questioning (Morrisey, 1987; the full interview schedule can be found in appendix 10).

Analysis

TNA is concerned with the spoken content and the 'what's' of stories rather than their structure (Riessman & Speedy, 2007). TNA identifies common elements of narratives to theorise across participants (Riessman & Speedy, 2007). By employing TNA greater attention could be paid to the wider context that may be influencing an individual's narrative (Kim, 2015).

Transcription formed part of the analysis where initial ideas were noted down (Riessman, 1993). The process of analysis involved reading and re-reading each interview, then considering the story in context (Bonnett et al, 2018). Master narratives were developed for each participant detailing the emotional tone, form and narrative sequences of the narrative to give the reader an overall summary of participant narratives; a description can be found in table 9 below (Gergen & Gergen, 1986; McAdams & McLean 2013).

Each individual interview was broken down into key narratives relating to the research questions, and then the meaning of each account (theme) was considered in detail before themes were compared across interviews. Unlike other thematic methods sentences or fragmentations of data were not singled out, instead narratives were kept intact and given themes based on full segments of data (Riessman, 2003). Grand narratives were deciphered for each participant and then patterns between and within narratives were are highlighted as well as divergences between people's accounts which are discussed below.

There is no set definition of what constitutes a narrative so here a narrative was considered anything that related to the experience of inpatient admission and the ToL group (Riessman, 2005).

Table 9: *Table to show narrative features*

Narrative tone		The emotional feeling that arises when listening to a story
Narrative Form (Gergen & Gergen, 1986)	Progressive	The protagonist moves forwards towards a goal
	Stable	The protagonist remains in the same position- unchanged
	Regressive	The protagonist moves further from a desired goal or state
Narrative constructs (McAdams & McLean 2013)	Agency	The degree to which the protagonist effects change in their own story
	Communion	The degree to which the protagonist demonstrates interpersonal connection. This type of story emphasizes intimacy and loving relationships.
	Redemption	The degree to which the protagonist uses a negative experience to lead to a good outcome
	Contamination	The degree to which a positive experience is turned negative
	Meaning making	The degree to which the protagonist learns something from an event
	Exploratory narrative processing	The degree to which self-exploration is demonstrated in the story
	Coherent positive resolution	The degree to which any tensions in the story are resolved in a positive ending

Validity of the narrative approach

Narratives are situated within context, and therefore there are many things that may have impacted this analysis (see appendix 11 for reflexive statement). To maintain quality assurance throughout the research process the researcher participated in a bracketing interview (appendix 12) to consider her own beliefs or thoughts about the research and a research diary (appendix 13) was kept throughout the research. In addition, coding discussions were held with a supervisor to validate the different codes from three transcripts. Finally, quotes were used throughout the results section to ensure findings were grounded in data (Elliot, Fischer & Rennie, 1999).

Epistemological position

The narrative approach and TNA are positioned strongly within post-structuralism discourses and social constructionism. The position of the author aligns with these fields. Narrative approaches suggest that there are no tangible, observable truths, only discourses that guide action (White, 1997). They do however posit that power determines which discourses are seen as valid, truthful knowledge (Smith, 1997). Therefore, there may exist dominant discourses which can be mistaken for 'reality'. This research presents inpatient experiences through the lens of service users; it does not aim to present objective truths, only the truths of their experiences (Personal Narratives Group, 1989).

Results

This section begins by summarising each participants' narrative, highlighting the form, tone and content and showing theme development in table 10 below.

Table 10: *Table to give an overview of each participants' master narrative*

Pseudonym	*Overview of narrative including form and tone*	Key themes in narrative	Grand narratives
Shola	A story of eagerness to move on	Positive connections	
	The emotional tone of Shola's narrative was matter of fact, cautious and restrained. The story was one of acceptance and the desire to move forward. Shola spoke of her admission to hospital as a helpful, but scary experience. She storied doctors and nurses as helpful but storied other service users as intimidating. Shola's narrative was progressive moving from unwell to well and spoke of her eagerness to return home to her children and freedom. The ToL group was described as a positive experience, one which allowed Shola to connect with others on the ward in a positive way. Shola was proud to share her tree story with others.	Violence	Illness discourse
		Value of peer support worker	Power
		Medicalised explanation of difficulties / admission as helpful	Others
			ToL
		Problem focus on ward	
		Tree of life as offering difference	
	A story of frustration and loss	Punitive approach on the ward	Counter narrative
Leonard	The emotional tone of Leonard's narrative was one of frustration, anger and desperation. Leonard's story was chaotic, one of restriction, fighting back and regret. Leonard's narrative was one of negative stability as he spoke of his life prior to admission and the despair he now felt. There were many contamination elements in Leonard's narrative. Leonard hoped to 'get out' of the ward and to	Lack of agency	Power
		Fighting back – violence	
		ToL and empowerment	

	return home but described his lack of influence and hopelessness surrounding this. Leonard described his experience of being admitted to hospital as negative and was eager to describe the bad experiences he had. Leonard talked of how 'they' treated him like a child, and how he was punished for doing things wrong. Staff were storied as people to be wary of, but also people who could help him leave the ward. The ToL group was described as a positive experience, one that helped him to connect with staff in a different way.		ToL
Mariam	**A story of survival** The emotional tone of Mariam's narrative was shock, disbelief and disgust. Mariam's story was one of survival, and one which ended with the desire to support and fight for others in her situation. The narrative was progressive as she had moved from her traumatic admission and reached discharge and it also demonstrated exploratory narrative processing and meaning making. Mariam storied her experience of the ward as traumatic, violating and oppressive and others were storied as persecutory, abusive and dismissive. Mariam was clear that she was not mentally unwell and blamed the system for many of the experiences she had in hospital that were traumatising. The ward environment was storied as un-therapeutic, and even damaging. The ToL was storied as something different, hopeful and something that tapped into a creative side of her, whilst the peer support workers were storied as the only people who wanted to help or who could be trusted. There were themes of of fighting back and resisting the oppression she faced. Mariam's narrative was also the only narrative to demonstrate redemptive qualities as she endeavoured to write a book on her experiences to help others.	Non-mental illness understanding Admission as negative Coercion Abuse Ignored Fighting back Value of peer support worker The system Problem focus ToL and hope ToL and human connection ToL and empowerment	Power Counter narrative Others System ToL as restorative
Anton	**A bump-in-the-road story** The emotional tone of Anton's narrative was matter of fact, but not cold and was sparse in detail. Anton's narrative was progressive due to his movement from unwell to well. Anton hoped to go home, and the ward was storied as helpful, if not a little inconvenient. Other patients were storied as loud and intrusive, but not harmful, and medical staff were storied as providing adequate medical attention but	Admission as helpful Medical understanding Other service users- anger Lack of personal agency	Illness discourse Others Power ToL as positive

	little else. The ToL group was storied as a good experience where his tree and certificate were something to be proud of and were kept in his wallet; but something that did not make a huge difference to his admission.	ToL and pride	
Marcus	A story of enlightenment	Admission as helpful	Power
	The emotional tone of Marcus' narrative was calm, loving and content. Marcus' story was appreciative, and goal focused on his future plans and was progressive in nature due to the realisation in his mind of his life's goals which had previously evaded him. Marcus' narrative focused on communion elements, storying others as pleasant and loving, although the protagonist spoke about a lack of agency in making changes to his care. Marcus spoke of wanting alternatives to medication which did not seem to match the story of his appreciation or 'gentle' experiences. Others were storied as interested, helpful and loving. The ToL group was storied as enjoyable but nothing different to his usual experiences on the ward.	Others as peaceful	Counter narrative
		Close connections	Positivity
		Problem focus	
		Spirituality	
		No choice (medication)	
		ToL as positive experience – however similar to positive ward experiences	
Warren	A story of challenging the system	Platforms to express emotions	Power
	The emotional tone of Warren's narrative was calm, composed and disheartening. Warren's narrative was stable as he described his stuck-ness on the ward and a deep lack of agency at his inability to reach discharge. Warren's narrative was reflective, expressing exploratory narrative processing with Warren actively trying to make understand his experiences whilst acknowledging the challenges in the mental health system. Warren storied staff on the ward as disconnected, stressed and overworked whilst acknowledging the wider systemic influences of low wages and limited resources. Warren was dissatisfied with the medical model and its repression of emotions. The ToL group was storied as transformative, safe and providing the human connection that he felt was absent from his inpatient experience. Warren's narrative in many ways was the most eloquent of all participants and he was often able to put a name to the experiences that many other participants gave examples of.	Spirituality	Counter narrative
		Admission as bad experience	Others
		No choice (medication)	The system
		Failing system	ToL as restorative
		Custodial values	
		Ignored by staff	
		Positive connections	
		Value of peer support	
		Medical model – one size fits all	

		Resistance	
		Lack of agency	
		Reduced personal control	
		ToL and a different focus	
		ToL and identity	
Bilal	A story of the quest to return home	No choice	Counter narrative
	Bilal's narrative was regressive in that he started with stories of home, a better life and finished with his distance from being where he wanted to be. The emotional tone of Bilal's narrative was anger and frustration. He compared his psychiatric treatment in the UK to his life in India and expressed a dislike for the UK system. Power of the system was the main theme along with the lack of agency, freedom and freewill. Bilal storied the ToL group as irrelevant as it did not help him to get his freedom back. He described it as unhelpful talking about his life when he felt so far detached from it. Bilal's narrative demonstrated many examples of contamination where positive stories or events were turned negative, erasing the previous positivity.	No freewill	Power
		Disagreeing with mental illness	System
		Alcoholism	
		Loss of freedom	
		Dislike of UK mental health system	
		Fighting back	
		ToL unhelpful	

Narratives varied in structure and subjective content; individual themes are detailed in table 2 above. Cross participant themes are presented in more detail below.

Meaning making – *"It's a mad house- that's not who I am as a person"*

Each participant used their narrative to express the meaning attributed to their experiences; a story that attempted to make sense of why they had been admitted to an inpatient ward, and this meaning generally mediated the way that people storied their experiences of inpatient care. For Mariam, Leonard, Marcus, Bilal and Warren, the meaning they attributed to the events preceding their admission took a form that moved away from the illness model of mental health.

"I don't feel like I have an illness. I don't feel mad, I don't feel bipolar either."-Bilal.

Similarly, Marcus spoke about his personal understanding of the difficulties he had experienced:

"My main goal in life … I wasn't able to visualise it, so all I could do was think… and I meditated a lot. I'd be in a prayerful state most of the time, because I didn't have the right answers yet". - Marcus

For Shola and Anton the meaning they attributed to the events preceding their admission were centred on mental illness discourse.

"It made sense being in hospital because I have an illness…I had been stopped for a while [medication] which is how I ended up in here". – Anton

The narrative held about what had led to their admission, and whether it was congruent or incongruent with the dominant medical discourse that exists in inpatient settings, seemed to influence the way that participants told their stories and how they and others were characterised. Those who adopted understandings of their difficulties that clashed

with the dominant 'mental illness' discourse of inpatient settings, described their ward experience in a negative light. For example, Warren who described experiencing stress in the time leading up to his admission,

"I got to a point at work where I felt I couldn't cope anymore… I was homeless"- Warren

could not make sense of why he had been admitted to hospital and his narrative referred to this incongruence and confusion throughout and he storied his experience as a *"nightmare"*. In an even more dramatic narrative of her experiences Mariam described her admission as *"trauma"* which did not fit of her pre-conceptions of an environment that is supposed to *"heal"*.

"I mean coming out of that environment now it is trauma." -Mariam

However, those who developed a medicalised meaning to their experiences, and whose narratives were congruent with the dominant medical discourse storied their experiences, themselves and others in a more positive way.

"It has been good being in hospital for me. I know I am sick, and I know it's helpful for me"- Shola

The only participant whose narrative diverged from this was Marcus, whom although he held spiritual discourses for his experiences prior to admission, he also reported a positive and healing experience on the ward. It must be noted that Marcus was the only service user who stayed on the ward voluntarily and was not under section, so this may have influenced the experiences he had.

Power -*"It's like a dictatorship" "There is too much control"*

Stories of power, particularly the dominance of the medical model, were prevalent in every narrative although were storied differently depending on whether the powerful influence

matched their own beliefs. This was often talked about in terms of how participants felt powerless in their care, but also how they felt there was lack of choice, particularly in relation to medication which many participants expressed were coerced into taking without access to alternatives such as talking therapy.

"I think it [talking therapy] works better than medication anyway"-Marcus

For those who held counter narratives to the mental illness discourse, this exertion of power was storied as negative and narratives were used to express difference.

"The worst part for me here is that there is too much control… I would rather choose what works for me." - Bilal

For those who described a positive experience of inpatient admission themes of powerlessness were still present but were storied as less shocking or troubling.

Anton, who reported a pleasant experience on the ward and who found the admission helpful as well as adopting a medicalised discourse for his experiences, spoke of a few incidents where he was unable to influence the path of his admission.

*"I really wana go home. I'm trying to make a plan with the professionals, but it takes time…Got to wait until **they** think I'm ready to go home"*- Anton

Resistance - *"I'll say yes to everything because that's the only way to get out of here"*

Bamberg and Andrews (2004) suggest that people make efforts to resist and live in opposition to dominant discourses and labelled these attempts counter narratives. For those participants who held counter narratives, stories of resistance to the dominant medical model were given importance throughout their narratives. Narrative therapists also suggest that resistance, or responses to problems may not always be obvious, but is an attempt to lessen the impact in some way (White, 1997).

Warren, Mariam and Bilal held the strongest counter narratives to the power of the medical model of distress and spoke of the most powerful resistance; although Marcus and Leonard also both protested the medical discourse, whilst Anton expressed a lack of choice over taking medication. Mariam and Warren both questioned the forceful use of medication to suppress distressing emotions in an environment they felt should be therapeutic and used their narratives to question the practices within mental health care.

> *"They still see these symptoms I have as something that needs to be fought and removed from me and I'm thinking that's not so…"* – Warren

Mariam described her experiences of being forcefully injected with medication when she did not want to take it as traumatic rather than healing.

> *"I cannot believe those places are supposed to be therapeutic when there is not even therapy. It's just all medication and then holding, drugging and releasing. Nothing is healed, nothing is worked on"* – Mariam.

Warren felt that his understanding of his distress, linked to emotion and situational influences did not fit with the suppression of emotions through the use of medication or physical restraint.

> *"They're restraining him as opposed to helping him work the emotion out of his system … there needs to be better platforms for people to express themselves."*-Warren

The resistance came in different forms and for some the stories were of violent acts, such as Mariam in the context of her ongoing experiences of abuse from staff:

> *"Because I couldn't breathe, and I was literally going to pass out. And I was restrained so I took all my energy, all my energy and I swung back, and I hit him in the face"* – Mariam

Or for Bilal and his frustration at the system

"It is getting so tedious getting bounded up all the time that I went and threw some paint on some painting…for that the doctor wasn't exactly happy with me"- Bilal

For Anton and Warren, the resistance to the powerlessness they were experiencing took the form of mental resistance or surrender. In both cases it was holding in their own thoughts and opinions about taking medication and agreeing with everything they were told by the staff and the consultants in order to manipulate the process and be discharged earlier.

"Now I know, if I didn't take the depot they would keep me in here longer."-Anton

Challenging the system -"*Everyone is under stress because it is a failing system*"

Mariam, Warren and Bilal used their story of inpatient experience to question and challenge the system of mental health care in the UK. This may have been as an attempt to resolve the incongruence they felt between their own counter narratives and ideals and the reality of the care that they received.

Mariam's questioning of the mental health system centred largely around the abusive experiences featured within her narrative. Questioning the system appeared to serve an important function in making sense of what had happened to her, but also fit with the her narrative of advocating for others and wanting to use her experiences to make a difference.

"It's just the level of abuse in the system. It's the way that people are towards what would be classed as mental health or mentally disabled, mentally challenged individuals" Mariam

A strong narrative throughout Mariam's story of her experiences was the loss of human connection whilst on the ward. This was storied mainly in lack of empathy she felt from staff, but also in terms of the unseen leaders of the system. Mariam felt as though there was no connection from the leadership of the ward, or the trust itself which enabled abusive practices to go unnoticed.

"The patients are more sympathetic than the staff are, staff aren't paid well enough for their

job, and they don't want to be there. They don't have ongoing training … no checks and

balances with the staff, it's like a dictatorship". Mariam

Warren's questioning of the system focused on the power that the medical model held

within mental health care and the way that its power did not leave any space for

psychological, personal or spiritual understandings of people's experience.

"Generally, it's their way or no way and that is what I think is wrong with the system…I feel

like even psychosis…it's all part of just gifts. Don't worry we're going to strip all that

intuition from you, you'll be just a plain person when you come out of here. It's like that's not

actually what I'm going for". -Warren

Bilal compared his experiences of the Indian and British mental health system,

describing his preference for the Indian mental health approach that gives people more

choice, freedom and freewill.

"In India there is choice, your treatment is personal, psychiatry is personal… I haven't felt in

control of my treatment here, it's just a question of the government is paying for it so they

just do what they want… The system makes all the decisions"- Bilal

Both Mariam and Warren commented on the reactive approach of inpatient mental health

care, an approach that both felt did not look deeper into the causes of people's problems but

instead was intended to "fight fires"- Warren.

"it's just all medication and then holding, drugging and releasing – nothing is healed,

nothing is worked on"-Mariam

Similarly both warren and Mariam questioned the practices of section and restricting people

in general. Mariam felt the practices were outdated and in need of review:

"just the section practices in general have been round since the 80's and obviously need to be revisited… I mean 1983- we're in 2019, there's a big difference" – Mariam

Whereas Warren and Bilal both felt compulsory detention should only be used when absolutely necessary, but instead the restrictive practices were being used in Warren's opinion to detain and contain difficult emotions that would benefit from being safely expressed; as was the theme throughout his narrative.

"I think if anybody is going to harm someone then detain them but that's not where I was coming from, but they still feel the need to detain and contain…"-Warren

Warren and Bilal expressed they felt inpatient care could be helpful due to the resources that could be available for people, and Warren said it had helped him connect with important people but that he felt it could have been done in a different way.

"This could be a helpful place for people that are unwell, if THEY wanted to. If it was free choice." - Bilal

Paternalistic approaches - ***"I feel like they just treat me like a kid"***

Participants also experienced the ward staff as holding power, which for many was experienced as a custodial, or punitive approach rather than therapeutic values. For example, Leonard spoke of his experiences of feeling like a 'kid' due to the restriction of ward life and the rules in place which meant he was unable to do certain things. Leonard spoke of being told it is a 'privilege to be 'let out' into the grounds but also spoke of how this 'privilege' was used to enforce other rules and restrictions which if he broke would mean he was in 'trouble'. Leonard likened this experience to being a 'kid'.

"How am I an adult if they make rules for when I do something wrong? … I'm going somewhere, and they say I can't, I feel like they just treat me like a kid"- Leonard

Similarly, Mariam and Warren described experiences of feeling as though custodial values prevailed on the ward at the loss of compassionate values.

"Instead of being loving and compassionate they have to rely on law to cope. So, everything comes as you're allowed to do this, you're not allowed to do this". – Warren

Others

Violence- *"I don't think that environment is holistic to support help and heal"*

Stories of other service users stressed violent and aggressive behaviour on the wards that often-left people feeling unsafe.

"Some of the patients, they are very noisy…sometimes they can be a bit angry"- Anton

Stories often depicted the ward as a dangerous or unpleasant environment to be in.

Some people get angry. If people get angry, sometimes you can be in the wrong place. They might take it out on you."-Shola

"I mean coming out of that environment now it is trauma"- Mariam

Mariam strongly described her experiences of being abused by other service users and by a member of staff, and that trying to have her voice heard, or to access her rights over her treatment was seen as 'bad' behaviour to be punished.

"Like beat the s**t out of me, choked me with my own scarf, dragged me down the hallway and threw into my room and try to assault me in the bathroom"– Mariam

Positive connections -*"There are a few [people] that are a treat to be around"*

For Marcus and Warren there there were some staff that connected more profoundly with patients but that these staff were rare. Marcus identified one member of the team who he

felt he could express his faith with, but without this member of staff there was a "communication barrier".

"I can really express my faith when *Removed name* is around... there's no communication barrier"-Marcus

Both Warren and Mariam acknowledged 'rare' members of the team they felt interacted with service users beyond medical duties but acknowledged the challenges of being seen as compassionate by others.

"There are a few that are really nice and that are a treat to be around, but they are exhausted, nice people get used more"-Warren

Problem focus -"*The NHS it generally just focuses on problems*"

There was a theme across narratives that interactions with staff mainly centred on problems. The impact of this varied depending on whether the participants had adopted a medicalised discourse for their experiences. For Anton, Shola who adopted a medical discourse, and Marcus who was not admitted under section, staff on the ward were storied as helpful and pleasant but storied as mainly focused on problems and medical issues, such as medication or checking for symptoms.

"If you have a problem, they want to know about that. And they need to check on you all the time and ask about voices… to know if I'm sick or not"- Shola

This was echoed by Marcus, who similarly had a positive experience of his admission but stated about his interactions with most medical staff.

"As long as I take my medication, they're not worried, they just check that I'm not suffering from any symptoms"-Marcus

For Mariam, Warren and Leonard staff were storied as dismissive or even abusive and people who held all the power in relationships. They experienced the problem focus in relationships with staff as dismissive and they felt ignored

"There wasn't much interest unless people were escalating…Interaction just seems to be putting out fires, so unless I'm on fire there's not very much time to talk or attention"

The Tree of Life group; A different approach ***"It's different to other things"***

The ToL group was storied as a positive experience for all but one participant. It seemed to be most powerful for those whose narratives described a particularly challenging experience of life on the ward, and least impactful for those who had a positive experience.

"Positive. Yeah really positive. It said my skills and stuff, other skills like strong. It was positive to hear that" -Leonard

In many of the narratives the ToL was storied as offering a different experience to usual experiences on the ward. For Shola, who described often feeling afraid of others, the ToL created a friendly environment:

"It felt friendly. It's never usually friendly on the ward" Shola

It also gave an opportunity for Shola to talk about herself in a different way, away from her illness:

"they asked about my roots – I remember that. People always think I'm from [country]- But I am different [country]. It's different to other things, more talking about what I like" – Shola

For Mariam and Warren the difference was feeling a human connection with people in an environment where they both felt dehumanised. For Mariam this was in relation to completing the group with other members of ward staff and was implicated in the way that other people responded to her:

"It also brings a human tie back into this dynamics because it is very like a clinical detached repression and then when you're in a creative environment like that, it helps them [staff]become a little bit more compassionate".

For Warren this was more closely linked to identity and how he had felt about himself in the group compared to how he had felt about himself over the course of his admission:

When a person speaks about their beliefs… it helps to reaffirm in ourselves. It's like its reminding me what it means … to be an individual and just to be human." –Warren

For Warren, the ToL offered a strengths-based approach in an environment that he storied as predominantly problem focused. The approach of the ToL group was storied as something that Warren felt a therapeutic admission should consist of, in so much that he felt the hospital should adopt a more ToL based approach. Although Warren was clear that he had benefitted from the ToL group, he had not felt that it had made a huge difference to his admission due to the short nature of the group existing within a problem focused system:

"This [the ToL] feels good because it doesn't focus on the symptoms of a person's terrible situation. It focuses on the core person. I felt like if the hospital was like this, focusing on the core person as opposed to a particular event; it's better to focus on" … "I just really liked it. I can't say its particularly changed things"- Warren.

For Anton and Marcus, although they had enjoyed the group experience and had found the experience beneficial, it wasn't storied as anything different to their usual experiences on the ward. They spoke of feeling proud and enjoying the creativity, particularly Anton who carried his certificate with him in his wallet.

I'm proud, I keep it in my wallet [Certificate]. It goes on the wall in my room [Tree]. I look upon it every day". -Anton

Bilal held a divergent narrative where he described the ToL group as irrelevant during his inpatient admission. Bilal felt that it was no good focusing on positives when he was experiencing a difficult time and feeling so frustrated and unable to make any changes to his care.

"I couldn't focus on talking about my life and where I want to be when I have so little control and freedom over what I can actually do."-Bilal

Hope - *"There's a future out of this"*

For some, the ToL group was storied as offering hope to participants for the first time throughout their admission. For Mariam the ToL group helped her to put her life into perspective and provided a source of strength to help her get through her experiences:

"This is like thinking about where you wanna be... you may be going through hell right now, but it's not gunna be forever. It's like self-life coaching, being an advocate for yourself like really advocating for yourself and them um just being creative" – Mariam

For Leonard, the ToL group was a place where he felt listened to and able to speak about what he wanted to do after his admission:

"I remember writing about what I wanna do when I leave here for the first time... the ideas came to me in the group."-Leonard

Warren described feeling able to get a clearer picture of where he saw himself after his admission:

"I have a bit of an understanding of about where I would like to go and who I would like to be. When a person speaks about their beliefs... it helps to reaffirm in ourselves. It's like its reminding me what it means to be a person, to be an individual and just to be human." -
Warren

For Leonard, the writing of plans for his future seemed to empower him about being able to move on to life after his admission:

"It felt good... I feel like sometimes when you write positive things then you want them to happen" –Leonard

The value of a peer worker facilitator – *"If I managed a service, I'd want to know what it felt like to be a user"*

For Mariam, Leonard, Shola and Warren the peer worker in the group was storied as a key element of making the ToL group a positive experience. The peer trainer was one of the most consistent elements of the group that was described as offering a positive experience, over and above other elements such as the creativity of the group or receiving a certificate. Especially the having 'been there' empathy and understanding the facilitator held of the participants' situation

"[Having a service user facilitator] made me comfortable. I think [all staff] should be stuck on section"-Warren

Mariam felt quite strongly that the impact of the Tol group would not have been the same had it not been run a peer facilitator.

"I think it is relevant to the facilitator. She is like a holistic person and that is her goal. So even in that toxic environment, she would be able to take you out of that toxic environment for those few hours"-Mariam

Considering the results in context

Participants were interviewed in a context that takes a medicalised approach to their distress or difficulties. This largely Western discourse locates the 'illness' within people

rather than acknowledging other understandings of distress which may have influenced the understandings that participants brought to the interview with them. Thus, participants may have felt compelled to adopt certain discourses for fear of the contrary being interpreted as 'symptoms'. The research was completed during an ongoing shortage of finances within the NHS, as well as Brexit negotiations which could affect NHS staff. The Trust the research was completed in had been rated inadequate at a recent Care-Quality-Commission visit (CQC). This can place additional stress and strain on the workers in the NHS. Staff shortages, lack of resources and challenging environments have all been shown to reduce mental health staff's capacity to focus on 'recovery' and have been shown to increase levels of staff burnout (Waldemar et al, 2015). As acknowledged by many participants 'the system' may have impacted on staff interactions.

Discussion

1. **What stories do people tell about their experiences of inpatient admission?**

   a. **Do these stories reflect recovery focused practices on inpatient wards?**

Although the narrative approach stresses there are no observable truths, just people's experiences, there were many common experiences shared between participants. One of the key elements of recovery focused care is having choice, agency and self-management of difficulties (Leamy et al, 2011). The stories people told of their inpatient admission varied from positive to negative, although they all expressed a lack of control and choice over their care and in some cases described abusive and traumatic practices to coerce them into adopting certain treatment protocols. In line with other literature, many participants reported feeling controlled even though they did not pose a risk to self or others and despite care guidelines, all participants expressed a lack of agency or choice over medication and

described having no access to alternatives such as talking therapy (NICE, 2014; Johansson et al. 2006).

Recovery orientated services aim to adopt a positive approach optimising an individual's strengths and resources to reach goals, however, staff were mostly storied as interacting mainly around problems, risk or illness and uninterested in service user's wider identities. Finally, connecting with others has been found to be another important recovery process particularly on the dimensions of getting support from others or having access to a supportive environment but the inpatient environment was often described as dangerous due to the threat of violence (Leamy et al, 2011). Thus, this project supports wider literature that suggests people often experience less 'recovery principles' in inpatient settings (Waldemar et al, 2018) and that for some, coercive practices in mental health care are experienced as hindering recovery or exacerbating the traumatic experience of being detained (Slade et al, 2014; Waldemar et al, 2018).

Many have called for systemic change to mental health care in the UK and this was replicated for many participants in this study who felt the current system did not work (Jacob, 2015). Some question whether inpatient wards need to adopt recovery principles, or activities, due to their intentions of stabilisation and symptom reduction for those in crisis (Waldermar, 2015). However, the current study revealed that those who are dissatisfied with the current system call for change that aligns with the recovery movement such as more choice, more compassion, less coercion and alternatives to medication.

Some have suggested that narratives are an essential part of meaning making, particularly at stressful or difficult times when narratives can be used to make sense of events and render them meaningful (Rimmon-Kenan 2002). Perhaps unsurprisingly service users'

narratives of their experience centred on making sense of their experiences and attributing meaning to their experiences that led up to, and of inpatient admission. The way that service users story their inpatient admission appeared mediated by the meaning they attribute to their pre-admission experiences, and whether this aligns with the mental illness discourse that dominates inpatient care. There appeared to be a distinction for those whose personal understandings aligned with the dominant medical discourse of mental illness from those who held different personal understandings of their experiences such as psychological or spiritual discourses. Those who aligned with the medical discourse storied their experience as helpful and positive compared to those who held counter narratives storying the experience as difficult, frustrating and even traumatic. Stories of resistance to the power of the dominant mental illness model appeared to serve important functions in helping participants express the differences between their held beliefs and the reality of inpatient care. This could be linked with theories on cognitive dissonance (Festinger, 1957). For those whose own beliefs and attitudes fit with the medical discourse, being on the ward did not cause internal conflict hence reducing the discomfort associated with being detained under the mental health act. However for those who were being 'forced' to comply with the medical discourse which did not match their own attitudes or beliefs, being on the ward was a difficult experience causing discomfort. Resisting this discourse may have helped to re-align their actions with their own attitudes and beliefs (Festinger, 1957).

What stories do people tell about their experience of the Tree of Life group?

    a) To what extent is the ToL reflected as promoting recovery processes?

The ToL group was storied as a positive experience by all but one participant. For those who described a difficult or negative experience on the ward the group was generally storied as a meaningful event that offered a different approach from their typical experiences on the ward. It was storied as offering hope, and new conversations about future possibilities;

some described feeling hopeful for the first time since their admission. For others the group was described as a place to feel human again, a group that focuses on the core person rather than just the problem; alluding that the group may help participants connect with an identity away from their illness. Thus, suggesting that the ToL group promoted some recovery principles. For those who described their experience on the ward as positive and helpful, the ToL was still storied as positive and as offering new conversations but its impact was not as restorative as those who had difficult experiences. The peer worker was highlighted by many as an important element of the group who helped to make the group a fulfilling experience, further aligning the group with recovery values which emphasise peer support.

Some researchers feel 'bottom-up' activities (such as the ToL group) are one way of improving recovery focus on inpatient wards (Davidson et al, 2009). Although others have aired caution that recovery activities, without systemic change, may come to be tokenistic; adapting to inpatient culture rather than changing it (Slade et al. 2012). This also fit with accounts from this study which appeared to suggest that although the ToL group was beneficial, its impact on the scope of participants' wider admission was limited and the group's values did not translate to the wider admission. Moreover, Bilal highlighted this in his interview where he expressed that did not find the group helpful thinking about the future or 'positive' parts of his life when he had so little control on the path of his admission or treatment outside of the group.

What connections, if any do service users make between the ToL group and developing recovery aligned narratives; narratives of strength, hope and resilience?

Some participants connected their experience of the ToL group with developing a different story of their current situation that involved renewed hope, or optimism towards the future. These tended to be the participants who had described the most difficult experiences,

although even those who described a positive admission story reported themes that linked with empowering discourses such as feeling proud of and acknowledging their strengths. However this was not the case for Bilal who found that thinking about the future led to feelings of hopelessness when he felt so powerless to make any change to his current situation. also described feeling listened to and described having the opportunity to attribute their own meaning and understanding to their experiences in a way that was not always possible on the ward. Literature on narrative identity has shown that the meaning people attribute to adverse life experiences through narratives can be indicative of subsequent well-being, with those who develop empowering, redemptive stories (as the ToL may promote) boasting better adaptation to life after the adverse experience (McAdams & McLean, 2013).

Impact of context

It is noted by the author that although the ToL group aims to bring forth subjugated narrative, it was still delivered within a wider powerful dominant narrative which may be experienced truth or reality for participants, minimising the possible effects of the ToL group (Smith, 1997). Without the storms element of the group it is less possible for such dominant narratives to be challenged and considered. Davies (2009) lends a useful concept describing the limited scope of narrative therapy techniques in illness discourse dominated mental health services using Burnham's (1992) Approach Method Technique framework. The ToL is a narrative therapy 'technique' that externalises distress, prioritises personal narratives, focuses on strengths and promotes agency in responses to problems. However, this technique differs from the approaches of mental health services with the dominant discourse that problems and illness are located within an individual and that adopt a problem focus. This may limit the scope of the ToL's effectiveness in helping participants to develop recovery narratives. This may depend on participants' beliefs; for those with counter narratives, the ToL may be an 'experience near' phenomenon that fits their own narratives (White, 1997). For those with

illness centred discourses, the ToL group may be an 'experience far' concept less helpful in understanding their experiences (White, 1997).

A note on narrative structure and form

Although this analysis was primarily concerned with the 'what's' of peoples' stories some attention was paid to the form and structure of narratives (see table 9 & 10 for more detail). There did not appear to be a link between participants' meaning of their experience and the form their narrative held, although those who had reached a resolution to their situation (e.g. discharge or probable discharge) held more progressive narratives. It appeared that most participants were working towards the same end goal which was to be discharged, although for Anton the progression in his narrative was towards realising his life goals on a more spiritual level. Perhaps unsurprisingly, those participants who told stories of feeling far from discharge held regressive narratives (Bilal and Leonard). Although not the case for Leonard, it may be that the ToL is more or less helpful for people depending on the narrative they hold of their current situation. The ToL uses a progressive approach, intending to move people towards new hopeful narratives and goals. This may not fit for people whose narrative may be identified as regressive, moving away from a desired goal or for those who do not describe agency in their narratives.

Limitations

The group used in this study was not the full ToL group as it did not include the storms element. Although facilitators have reasons why this element is not included, this is a key part of the group and the impact of leaving it out has not been fully explored. Narrative therapists believe that everyone responds to the hardships they experience in some way, and this is still important even when someone's current ability for action is reduced (White,

2006). Including the storms part of the methodology may have enabled participants to feel that their struggles were acknowledged and may have empowered them further by recognising their strengths in dealing with problems. Moreover, it appeared throughout personal narratives that people did want a space to talk about difficulties they had on the ward and the ToL group could be one space for this. Although there are challenges to running longer sessions in inpatient settings it is recommended that those who respond well to the group should be given space to think about storms and responses to storms. The storms element also enables participants to think together about how to overcome future challenges they may face which may be helpful in a mental health context.

Although this field has previously been limited by structured interview techniques, the author noted some participants struggled with the unstructured narrative interview and forming a coherent narrative of their experience. It's noted that psychosis can make it difficult for people to link events to the self or reflect on one's internal world (Lysaker et al, 2013; Allé et al, 2015).

Finally, participants were given £10 for their participation. This may have led to bias as to who participated in the project but may also have encouraged people to participate for other motives. Secondly, as far as possible it was attempted that representative quotes both positive and negative were selected. This was decided in conjunction with the second researcher to try to minimise bias, however it is noted that the second researcher also has vested interest in the project.

Research implications

This was an exploratory study in an under-researched field which provides a gateway for further exploration into experiences of inpatients and the utility of the ToL group. Future research may benefit from exploring the impact of the full Tree of Life group, including the

storms element, in inpatient settings. Research could also explore this in a more experimental way, comparing those who have attended the ToL group and their experiences of inpatient admission to those who have not attended the ToL group. Moreover, it would be helpful to explore the efficacy of the ToL group with and without the storms element.

Research could explore the impact of the meaning attributed to admission and how this impacts on how the admission is experienced; and whether the ToL can be used as a tool to help express these beliefs away from the medical discourse in a safe way, so that such beliefs will not be interpreted as symptoms of illness. In line with ideas on narrative identity further research could explore the link between the types of narratives held of admission and post discharge wellbeing and adaptation.

Clinical implications

This study has shown that inpatient care is experienced in different ways and it has highlighted the importance of personal meaning making on those experiences. The ToL group can be useful for some service users but appears to be of more benefit for those whom attribute their experiences away from an illness discourse. More widely, it has shown that service users desire a wider option of interventions beyond medication and appreciate conversations away from problems, towards other aspects of identity such as strengths and hopes for the future. It has also shown the value of peer support on inpatient wards.

The ToL group was found to be a positive experience for most participants which suggests it may be an enjoyable ward activity which could be useful as service users have suggested they would like more activities on inpatient wards but ward activities are an under-researched area (NICE, 2014). Moreover, the ToL's alignment with values of recovery fits with current guidance on using peer support to promote personal recovery in psychosis (NICE, 2014). Participants' narratives outlined the reduced agency people feel in inpatient

care which emphasises the importance of giving service users choice to participate in the ToL group. Moreover, it may be difficult for some people to think about hope for the future when they currently feel powerless, so it is important that service users are well informed on the intentions and activities in the group before participating.

Finally, without the wider systemic change to mental health care, particularly inpatient care, it is important for clinicians to ensure that the ToL group does not become a 'token' exercise that represents recovery focused care (Slade et al. 2012).

Conclusion

In conclusion, the findings from this project reflected the wider literature in suggesting that people's stories of inpatient admission overall do not reflect recovery principles. This study goes beyond existing literature to suggest that generally the meaning people attribute to their pre-admission experiences, and whether it fits with dominant discourses of mental illness, appear to mediate the experiences they have of inpatient care. Finally, the ToL group was shown to reflect some recovery focused values such as instilling hope, empowerment and reaffirming identity beyond illness; although its impact on admission narratives appeared to be limited, possibly due to the influence of the wider context and the dominance of the medical model in inpatient settings.

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Section C: Appendices and supporting information

Appendix 1: Table to show Outcomes from research papers and quality analysis

Author	N	Context	Design	Analysis	Measures	Quality Analysis	Outcome measured	Outcome
						Qualitative studies critically appraised using Critical Appraisal Skills Programme framework for qualitative research (CASP, 2018; appendix 1)		
Ibrahim & Tchanturia (2017)	5	Eating disorder service	Qualitative (Qual)	Thematic analysis	Interview	✓ Clear statement of research aims ✓ Appropriate choice of methodology ✗ Use of thematic analysis not justified ✓ Appropriate recruitment strategy ✓ Data collected addressed research issue ✓ Limitations and bias considered ✗ Ethical issues not described ✓ Rigorous data analysis ✓ Clear statement of findings	Experience	An image to remember, share and change Offering an alternative perspective Providing hope Creating a community
Wellman, Lepori & szlachcic (2016)	5	Adult psychiatric inpatient ward	Qual	Thematic analysis	Most important event questionnaire after each session 30 minute focus group Unstructured questionnaire	✓ Clear statement of aims ✓ Appropriate methodology ✓ Appropriate research design to address aims ✓ Appropriate recruitment strategy ✓ Data collected in a way that addressed the issue ✓ Limitations considered ✓ Ethical issues considered ✓ Rigorous data analysis ✓ Clear statement of findings	Experience	Community Personal refection Usefulness of metaphor
Casdagli, Christie, Girling, Ali & Fredman 2017	?	Paediatric diabetes service	Qual	Thematic analysis	Semi structured group interview	✗ Aims of research not clearly stated ✗ Appropriate methodology ✗ Research design not justified ✗ Recruitment strategy not discussed ✗ Data collection not well described ✓ Limitations considered	Experience	Connecting with others Building a positive view of the self.

						✓ No consideration of ethical issues		
Fraser, Williams, Hayes, Akpan & Bowerman 2018	16	Inpatient psychiatric ward London Two-hour workshops	Qualitative	Thematic analysis of staff focus groups.	Semi structured interview	× Did not describe aims or rational e for research × Very brief method section × Did not describe questions asked in interviews × Did not elaborate on themes or provide discussion of results × Did not describe recruitment strategy × Did not describe ethics or consent process × No clear statement of findings	Staff experience	Relating to each other Accessibility and involvement of model Impact of Tree of Life on staff Improves environment Challenges

Case study critically appraised using Evidence Based Medicine and Practice (Roever & Reiss, 2015)

Schweitzer, Vromans, Ranke, & Griffin, (2014).	1	Refugee	Case study		Observations	✓ Study addressed a clearly focused issue ✓ Clients background well described ✓ Pt described as representative of wider population ✓ Methods for collecting data well described ✓ Group protocol well described ✓ Researchers perspective described × Study design not suitable for aims of research × No formal data analysis × Conclusions not justified by the results × Not generalizable × Observations only recorded from one main source with 'input' form other facilitators × Researchers perspective heavily influenced findings	Therapeutic factors contributing to change	Alternative stories of self Group cohesion Corrective emotional experience Outsider witnessing Instillation of hope.

Mixed methods studies critically appraised with The Mixed Methods Appraisal Tool (MMAT, 2018)

| Randle-Phillips, Farquhar, & Thomas (2016) | 4 | Learning disabilities service | Mixed methods, repeated measures | Thematic analysis for qual data | Descriptive statistics provided for quant data | CORE LD
Rosenberg self-esteem Inventory
TOL questionnaire

Interviews | ✓ Clear aims of research
✓ Data collected addresses research aims
✓ Qual results adequately interpreted
✕ Qual/Quant data not effectively integrated to answer research question
✕ Divergences/similarities between data not adequately discussed
✕ Quant data analysis did not adhere to quality criteria for own tradition- specifically no formal analysis
✕ Rationale for mixed methods not discussed | Self esteem

Symptoms of distress

Experience | Scores not analysed but 'generally remained the same'.

Main themes:

Positive emotional response

Social interaction |
| German (2013) | 29 | School | Mixed methods, repeated measures | Content analysis | Statistical analysis

(t-test, ANOVA, ANCOVA) | Beck youth inventory of self-concept

Before and after questionnaire (cultural knowledge)

Semi structure interview about experience of ToL | ✓ Clear research aims
✓ Data collected addresses research questions
✓ Adequate rationale for mixed methods
✓ Different components effectively integrated to answer research question
✓ Results adequately interpreted
✕ Divergences/similarities between quant and qual not discussed
✕ Different methods do not adhere to quality criteria for own tradition | Self-concept

Experience

Cultural knowledge | Significant improvement in self-concept post ToL compared to pre ToL

Children enjoyed attending the ToL group.

Improvements in cultural knowledge of themselves and others |

| Ibrahim & Allen, 2018 | 6 | Adult bipolar disorder service | Mixed methods | Thematic analysis | Statistical analysis | Clinical Outcomes in Routine Evaluation – Outcome Measure

The Mental Health Recovery Measure | ✓ Clear research questions
✓ Data addresses research questions
✓ Results adequately interpreted
× Rationale for mixed methods not described
× Qual/Quant not effectively integrated to answer research question
× Inconsistencies between quant and qual not addressed
× Different methods do not adhere to quality criteria for own tradition | Symptoms of distress

Recovery | Scores on the CORE increased from pre to post.

Scores on the Mental Health Recovery Measure remained the same. |

Appendix 2: Favourable opinion letter from REC for previous project & amendment letter for current project

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Appendix 3: Trust R&D approval

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Appendix 4: Participant information sheet

Canterbury
Christ Church
University

Version 2: 25.09.2018

Participant information sheet

Research study: Weathering the storm: The construction and deconstruction of the stories people tell about themselves after admission to an inpatient ward, and the tree of life group

Introduction

Hello, my name is Sophie Parham and I am a Trainee Clinical Psychologist at Salomons Centre for Applied Psychology, Canterbury Christ Church University. I am leading on a research project that you might be interested in. Here is what you need to know before you decide whether you would like to take part.

What is the research about?

I would like to interview you because I am interested in the stories you tell about your experience of being in hospital and what you think about your experience of the Tree of Life group. This is a unique group as it is run by 'peer trainers' and your experience might help us to know more about it for future participants in similar inpatient wards.

What does being involved in the research mean I will have to do that is different to what I would normally be doing?

I will be asking around 10 people on the ward who attend the Tree of Life group to have an interview with me over the next few months. This means you will meet with me for a maximum of two hours to talk about your experience of being in hospital and your experience of the Tree of Life group that you attended on the ward. I may also ask if I can use some of your work (such as drawings of your tree) for the Tree of Life group in my research report. I will only do this if you give me written permission to do so.

Do I have to take part?

No, you do not have to take part

If you do want to take part, I will ask you to sign a consent form This means you've attended the Tree of Life on the ward and then agree to have an interview with me after. You will not be treated any differently by your care team if you decide not to take part in the research.

I will ask your "responsible clinician" (normally your Consultant doctor) to make sure they also agree that participating in the interview is acceptable.

What is the Tree of Life group?

The Tree of Life group is a therapy group that is a therapy group run on the ward you have been admitted to. It is run by two peer trainers who have both attended the group themselves. The group involves drawing a tree with different parts of the tree representing different parts of your life. The Tree of Life helps you to think about your life focusing on strengths and the skills you have used to get through hard times. If you would like some more information on the Tree of Life group, you can ask staff on the ward.

If I say no, does this mean I can't attend the Tree of Life group?

If you decide not to take part in my research, you will still be able to attend the Tree of Life group. The interview is the research part, so the only difference is that you will not have an interview with me after. Not taking part in the research will have no effect on your clinical care.

What if I change my mind?

You can drop out of the research study if you change your mind later. This does not mean you have to stop attending the Tree of Life group. If you do stop being in the study, you can ask me to delete any information I have about you or anything you said to me in the interview (as long as you do this before it has already been analysed). If you didn't want to be in the study anymore, this wouldn't affect how the staff in hospital treat you. Being in the study won't affect any of the treatment you get in hospital or any treatment after that.

What will happen to me if I take part?

If you decide to take part, we would meet in a quiet and private room on the ward at a time that is suitable for you after the Tree of Life group has finished. I would like you to meet with me for a maximum of two hours; you can take breaks during the interview if you chose to do so.

I will have several questions I want to ask you, but it isn't a test and there are no right or wrong answers – I would like to know what you think about your experiences in Tree of Life.

I'll use a digital recorder to record the interview to help me remember what we have spoken about and so that I can listen back to it afterwards. You don't have to tell me anything you don't want to, and we will only talk about things you feel comfortable telling me. You have control over anything you do or don't want us to talk about.

Sometimes people find it hard to talk about their experience in hospital. I might ask you some questions make you feel emotional, but we can stop or take a break if it gets a bit too much. You can ask to stop the interview at any time. We could always meet later if that would be better for you.

The questions aren't meant to make you upset and I'll ask you a bit about things that you like and things that make you feel good too. Everyone in the study will be asked roughly the same questions but because everyone's experience is different, it will be different for each person.

Are there any downsides or negatives about taking part?

You might feel upset or emotional when we talk about some of the topics in the interview, but we can take a break or stop and I can spend some time with you talking any difficult parts through. You might also want to speak to your named nurse on the day of the interview. Remember that the questions aren't designed to upset you and you have control all the time over what you feel ok to talk about. There will always be support available on the ward after the interview has finished.

Will you tell anyone about what I said in my interview?

The only time I have to tell someone about something you told me is if you told me that you were going to harm yourself or if someone else would be hurt if I didn't tell someone about it; usually a member of staff on your ward (a nurse or a doctor who knows you). I wouldn't tell them anything else about what you said in the interview unless you asked me to.

What will happen if I don't want to carry on with the study after the interview?

If you didn't want to be involved in the study anymore, I will ask you whether you would like to withdraw all your information from the study. If you do, I can delete the information I have about you and your interview recording. I can do this up to one day after the interview.

How will you keep all my information safe?

Information with your name or address on it will be kept in a locked cabinet. Any information about you which leaves the hospital will have your name and address taken off and all your other details changed so that no one would know it was you. When I record your interview, I'll keep the recording on a memory stick which uses "encryption". This means it uses a secure password that only I can open to play the files.

I will write out your interview recording into words (this is called "transcription") and I will ask you to pick a 'fake name' for yourself so that I can use this name instead of your real one. I will also change the names of anyone you talk about or anything you say that might tell someone else who you are.

Two other people might ask to look at an anonymous written copy of our interview with your details changed. They are the research supervisor's Dr [redacted] and Dr [redacted]. I would not share any other details about you with the supervisors. The written copies of the interview will be destroyed at the end of the research project. The audio recordings will also be destroyed at the end of the project.

The anonymous transcripts will be kept in digital form in a locked cabinet at Salomons Centre for Applied Psychology, Canterbury Christ Church University, Tunbridge Wells campus for 10 years. After 10 years it will be destroyed.

Canterbury Christ Church University is the sponsor for this study based in the United Kingdom. We will be using information from you in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. Canterbury Christ Church University will keep identifiable information about you for 10 years after the study has finished.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible.

You can find out more about how we use your information by contacting Fergal Jones, Research Director, Salomons Centre, Canterbury Christ Church University, 1 Meadow Rd, Tunbridge Wells, Kent TN1 2YG email: **fergal.jones@canterbury.ac.uk.**

As a university we use personally-identifiable information to conduct research to improve health, care and services. As a publicly-funded organisation, we have to ensure that it is in the public interest when we use personally-identifiable information from people who have agreed to take part in research. This means that when you agree to take part in a research study, we will use your data in the ways needed to conduct and analyse the research study. Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible.

Health and care research should serve the public interest, which means that we have to demonstrate that our research serves the interests of society as a whole. We do this by following the **UK Policy Framework for Health and Social Care Research**.

If you wish to raise a complaint on how we have handled your personal data, you can contact our Data Protection Officer who will investigate the matter. If you are not satisfied with our response or believe we are processing your personal data in a way that is not lawful you can complain to the Information Commissioner's Office (ICO).

Our Data Protection Officer is Prof Fergal Jones and you can contact them at **fergal.jones@canterbury.ac.uk.**

What will happen to the results of the research study?

The results of the study get written up into a report (a thesis) that will be submitted as part of my doctoral degree in clinical psychology at Canterbury Christ Church University. A summary of the report can be read by staff at the in-patient unit and other similar services in the [redacted] trust. I will put quotes from some of the interviews into the report but remember that your name will be changed and the details of anything you talked about, so you cannot be identified. I will also prepare an article for a professional journal based on the research. I would like to be able to contact you once after interview so that I can share the results of the research with you before it goes into the report to ask you to comment on the results. If you think I've got something wrong, you can ask me to change it. The results will be made up of some of the things you said, and some things other people said too.

<div align="center">Thank you for reading this information.</div>

You will be given a copy of this sheet and one of your signed assent forms to keep.

Other things you need to know:

Who is organising and funding the research?

This research will be paid for by Canterbury Christ Church University. Some of the psychologists in the in-patient services in [redacted] are helping me to set the study up.

Who has reviewed the study?

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee. The committee have given this study 'favourable opinion' on the 1st of November 2018. This means the committee have said that this study meets ethical standards.

What if there is a problem?

If you have any problems during the interview, please let me know. If I can't sort the problem out straight away, I can talk to the staff on your ward. If you feel like the problem really hasn't been sorted out, you can make a formal complaint. You can do this by contacting the Research Director for the Doctorate in Clinical Psychology:

Fergal Jones, Research Director, Salomons Centre, Canterbury Christ Church University, 1 Meadow Rd, Tunbridge Wells, Kent TN1 2YG email: **fergal.jones@canterbury.ac.uk**

Do you want some more help before you make a decision?

Try talking this information sheet through with your family, a friend or someone on the ward.

If you want any help to understand anything in this information sheet or you want to ask some more questions, please contact me.

Sophie Parham, Trainee Clinical Psychologist Canterbury Christ Church University, Salomons Centre

You can leave a message for me on a 24-hour voicemail phone line at 0333 011 7101. Please say that the message is for me Sophie Parham and leave a contact number so that I can get back to you.

Appendix 5: Consent form

Consent form

Title of project: Weathering the storm: The construction and deconstruction of the stories people tell about themselves after admission to an inpatient ward, and the tree of life group
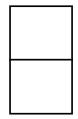
Name of researcher: Sophie Parham

Please put your initials in each box

1. I confirm that I have read the information sheet dated 25.09.18 for this study and I confirm that I understand the information and the purpose of the study. I have had the opportunity to think about the information and to ask questions. I fully understand what I am being asked to do.

2. I understand that my participation is voluntary and that I can stop at any time without giving any reason. My medical care and legal rights would not be affected by this. I understand I can still attend the Tree of Life group if I drop out of the research. I understand that my rights to access, change or move my information are limited, as Canterbury Christ Church University need to manage my information in specific ways in order for the research to be reliable and accurate.

3. I understand that data collected during the study may be looked at by the lead supervisors [redacted]. I give permission for these people to have access to this data in anonymous form.

4. I confirm that I understand although the interview is confidential, my information may need to be shared if the interviewer feels that I or someone else may be at risk of harm.

5. I agree that I can be contacted in future for the purpose of "respondent validation" (this means to confirm that the research matches what I told the researcher in my interview)

6. I agree that anonymous quotes from my interview may be used in published reports of the study finding

7. I agree to take part in the above study.

Name of Participant_____   Date_____
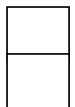Signature_____

Name of Researcher _____   Date_____
Signature_____

Appendix 6: Excerpts from research diary

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Appendix 7: Example annotated transcript

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Appendix 8: Summary report for ethics

Summary for ethics committee and end of study report

Exploring 'recovery' in narratives of inpatient admission after participation in the Tree of Life group.

Summary of research

Thank you for approving the study below. This study has now been completed and data collection has ended. I will not be recruiting anymore participants or continuing with data collection in any way and I have provided a summary of the project below.

Overview of the aims of the study

The aim of this study was to explore how people story their experiences of inpatient care and the Tree of Life group. Research suggests that inpatient wards do not always promote 'recovery' due to the restrictive, coercive and problem focused practices that are key to dominant discourses surrounding mental illness. Some have suggested the Tree of Life project could be one way of improving the recovery focus of inpatient wards as it is a group activity that focuses on empowering participants by focusing on strengths and hope for the future, rather than defining them by the problems they have. Seven people were interviewed using narrative interviewing and the data was analysed using Thematic Narrative Analysis.

Research questions

1. How do people story their experiences of inpatient care?
2. How do people story their experiences of the ToL group?
3. What connections if any do people make between attending the ToL group and developing 'recovery aligned' narratives of hope or resilience?

Findings

A number of themes were derived from the data.

   1. Meaning making

It was noticed that most people spoke about the meaning they had attributed to their experiences prior to admission. For most participants, this meaning moved away from discourses of mental illness that dominate in inpatient settings, towards more spiritual or psychological understandings of experiences. The meaning that people attributed to their

experiences set the scene for the rest of their story. Those who held understandings of their experiences that were incongruent with the mental illness discourse mostly described their admission in a negative light compared to those who agreed with the mental illness discourse.

2. **Using stories to express challenges or difference of inpatient care**

For those people whose understanding of their experiences prior to admission did not match the dominant 'mental illness' discourse, their stories mainly expressed the parts of their inpatient experience that they disagreed with. Mainly this involved stories of feeling powerless; disagreeing with the restrictive rules and coercive practices that exist in inpatient settings with most people focusing on the use of medication. For some people the stories they told involved examples of some difficult experiences they had which made them question the 'therapeutic-ness' of inpatient settings. I interpreted this as the incongruence between their ideals and reality of inpatient care leading to some distress. For these people stories of how they had resisted the influence of the powerful ideas linked to the treatment of 'mental illness' seemed to be important parts of their story, possibly because these were ways to stay connected with their true beliefs.

3. **Using stories to try to make sense of the incongruence between personal narratives and that of inpatient wards**

For a few people who held counter narratives of their experience (meanings that did not match) to the meanings the ward held, their stories were sometimes used to try to make sense of that mis-match. This was in the form of questioning the wider system and practices in mental health care in the UK. Some of the main themes were that people could not understand why there was so much focus enforcing people to take medication, restricting their liberty and using what felt like 'custodial' approaches instead of compassionate ones. These people acknowledged the lack of resources and presence of senior management as things that may have contributed to the negative experiences they had. These people also thought about what could be different about their experiences which included; better platforms to express emotions, less medication, more input from senior management and reformation of the mental health act.

4. **Others**

Others featured heavily in people's stories of their inpatient admission and were often talked about to show some of the difficult of positive things that had happened throughout the admission.

Many mentioned negative interactions with staff or other service users and often spoke about situations which showed they felt ignored by staff on the ward. In most people's stories of their experiences people spoke about rare or less common members of staff that they felt they could connect with, or who were helpful and made a difference during their inpatient experience.

People also spoke about other service users and often described how they can be aggressive or violent, but also sometimes used examples of other service users to illustrate points throughout their stories of experiences.

Some also used narratives to talk about the positive connections they made on the ward. These connections were talked about as unusual but a very important part of the admission. For lots of people this included talking about a peer support worker who offered different conversations away from problems for service users. Although some people still acknowledged that although having a peer support worker was helpful, it didn't always change things or make much difference to the admission. It also included members of the nursing team that went beyond their medical duties and built deeper connections with service users.

5. **The Tree of Life group**

Most people used the ToL group to tell a restorative story, a story that was more positive and one that focused on hope for the future. All but one person talked about finding the ToL group a positive experience on the ward and enjoyed its creativity and possibility for different sorts of conversations. Some people liked it and found it more important to their admission than others. The people that liked it most tended to be the people who had a difficult experience of being an inpatient and who disagreed with being told they have a 'mental illnesses'. Although this was not true for everyone. Some people thought that the group was OK, but did not have much of an impact on their admission and one person did not like the ToL group at all because they found it difficult to think about things they want to do in the future when they felt they had no control over choices in their life whilst on the ward.

Conclusions

In conclusion, the findings from this project reflected the wider literature in suggesting that people's stories of inpatient wards do not reflect the move in mental health towards recovery focused care. This study goes beyond existing literature to suggest that generally the meaning people attribute to their pre-admission experiences, and whether or not it fits with dominant discourses of mental illness, appear to mediate the experiences they have of inpatient care. Finally, the ToL group was shown to reflect some recovery focused values such as instilling hope, empowerment and reaffirming identity beyond illness; although its impact on admission narratives appeared to be limited, possibly due to the influence of the wider context and the dominance of the medical model in inpatient settings.

Appendix 9: Summary report for participants and wards

Summary of research

Weathering the storm: exploring stories of people who have experienced inpatient admission and the Tree of Life group.

Dear [participant]

Thank you for participating in my research and helping me to understand how people story their experience of inpatient admission and their experience of the tree of life group.

I am going to briefly outline the research, explain how I analysed the interview data and inform you of the findings.

Overview of the aims of the study

The aim of this study was to explore how people story their experiences of inpatient care and the Tree of Life group. Research suggests that people do not always feel like themselves during psychiatric inpatient admissions and do not have the opportunity to think about their strengths, or the ways they may have coped with the difficulties they have experienced. Some people had suggested the Tree of Life group could be one way of helping people stay connected with their lives outside of the ward and one way of having different conversations with service users that revolve more around their strengths rather than problems and difficulties. Research also suggests that people use stories to make sense of events in our lives, particularly during difficult times or when things are not going the way we had hoped. I thought stories would be a good way to explore people's experience of inpatient care because it can be a challenging time and by letting people tell their story, they would have freedom to talk about what they thought was important; rather than just answering set questions. Eight people took part in the study.

Thematic Narrative Analysis

When interviews are used in research (like how I interviewed you) this is known as qualitative data. Thematic Narrative analysis is one way of looking at qualitative data and it explores the different ways that people use stories to talk about their experiences. It also pays attention to what people said about their experiences.

Research questions

There were three questions I intended to answer throughout this research:

4. How do people story their experiences of inpatient care?
5. How do people story their experiences of the ToL group?
6. What connections if any do people make between attending the ToL group and developing narratives of hope or resilience?

Findings

My analysis of the interviews from all the participants found a number of themes which I made a note of and considered in detail. I noticed that people told different kinds of stories, but they tended to fit into a smaller number of types of story.

Meaning making

It was noticed that most people used the interview to try and make sense of some of the events that had led up to their admission. Many people were 'attributing meaning' to their experiences. For some people this 'meaning' fit with the ideas mainly used in mental health settings, that they had a 'mental illness'. For others this meaning making moved away from the dominant idea of 'mental illness' and took the form of spiritual or psychological understandings. I thought that this meaning making seemed to set the scene for telling the rest of the story.

Using stories to express challenges or difference of inpatient care

I noticed that for those people whose understanding of their experiences prior to admission did not match the dominant 'mental illness' idea that exists in inpatient settings, their stories mainly expressed the parts of their inpatient experience that they disagreed with. Mainly this involved disagreeing with the restrictive rules and coercive practices that exist in inpatient settings with most people focusing on the use of medication. For some people the stories they told involved examples of some difficult experiences they had which made them question the 'therapeutic-ness' of inpatient settings. I interpreted this as the incongruence between their ideals and reality of inpatient care leading to some distress. For these people stories of how they had resisted the influence of the powerful ideas linked to the treatment of 'mental illness' seemed to be important parts of their story, possibly because these were ways to stay connected with their true beliefs.

Using stories to try to make sense of the incongruence between personal narratives and that of inpatient wards

For a few people who held 'incongruent' meanings of their experience (meanings that did not match) to the meanings the ward held, their stories were sometimes used to try to make sense of that mis-match. This was in the form of questioning the wider system and practices in mental health care in the UK. Some of the main themes were that people could not understand why there was so much focus enforcing people to take medication, restricting their liberty and using what felt like 'custodial' approaches instead of compassionate ones. These people acknowledged the lack of resources and presence of senior management as things that may have contributed to the negative experiences they had. These people also thought about what could be different about their experiences which included; better platforms to express emotions, less medication, more input from senior management and reformation of the mental health act.

Others

Others featured heavily in people's stories of their inpatient admission and were often talked about to show some of the difficult of positive things that had happened throughout the admission.

Many mentioned negative interactions with staff or other service users and often spoke about situations which showed they felt ignored by staff on the ward. In most people's stories of their experiences people spoke about rare or less common members of staff that they felt they could connect with, or who were helpful and made a difference during their inpatient experience.

People also spoke about other service users and often described how they can be aggressive or violent, but also sometimes used examples of other service users to illustrate points throughout their stories of experiences.

Some also used narratives to talk about the positive connections they made on the ward. These connections were talked about as unusual but a very important part of the admission. For lots of people this included talking about a peer support worker who offered different conversations away from problems for service users. Although some people still acknowledged that although having a peer support worker was helpful, it didn't always change things or make much difference to the admission. It also included members of the

nursing team that went beyond their medical duties and built deeper connections with service users.

The Tree of Life group

Most people used the ToL group to tell a restorative story, a story that was more positive and one that focused on hope for the future. All but one person talked about finding the ToL group a positive experience on the ward and enjoyed its creativity and possibility for different sorts of conversations. Some people liked it and found it more important to their admission than others. The people that liked it most tended to be the people who had a difficult experience of being an inpatient and who disagreed with being told they have a 'mental illnesses'. Although this was not true for everyone. Some people thought that the group was OK, but did not have much of an impact on their admission and one person did not like the ToL group at all because they found it difficult to think about things they want to do in the future when they felt they had no control over choices in their life whilst on the ward.

Conclusions

I have mentioned the ideas that most stood out to me when looking at the different stories of inpatient admission and the Tree of Life group. At some points I have used ideas from existing research to help me make sense of your stories. This is just one way of looking at the different experiences you spoke about and these are just my interpretations of your experiences; so they may not exactly reflect what you intended when you told me your story. If you would like to contact me to let me know your thoughts about my interpretations, or to talk about this research further please contact me on:

Appendix 10: Interview Schedule

<u>Narrative inquiry interview -Jeong-Hee Kim 2015</u>

The narrative inquiry interview is formed of two phases. The first phase is the narration phase where the interviewee is asked one main question and left uninterrupted whilst telling their narrative. The researcher restricts their intervention and does not ask questions, only showing they are listening using active listening techniques such as summarising, reflecting statements back to the interviewee and verbal and non-verbal signs of listening ('nodding', 'hmmm', 'I understand', 'ok').

The second phase is the conversation phase where the interviewer can ask some semi structured questions asking for clarification and further detail on what was said in the narration phase. The interviewer may also bring in additional concepts that are related to their theoretical interests (Spence, 1982). The narration and conversation phases do not have to run linearly and the interview can weave between the two.

During this part of the interview the researcher can use the 'two factor sentence technique' where part of the participants story is repeated as a statement and followed with a question aiming to expand that part of the story (Morrisey, 1987).

i.e. you have talked about how difficult you found those first few days of your admission on the ward. Could you tell me what helped you to get through those first few days?

In the final part of the interview the researcher can bring in new points that the participant may not have mentioned in their narrative that are related to the researchers own interests and the purpose of the study (for example if the participant has not mentioned the Tree of Life group).

<u>Interview schedule</u>

1. *Narration phase*

"I would like you to tell me your life story since being diagnosed with diabetes including all of the events and experiences that have been important to you personally. Perhaps start around the time you knew you were going to be admitted to hospital. I am going to listen to your story and I may ask some questions about the things you tell me so that I can make sure I have a good understanding of your experiences."

2. Conversation phase

Cue phrases are linked to theoretical terms the researcher is interested in – may be cue points to look out for and ask participant to expand on:

➢ Tree of Life metaphor (storms etc)

➢ Negative/ Problem (difficult, bad, illness, out of control, not managing levels)

➢ Risk (danger, self-harm)

➢ Negative experiences (hypo, DKA etc)

➢ Anything related losing contact with what makes the person who they are (not being able to see friends, continue with hobbies, eat favourite foods, see family, got to school etc).

➢ Positive/Strengths (resilience, not my fault, get through this)

➢ Support (kindness, positive, helpful)

➢ Diagnosis vs being seen as an individual (for example staff wanting to have conversations about the individual's strengths, hobbies, the person outside of their illness rather than just their level of risk, medication and management of their illness)

"You said [their cue-phrase]; can you remember any (more) detail about that/the/a particular [moment, situation, How it all happened?]

i.e. you said you felt as though you were a failure could you tell me more about how you got to that conclusion? Who/what led you to believe that about yourself? Can you think of any specific examples?

'You said that you 'knew you were finished': can you remember any more detail about that moment when you had that thought?'.

You said you realised you could get through. Could you give me some more detail about how you knew that?... can you think of any specific words or times when you knew that? What helped you to know that? What did they do to help you know that? How did they support you?

You said that your mum was always there for you. In what ways did she show she was there for you? How did you know that she was there?

Final section of the interview (interviewer can bring in new topics)

Thank you for telling me your story. I wanted to ask you just a few more questions about your time with the diabetes service.

<u>Examples of further questions (if not already covered)</u>

How would you have described yourself before your admission (or before your difficult experiences/diagnosis)?

What may someone have noticed about you in those early days of your admission?

Was there anything on the ward that helped you to make sense of your time on the ward or what had happened?

Thinking about your early days of diagnosis, how do you feel about it now?

Anything that you found really unhelpful or difficult about the interactions you had with people soon after diagnosis?

Was there anything that stands out to you as a 'turning point' during your diabetes journey?

I'm now going to ask some questions about the Tree of Life group. Was there anything about the Tree of Life group that helped you to make sense of your diagnosis?

What may someone have noticed about you in the Tree of Life group or now?

What helped you to think about your experience in that way?

Is there anything from the Tree of Life group that you have been able to hold on to (remember, still think of)?

Did the Tree of Life group help you to think about yourself in a different way? If so how?

Look out for metaphors in the way a person talks about their experience that are linked to the Tree of Life group.

Reference

Kim., J. (2015). Understanding narrative inquiry: The crafting and analysis of stories as research. London. Sage.

Appendix 11: Reflexive statement

As the writer of this project, I am not immune from context, just as you, the reader (and assessor) of this project are not immune from context. My decisions as the analyst and interviewer has impacted on what has been included or left out of this project.

Having worked within inpatient psychiatric wards I have strong feelings regarding the approaches used in such places. Through my own experiences I have witnessed the oppression, forceful detention and abuses that can occur. This will have undoubtedly affected the attention I paid to narratives of trauma and abuse. It encouraged me to research approaches that privilege the opposite of the custodial values that can prevail such as narrative approaches, and the ToL group. Thus, it is likely that I will privilege stories of different that arise from this group. I have a keen interest in narrative therapy and have helped set up several ToL groups. I have witnessed how they can make a difference for people so I am likely to be guided by my construction of the ToL group as a helpful experience. I also carry beliefs that align with the mental health recovery movement. This project is written from a social constructionist perspective where even mental illness itself could be a social construction, all be it a dominant discourse within society. Therefore I feel I protest the heavy focus on the illness model within mental health care and may privilege stories that hold similar views to mine. In order to be reflexive I have used supervisors to challenge my beliefs and to remind me that I, as many others, hold discourses of my own that may not be discourses shared with others. The filter of my own cultural, professional, religious and social values will undoubtedly influence the way that I interpret, analyse and pay attention to the stories told to me. Furthermore, as the sole interviewer, I recognise that each interview was co-constructed by the interviewee and myself, —the researcher does not find narratives but instead participates in their creation (Riessman, 2008, p21).

Appendix 12: Bracketing interview

Interviewer: So, what made you want to carry out this research?

Researcher: Erm, I was interested in this research because I've previously worked on an inpatient ward and I felt like a lot of the interactions with service users were very negative or focused around illness erm and I didn't feel like there were many activities that could ring out a sense of who the person was outside of their illness. I felt like the ToL was one way of doing that. I was quite impressed seeing it on inpatient wards that I've worked in.

Interviewer: Ok erm, so it sounds like you had some experience of the ToL group. What do you think you expect to find doing this research?

Researcher: Well there's two parts to my research. The first part is how do service users story their experiences of inpatient care and the second part is more focused on how the service users story their experience of the ToL group. So, I guess I'm expecting to find, what I think that people will probably story their experience of inpatient care as quite negative erm maybe like a lack of control a lack of agency erm or what I would describe as away from recovery focused values. So, what I don't expect inpatient wards to hold many recovery focused values like giving people agency over their care erm empowering them or offering hope. I sort of expect people to talk about things that mean they haven't had much control and that their interactions with staff have been quite problem focused. Whereas I feel like the ToL group might be one way erm or might be storied as a bit more recovery focused, a bit more focused on the individual, on their strengths and where they want to be in their life and how they coped with things.

I am expecting to see a bit of a split generally between inpatient admission and experience of the Tree of life group.

Interviewer: Ok so having these ideas about a, inpatient care and also the tree of life group within inpatient care. How do you think your preconceptions and your previous experiences will influence how you carry out the research?

Researcher: Well I think that is an important one because it is narrative interviewing there is not set structure, you're just listening to the stories and there is an opportunity to ask questions about what we have spoken about and also then at the end bringing your own questions that relate to your interests. I suppose erm one thing to be really aware of is what I'm privileging, what stories I'm privileging. Is it that I'm really privileging those stories of negative inpatient care and negative interactions versus those persons who may have had a positive experience? Or there could be dominating negative stories but there might be positive stories within that am I going to shut those stories down or am I really going to give people the chance to talk about those. Erm and I guess the same with the ToL aspect. Am I going to really focus on those people that have had a positive experience versus those who aren't so bothered about it or didn't like it. So I guess my influence could be quite big on how those things come across in interview.

Interviewer: And how do you think you will manage some of those assumptions or manage what you are privileging from that data you are getting.

Researcher: I guess in the interview, I probably need n element of reflexivity in the moment t be aware of what I'm shutting down erm and I guess with narrative you are a bit more led by the person, just letting them speak and have their experiences told just while listening. That is one way of making sure there is a bit more of a balance. I suppose with the actual research erm just paying attention really to what stories are there, or even doing the analysis thinking about what narratives am I hearing here before going into detail in the analysis and

then checking once I've done the results the actually I've included all the stories that I've heard, or the main stories that I've heard .

Interviewer: OK and how do you think, because that is a bit about what you're bringing but I guess also do you think how the participants might perceive you will influence what stories they are able to share.

Researcher: I guess if I think about my original hypotheses about inpatient care being found as quite negative or quite coercive erm you know a lot of people will be under section and they might experience me as another mental health professional that really determines the path of their care. So although I'll do my very best to ensure participates that it is confidential and this is not related to their care and it says that in the information sheets, I imagine that some people may still be worried about speaking honestly to me about their experiences just in case it does influence their care. For example, in the medical discourse other understandings of distress are really shut down, and even seen as delusional sometimes such as spiritual or psychological so they might be scared of telling me their spiritual or psychological understandings of what's happened to them just in case it is interpreted as a symptom or as part of their illness. So that is something to be aware of, for example if I end up with some really really positive erm stories of admission that were all quite skewed, I would be wondering what influence their context has had on that and how they interpreted me as in their story.

Interviewer: OK and why, ok so the context is important, what – I cant think if you've answered this one but your influence on narratives.

Researcher: I think that is something about the interview but also within narrative analysis, it is very subjective, I am the researcher but I am bringing my own circumstances I cant be without my context and I can't just take I t off for the process of the analysis and say if you

looked at my research and my results you might interpret a completely different story. This is just my interpretation and maybe this is reminding me that I need to make that clear in writing my project that actually this is my story of the research but somebody else could have a completely different interpretation.

Interviewer: yeah, so it isn't like an objective approach

Researcher: Yeah so just being clear that I'm holding a discourse ad that there is no objective truth, but rather just different stories and I'm just trying to collate them together. I guess one thing with thematic narrative analysis the kind of, something to be cautious of is grouping narratives by themes, you do lose some of the context of the individual narrative so they might actually mean different things but they might actually come across as meaning the same thing and I'm just putting my thinking onto that but actually if I was to go back and talk to that individual in a lot of detail they might say no I didn't quite mean that. In narrative analysis, respondent validation isn't really used in narrative.

Interviewer: So, you're not going to do that?

Researcher: Yeah

Interviewer: So, what's the, and what are your views on taking the interviews, analysing them and then not going back to the participant?

Researcher: I mean I do feel a little bit uneasy about that because they're not getting the chance to say I didn't mean that but then again narrative is about my interpretation, so I'm bringing my own context and my own influences to it. So, it is not going to be completely free from my influence and my judgements. And giving participants to check the objectivity possibly belongs to positivist epistemological positions and with social constructions, seeing their words in writing may give them chance to re-construct the data – depending on the situation. They may want to remove something or change something which could create

different issues of validity- perhaps anything seen as 'negative' might be removed. I don't know. Of course as with any analysis I will make sure it is grounded in data and make sure I have quotes within the results to show how themes were derived from analyses and how I've got to them. But I suppose within the analysis the themes are not just, you know within thematic analysis the themes not just so and so said this or that. It's a bit broader than that, more about what stories are they holding, so this person is trying to do this or this and how power or influences are coming through in the analysis. It's less about specific segments of data but more about stories as a whole. So I guess in that sense there could be less space for me to misinterpret what people meant. Erm but I think that is an issue and something to be aware of and I will obviously do my best to keep it clear to themes that are coming through. And just because I'm not doing respondent validation it doesn't mean that the participants wont be aware of the grand themes, it just means I won't be checking individual stories with people.

Interviewer: and I was just thinking going back to your interview and because obviously it's a bit about inpatient ward and people's experience of that and a bit about the tree of life and I guess I'm wondering obviously you're going to see what they bring to that but I guess I was wondering do you think you're bringing anything with questions that you're asking that might draw out certain stories?

Researcher: yeah so I think although you go with an open mind, I've got certain ideas of questions that I would like to ask and that is related to topics that I am interested in. so I think that could bring out certain experiences but I have tried to keep it quite open. So instead of saying did staff talk to you about your problems and nothing else, its been a bit more what were your interactions like with other people on the ward.

Interviewer: Right ok.

Researcher: I'm trying not to lead the questions. I've tried to stay at a more open level. And with the interview that I'm suing if they say something, I'm interested a bit more specifically about what they have said, I can say 'oh you mentioned … can you tell me more about that'. So I'm trying my best not just to not lead with my own ideas but also to go with what they say. I mean I can own that, there will definitely be questions about things I am interested in knowing about things that are relevant to the research but I am going to try my best to have open ended questions. It might be hard in the moment but again n reflection I can look at my role in creating the narrative, how did I impact on what was spoken about throughout the stories.

Interviewer: OK, just checking if there are any more questions erm, is there anything else you think that is important in terms of any preconceptions or values that you hold that might influence any part of the research?

Researcher: erm, I think one thing I erm, I erm didn't think about which is a preconception I hold, was this idea that everyone is going to have a coherent narrative of their experience. So obviously narrative analysis requires people to hold narratives of their experience and erm having a coherent narrative is quite a westernised idea and one criticism of narrative analysis is that not everyone will have or want to have made sense of all their experience in a coherent way. A narrative is supposed to have certain features, but it doesn't be a complete narrative but I guess now I'm just thinking about my assumption of people holding these strong narratives of their experience, they're going to be inpatients who could be described as being in crisis, how will that influence their ability to hold a coherent narrative of their experience and then to lead on from that would be then where does that leave my impact on their narrative because if they haven't got a really long detailed account of their experiences off the cuff then I'm going be asking more questions and there's more scope for me to be asking questions.

Interviewer: Does the research then require people to have a certain level of reflective ability?

Researcher: yeah… erm it's not something that I have put as part of the inclusion criteria but obviously they need to be able to consent to the research and to be able to talk about their experiences. But I guess thinking about it now, I am assuming that people will be able to be quite reflective and talk about their interactions with others and almost have a meta level of thinking about how they have experience being an inpatient, when maybe not everybody is going to have those experiences or have that reflection.

Researcher: Erm I don't know but perhaps I'll find that even without having a fully coherent, or reflective narrative of their experiences they will still have important stories to tell that give lost of rich information. i.e. one way I was thinking about this was asking questions such as 'can you tell me an example of that' or can you tell me more about that. Just try to get some more details. But yeah I think that is one big preconception that I didn't realise that I had. I am expecting people to come with stories and I don't know what I'll di if they don't because that is the analysis.

Interviewer: ok is there anything else that you think will influence the research that we haven't spoken about?

Researcher: I think just generally my experiences of working in mental health and inpatient settings particularly I maybe disagree with some of the approaches that I've seen and there's something about the narrative approach that I like in terms of mental health because it does give people more choice and more agency and perhaps there is part of me that really wants it to be helpful because I've seen how upsetting and hard it ca be for people when they don't have any choice or any sense of what they're good at and everything is stripped away from them as an inpatient. Or maybe I'm really holding onto that narrative therapy can be one way of keeping people in touch with who they are and their identity away from an illness model.

And that is something I'm quite passionate about all over mental health care not just inpatient. But yeah so I think they could, they're definitely motivating me to do this work so I've got be aware of my values doing this work and make sure that they're not influencing how I am interpreting what people are saying to me.

Interviewer: OK anything else to add?

Researcher: Nope, thanks.

Appendix 13 – Theme development from individual narratives

Shola	Positive connections	*"well I like the doctors and nurses they are helpful"*
	Violence from others	*"Well, mostly people they, they shout, or the alarm and some people get angry. If people get angry, *long pause* Sometimes you can be in the wrong place. They might take it out on you.*
	Value of peer support worker	*"Peer trainer is interested in my life – it's nice she wants others to know more about me."*
	Medicalised explanation of difficulties / admission as helpful	*"It has been good being in hospital for me. I know I am sick, and I know it's helpful for me"*-
	Problem focus on ward	*"If you have a problem, they want to know about that. And they need to check on you all the time and ask about voices or you know, checking, to know if I'm sick, or not sick, or if I've taken my pills. That's big you know".*
	Tree of life as offering difference	*"It's different to other things, more talking about what I like.* *Was nice. It felt friendly. Never usually friendly on the ward. I felt good earlier, and this other lady she's always sad, but she was smiling.*
Leonard	Treated like a kid – punitive / paternalistic	*"How am I an adult if they make rules for when I do something wrong? Because I'm an adult and everything and I'm going somewhere and they say I can't, I feel like they just treat me like a kid* *"then they said I was in trouble and just said I couldn't go where I was going"*
	Lack of agency	*"I wanna get out of here, just any way of getting out of here, I just want to get out of here, but **they** won't let me"*
	Fighting back – violence	*"And I took a knife to him just to make him back off"*
	ToL and empowerment	*"It felt good yeah. I feel like sometimes when you write positive things then you want them to happen"* *"Positive. Yeah really positive. It said my skills and stuff, other skills like strong. It was positive to hear that"*

	ToL and hope	*"I remember writing about what I wanna do when I leave here for the first time... the ideas came to me in the group"*
	Value of peer support worker	*"She listened. Wanted to know about me. Helped me think. Was positive about me."*
Mariam	Non-mental illness understanding	*"what happened with the situation I was in, what happened was that I had, I have a cancer history and because of that I have um late effects from the chemotherapy"*
	Admission as negative experience	*"I mean coming out of that environment now it is trauma. If you did have, god forbid, if you did have symptoms I don't think that environment is holistic to support help and heal"*
	Coercion	*"at this point I had been, I had already been restrained once and drugged because they wanted to knock me out because I was, I was complaining too much"* *I cannot believe those places are supposed to be therapeutic when there is not even therapy, it's just all medication and then holding, drugging and releasing – nothing is healed, nothing is worked on"*
	Violence	*like beat the shit out of me, choked me with my own scarf, dragged me down the hallway and threw into my room and try to assault me in the bathroom"* *"the guy...was like "I'm kinda worried for you. He kinda like gave me the warning like "this is not a good place you're going to"*
	Ignored/ no voice	*"it was like in one ear and out the other like they wouldn't like give me *short pause* the respect to listen to what I was telling them"*
	Fighting back	*Because I couldn't breathe, and I was literally going to pass out. And I was restrained so I took all my energy, all my energy and I swung back and I hit him in the face"*

	Value of peer support worker	*"she is like a holistic person and that is her goal ya know so even in that toxic environment she would be able to take you out of that toxic environment for those few hours"*
	The system	*"It's just the level of abuse in the system. Itsss the way that people are towards what would be classed as mental health or mentally disabled, mentally challenged individuals"* *"A lot needs to change. The patients are more sympathetic than the staff are, staff aren't paid well enough for their job, and they don't want to be there. They don't have ongoing training and there is just a lack of staff and a really high turnover. There's no diversity with the Dr's or um no checks and balances with the staff it's like a dictatorship".* *"just the section practices in general have been round since the 80's and obviously need to be revisited... I mean 1983- we're in 2019, there's a big difference"*
	Problem focus	*They would like twist whatever you say something... somebody had overheard my conversation that I had met this guy and we had a fun time together. And I don't think that's weird, I think that I very common. But they made it like ah she's having promiscuous relationships with strangers. They would take whatever you would say and flip it."*
	ToL and hope	*"Umm Things like the Tree of life project were good for me because I was kinda like pause there's a future out of this. This is like thinking about where you wanna be like yeah you may be going through hell right now but it's not gunna be forever."*
	ToL and human connection	*"It also brings a human tie back into this dynamics because it is very like a clinical detached repression and then when you're in a creative environment like that...it helps them [nursing staff] maybe become a little bit more compassionate"*

	ToL and empowerment	*"It's like self-life coaching, being an advocate for yourself like really advocating for yourself and them um just being creative"*
Anton	Ward as positive experience	*"yeah I feel ten times better being in here"*
	Medical understanding	*"It made sense being in hospital because I have an illness…I had been stopped for a while [medication] which is how I ended up in here".*
	Other service users- anger	*"Some of the patients, they are very noisy"* *"Sometimes they can be a bit angry"*
	Lack of personal agency	*"They decide and I just have to take the depot. I don't always want the medication"* *"I really wanna go home. Got to wait until **they** think I'm ready to go home"* *"They would listen to me but it doesn't mean it would happen"*
	Learning the system	*"I used to kick off about not wanting to take the medication but now I know If I didn't take the depot they would keep me in here longer".*
	ToL and pride	*I'm proud, I keep it in my wallet [Certificate]. It goes on the wall in my room [Tree]. I look upon it every day".*
Marcus	Admission as positive	*"it's been gently inspiring being here… it's made me learn to deal with situations a bit more gently"*
	Peaceful environment	*"the ward is very peaceful, everybody [staff and patients] gets along with each other"*
	Close connections	*"I can really express my faith when *Removed name* is around... there's no communication barrier"*
	Problem focus	*"As long as I take my medication, they're not worried, they just check that I'm not suffering from any symptoms"*
	Spiritual understanding	*"My main goal in life … I wasn't able to visualise it, so all I could do was think… and I meditated a lot. I'd be in a prayerful state most of the time, because I didn't have the right answers yet".*

	Desire for alternatives to medication	*"I'm not sure the medication does work" "I think it [talking therapy] works better than medication anyway"*
	ToL as positive experience	*It was nice at the end, having someone read out my story and clapping. And hearing about others and clapping.*
	ToL as a similar experience to the ward	*Yeah I do [have those conversations] with staff and that on the ward".*
Warren	Restricted emotions	*"he's letting out an emotion that before was pent in, just give him some space to express"* *"They look for aggression and then try to contain it". The only way to let out emotions with that energy is anger... there needs to be better platforms for people to express themselves"* *The staff they're restraining him as opposed to helping him work that emotion out of his system*
	Non-mental illness understanding	*"They still see these symptoms as something to be fought, and removed from me and I'm thinking that's not so... don't worry we're going to strip all that intuition form you, you'll just be a plain person when you come out of here"* *"I got to a point at work where I felt I couldn't cope anymore... I was homeless"*
	Admission as bad experience	*"it's been a bit of a nightmare"*
	Alternatives to medication	*"Talking is always better... to feel understood, it's always nice to get empathy"*
	Failing system	*Everyone is under stress because there is just a failing system* *Generally it's their way or no way and that is what I think is wrong with the system in general...I feel like even psychosis...it's all part of just gifts.* *So, it has helped me, because I got a roof over my head and a meal, but I just don't think it's the best way... it's just some of the systems and the ways of dealing with things aren't fantastic" Warren*
	Punitive/ Custodial values	*"The staff under the NHS are so stressed that instead of being loving and compassionate they rely on law to cope. So everything comes as you're allowed to do this, you're not allowed to do this"*
	Ignored by staff	*"there wasn't much interest unless people were escalating"* *Interaction just seems to be putting out fires, so unless I'm on fire there's not very much time to talk or attention*

	Positive connections	*"There are a few that are really nice and that are a treat to be around, but they are exhausted, nice people get used more*
	Value of peer support	*"if I manage a service, I'd want to know what it felt like to be a user"*
	Medical model – one size fits all	*"I fit very much into what the NHS already has in place which is drugs to get better" They've got the understanding of psychosis, of me based on their model not based on my experience"*
	Resistance	*"I'll go with the doctor, I'll say yes to everything because that's the only way to get out and in fact if I chose not to go along with it now, even if chose to express myself freely now I will be here for much longer… so it's almost like they've forced me to close up, don't say anything just get through this stage and then express yourself somewhere else*
	Lack of agency	*"I'm so restricted and I don't feel I need to be…"* *"I've tried to [say I don't want the drugs] it's kind of seen as rebellion"* *"It almost feels like we are losing out if all we have to rely on is our rights…well I'm a nurse and I don't have to give you this, I don't have the resources , well you have to give it to me by law and it just gets, I don't know"*
	Reduced personal control	*"There's so much [incorrect] information on the system that's leading to medical decision.* *It would be nice if the nurses had more power to make decisions because they spend so much time with the patients but they have to wait and rely on the consultant".* *"I think if anybody is going to harm someone then detain them but that's not where I was coming from, but they still feel the need to detain and contain…"*

	ToL and a different focus	*"This [the ToL] feels good because it doesn't focus on the symptoms of a person's terrible situation. It focuses on the core person. I felt like if the hospital was like this, focusing on the core person as opposed to a particular event; it's better to focus on"… "I just really liked it. I can't say it's particularly changed things"-*
	ToL and identity	*When a person speaks about their beliefs… it helps to reaffirm in ourselves. It's like its reminding me what it means to be a person, to be an individual and just to be human." –*
Bilal	No choice	*The worst part for me here is that there is too much control*
	Desire for alternative option	*I think people need free will and free choice. Erm, you know like I can take chlorpromazine here that's something I tolerate, something **I want,** but instead they're saying you **must** take injections. I would rather choose what works for me.*
	No freewill	*This could be a helpful place for people that are unwell, if THEY wanted to. If it was free choice.*
	Meaning of experiences	*I don't feel like I have an illness. I don't feel mad, I don't feel bipolar either.*
	Dislike of UK mental health system	*In India there is choice, your treatment is personal, and psychiatry is personal… I haven't felt in control of my treatment here, it's just a question of the government is paying for it so they just do what they want… The system makes all the decisions*
	Fighting back	*It is getting so tedious getting bounded up all the time that I went and threw some paint on some painting…for that the doctor wasn't exactly happy with me.*
	ToL unhelpful	*I couldn't focus on talking about my life and where I want to be when I have so little control and freedom over what I can actually do.*

Appendix 14: Grand narrative themes

Power	Experiences of violence
	Power of medical model
	➢ Coercion
	➢ No choice
	➢ Desire for alternatives
	Lack of agency
	No free will
	Paternalistic/ punitive approaches
	Ignored/ unheard
	Abuse
	Resistance/fighting back
Others	Positive connections
	Difficult relationships
	Ward environment
	Reliance on others
	Problem focused conversations
Meaning of experiences pre-admission	Spiritual
	Psychological
	Mental illness
	Other non-mental illness
Experience of the admission	Traumatic
	Helpful
	Positive
	Gentle (Divergent narrative)
	Nightmare
Tree of Life group	Hope
	Empowerment
	Peer support worker
	Positive experience
	Divergent = unhelpful
	Creative activity
	Different experience
	➢ Feeling heard
	➢ Space for own experiences
	➢ Focus on strengths

Appendix 15: Timeline

- **Dec 2016-** Attended research fair

- **Dec 2016 – March 2017** Met with potential supervisors of an older adult service running the Tree of Life group

- **Feb 2017 -** Started MRP proposal

- **March 2017 -** Informed external supervisor is leaving her role (not clear on access to participants). Decided to change MRP project to ensure access to participants.

- **April -May 2017-** Changed MRP projects to adolescents ToL group on the ward I worked before training

- **May 2017** completed MRP proposal

- **June 2017 -** MRP committee meeting at uni

- **August 2017 -** Started ethics process

- **August 2017 -** Began thinking of ideas for lit review

- **October 2017 -** Second external supervisor left position no longer access to the ward or participants although lead psychologist of service guaranteed research could continue.

- **November 2017 -** submitted ethics

- **February 2018 -** Ethics review panel (The beast from the East snow day so spoke to ethics panel over the phone)

- **March 2018 -** Approval received

- **April 2018** - Submitted trust R & D form

- **July - September 2018**: Met with inpatient wards to discuss projects and to discuss recruitment

- **July to September**- Chasing up R&D approval for trust. Informed person handling left job. Started process again. Relieved approval September 2018

- **August 2018**- Trust put out to tender. Ward taken over by a new trust, internal collaborator left position. No longer access to participants, new psychologist unwilling to help with research as limited resources- Tree of Life group slot given up and no longer running on the ward. Project fell through.

- **September 2018 -** Submitted major amendment to recruit form an adult ward running ToL groups within the same trust

- **September- November –** met with psychologists discussed project got a plan in place for research.

- **November 2018 –** Approval for amendment received- completed lit review.

- **November 2018-** Submitted R&D form. Started writing intro, method etc. for section B.

- **Dec-Feb-** Chasing up R&D – no contact. Told process changing- missed application. Finally got approval from R&D in February

- **Jan 2019-** submitted another amendment to recruit discharged service users who attended the ToL group

- **Feb 2019- started recruitment –** 3 interviews completed.

- **March 2019 – Peer support worker who ran groups told contract is not being extended. Groups ceased running.**

- **March 2019-**Deferred MRP. Finished placement for 5 weeks (study leave and annual leave). Continued working on MRP as far as possible. Not giving up hope.

- **March 2019-** End of March peer support worker back in position. Recruitment continued.

- **March 2019 –** Internal supervisor left for maternity leave. Interim supervisor not clear

- **April 2019 –** given another supervisor met for the 1st time 8th April. Told I have enough participants to go for extended deadline rather than defer.

- **April 2019-** analysis, discussion and appendices completed.

- **April 2019-** submitted MRP.

Appendix 16: Journal publishing guidelines

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Appendix 17: NRES end of study form

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