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MONIQUE N. MALWAH BSc (Hons) MSc

**AN EXPLORATION INTO THE SOCIAL IDENTITY OF
MEMBERS OF SERVICE USER GROUPS THAT TRAIN
MENTAL HEALTH PROFESSIONALS**

**Section A: The salience of mental health-related identities
and their impact on recovery**

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user groups that train mental health professionals: a
grounded theory analysis**

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CANTERBURY CHRIST CHURCH UNIVERSITY

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Summary of the MRP portfolio

Section A consists of a review of the literature that explores the social identity of adults diagnosed with mental health problems. The review highlights the importance of social support and the possible usefulness of peer support (or service user) groups for the transformations of mental health-related identities. Gaps in the literature are identified, together with directions for future research.

Section B presents the findings of a grounded theory study that explored the social identity of members of service user groups that train mental health professionals (SUG-TR). The study also constructed an explanatory model of how participating in such groups contributes to the achievement and maintenance of positive social identity.

Section C offers an evaluation of the research study presented in section B. It explores the research skills learnt whilst undertaking the grounded theory study and identifies abilities that need to be further developed. A critical appraisal of the study will then be presented, before reflecting on possible clinical recommendations. Lastly, possible areas for future research are presented.

Section D consists of appendices containing relevant supporting material.

Contents Section A: Literature Review

| | |
|---|----|
| Abstract..... | 10 |
| Introduction..... | 11 |
| Social Psychological Perspectives on Identity..... | 11 |
| Social Identity Theory (SIT)..... | 13 |
| The Issues of Identity for People who Experience Mental Health Problems...13 | |
| Loss of self and identity..... | 13 |
| The emergence of mental health-related labels and social identities..... | 14 |
| ‘Mental patient’ identity..... | 15 |
| Service user identity..... | 16 |
| Mental health-related labels and stigma..... | 17 |
| Identity: a process in personal recovery..... | 18 |
| Rationale for Review..... | 18 |
| Literature Review: The Social Identity of Individuals Diagnosed with Mental Health Problems..... | 19 |
| Aim of Review..... | 19 |
| Literature Search Strategy..... | 19 |
| Literature Review..... | 20 |
| Mental health in-patient settings: an important context?..... | 20 |
| Shifts in perspective on mental health-related social identities..... | 22 |
| Strategies used to manage mental health-related identities..... | 24 |
| A possible relationship between recovery and social identity..... | 27 |
| Discussion..... | 29 |
| Summary of Findings..... | 29 |
| Clinical Implications..... | 30 |
| Research Implications..... | 30 |
| Conclusion..... | 31 |
| References..... | 32 |

Contents Section B: Empirical Paper

| | |
|---|----|
| Abstract..... | 43 |
| Introduction..... | 44 |
| Social Identity & Mental Health..... | 44 |
| Social Identity, Mental Health & Peer Support Groups..... | 45 |
| Involvement by Mental Health Service User Groups in Professional Training..... | 46 |
| Rationale for the Current Study..... | 47 |
| Aim of the Study..... | 47 |
| Method..... | 48 |
| Participants..... | 48 |
| Ethical Considerations..... | 50 |
| Design..... | 50 |
| Procedure..... | 50 |
| Analysis..... | 52 |
| Quality Assurance..... | 52 |
| Results..... | 53 |
| Categories..... | 53 |
| Model Summary..... | 54 |
| Impact of Receiving Psychiatric Diagnosis / Mental Illness..... | 58 |
| Loss of old/former self & relationships | 58 |
| Stigma..... | 60 |
| Self-stigma..... | 61 |
| Service providers' low expectations..... | 61 |
| Societal negative reactions..... | 62 |
| Participating in SUG-TR..... | 62 |
| Supportive network..... | 63 |
| Different norms & values..... | 63 |
| Personal growth & recovery..... | 64 |
| Contributing to Positive Social Identity..... | 65 |
| Helping others..... | 65 |
| Improving services..... | 66 |
| Self-identity..... | 66 |

| | |
|--|----|
| Bridging gaps with professionals..... | 69 |
| Members of staff teams..... | 70 |
| New group roles & opportunities..... | 70 |
| Challenges to Participating in SUG-TR..... | 71 |
| On-going mental health problems..... | 72 |
| Negative & ambivalent training experiences..... | 72 |
| Too much focus on group member identity..... | 73 |
| Discussion..... | 74 |
| Summary of Findings..... | 74 |
| SIT strategies..... | 74 |
| Self-identities that facilitated positive social identity..... | 76 |
| Towards new perspectives on identity and recovery..... | 77 |
| Limitations..... | 78 |
| Clinical Implications..... | 78 |
| Future Research..... | 79 |
| Conclusion..... | 80 |
| References..... | 81 |

Contents Section C: Critical appraisal

| | |
|-----------------|----|
| Question 1..... | 89 |
| Question 2..... | 91 |
| Question 3..... | 94 |
| Question 4..... | 95 |
| References..... | 97 |

List of Tables

| | |
|---|----|
| Table 1: Participant demographics..... | 48 |
| Table 2: Categories and sub-categories..... | 55 |
| Figure 1: Theoretical model..... | 57 |

Contents Section D: Appendices

| | |
|-------------------------|----|
| List of appendices..... | 99 |
|-------------------------|----|

Appendix A: Search strategy methodology

Appendix B: Table overview of reviewed studies

Appendix C: Participant information Sheet

Appendix D: Participant consent form

Appendix E: Interview schedule

Appendix F: Extracts of transcripts showing initial and focused coding

Appendix G: Extracts of memos kept during data analysis

Appendix H: Abridged version of research diary

Appendix I: Early diagrammatic model

Appendix J: Table displaying categories, sub-categories, and example quotes

Appendix K: NHS ethics approval

Appendix L: End of study declaration letter to REC

Appendix M: Journal guidelines

MONIQUE N. MALWAH BSc (Hons) MSc

THE ROLE OF SOCIAL IDENTITY IN PERSONAL
RECOVERY FOR INDIVIDUALS LABELLED WITH A
PSYCHIATRIC DIAGNOSIS

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| | |
|--|----|
| Abstract..... | 10 |
| Introduction..... | 11 |
| Social Psychological Perspectives on Identity..... | 11 |
| Social Identity Theory (SIT)..... | 12 |
| The Issues of Identity for People who Experience Mental Health Problems...13 | |
| Loss of self and identity..... | 13 |
| The emergence of mental health-related labels and social identities..... | 14 |
| ‘Mental patient’ identity..... | 15 |
| Service user identity..... | 16 |
| Mental health-related labels and stigma..... | 17 |
| Identity: a process in personal recovery..... | 18 |
| Rationale for Review..... | 18 |
| Literature Review: The Social Identity of Individuals Diagnosed with Mental Health Problems..... | 19 |
| Aim of Review..... | 19 |
| Literature Search Strategy..... | 19 |
| Literature Review..... | 20 |
| Mental health in-patient settings: an important context?..... | 20 |
| Shifts in perspective on mental health-related social identities..... | 22 |
| Strategies used to manage mental health-related identities..... | 25 |
| A possible relationship between recovery and social identity..... | 27 |
| Discussion..... | 29 |
| Summary of Findings..... | 29 |
| Clinical Implications..... | 30 |
| Research Implications..... | 30 |
| Conclusion..... | 31 |
| References..... | 32 |

Abstract

There is considerable evidence demonstrating that identity is an important issue for many people experiencing psychological distress (Barnes & Shardlow, 2006). The concept of social identity, including Social Identity Theory (SIT, Tajfel, 1982; Tajfel & Turner, 1979) is a useful framework to explore that aspect of a person's identity which is related to membership of a social minority group (such as people experiencing mental health problems). This review aimed to address two questions:

- (1) In what circumstances can a mental health-related social identity become salient?
- (2) How might this identity impact on the process of recovery from mental health problems?

A total of seven peer-reviewed papers were reviewed. The results suggest that mental health-related identities are perceived to be most salient when an individual experiences significant mental health problems or, as a result of such problems, is admitted into mental health in-patient services. Additionally, individuals used a number of different strategies, some related to SIT (such as social creativity) to manage their mental health-related identity so that a positive identity and the process of recovery could be enabled.

The review highlights the importance of social support and the possible usefulness of peer support (or service user) groups for the transformations of mental health-related identities to more socially valued identities. Gaps in the literature are identified, together with directions for future research.

Introduction

“Once I became my (psychiatric) diagnosis, there was no one left to recover.”

(Schwartz, 2011, para.2)

Identity is a recurring theme within mental health literature and it has been argued that some people experiencing mental health problems view their psychiatric diagnosis not as one of the features of their lives but the defining feature of their core identity (Thornicroft, 2006). Schwartz (2011, para. 2) wrote that for many of his peers, the diagnosis of a mental illness “...can become the lens that we see ourselves through. Our new label can overshadow the depth and breadth of who we are as people”. This illustrates the devastating effect that psychiatric diagnosis can have on identity.

This review will critically evaluate the literature that explores the social identity of adults diagnosed with mental health problems. It will begin with an outline of social psychological perspectives on identity and will then discuss the relevance of social identity to people experiencing mental health problems. The review will then examine the literature investigating the salience of mental health-related social identities and how these identities might impact on the process of recovery. It will conclude by indicating the gaps not yet explored in the literature and recommending directions for future research.

Social Psychological Perspectives on Identity

Mead (1913) conceptualises the mind as the individual importation of the social process. Erikson (1980) describes identity as a sense of self that develops over the life span and relates a person to their environment but also sets them apart from it.

Similarly, Reber and Reber (2001) describe it as an individual’s essential, continuous

self and the internal subjective concept of oneself as different from others. Charmaz (1995) defines identity as the way in which a person “defines, locates and differentiates self from others” (p. 659). These conceptualisations imply that an important aspect of one’s identity is formed through interactional processes with others.

The concept of social identity is frequently used to understand how an individual makes sense of who they are, based on their perceptions of their salient social groups and their impact on the individual’s participation in social life (Jenkins, 2008). Tajfel (1972, p.292) defines social identity as “the individual’s knowledge that he belongs to certain social groups together with some emotional and value significance to him of this group membership”.

Social Identity Theory (SIT).

Tajfel and Turner (1979) develop the concept of social identity further into Social Identity Theory (SIT). This postulates that individuals often belong to predetermined social groups that structure society, and that membership within that group predicts certain intergroup behaviours. These behaviours are based on perceived group status differences, the perceived legitimacy and stability of those differences and the perceived mobility from one group to another (Tajfel, 1982). Individuals frequently endeavour to achieve and maintain positive social identity through seeking out others from their social group (in-group) in order to satisfy a desire for self-determination and self-esteem. The out-group is perceived as the collective group to which the in-group compare themselves (positively or negatively). The original SIT was developed to explain the social positioning of ethnic minorities (Tajfel & Turner,

1979) but the theory has now been applied to a number of other minority groups, such as people with disabilities (e.g. Finlay & Lyons, 1998; Aviram & Rosenfeld, 2002) or mental health problems (e.g. Ison & Kent, 2010). It should be noted that the term 'minority group' refers to its devalued social positioning (Tajfel, 1981).

Applying the social identity framework to mental health, it has been argued that people identified or labelled as having mental health problems belong to a low status minority group (Ison & Kent, 2010). This social group is considered to possess characteristics that are negatively perceived by the rest of society (Jackson, Tudway, Giles, & Smith, 2009; Hall & Cheston, 2002) and this low status makes it difficult for members of this group to derive a positive social identity from their membership. The review will now explore why identity is a particularly significant issue for this group.

The Issues of Identity for People who Experience Mental Health Problems

Loss of self and identity.

There has been much debate in the literature about the impact of mental health problems on identity; some research has suggested that identity issues may be a causal factor of mental health problems (e.g. Gara, Rosenberg, & Cohen, 1987) or that they might be a consequence of experiencing mental ill health itself (e.g. Hemsley, 1998). However, the literature does converge on one point, namely that, regardless of when the impact occurs people who experience mental health problems can experience a profound loss to their sense of self and identity (e.g. Macias & Rodican, 1997; Baker, Procter, & Gibbons, 2009). For example, Sandy Jeffs (Jeffs & Pepper, 2005, p.92) describes the impact of schizophrenia on her identity: “with the onset of mental illness, one is often stripped of one’s identity and left with a sense of failure and

distress” (p.92). Davies (2001) interviewed 21 mental health in-patients and found that they described having lost an ‘old self’ which was no longer sustainable or viable whilst in hospital. Also, most of the male participants described the loss of their sexual self and saw this as a sign of a diminished social role and generalised impotence. The literature also suggests that the loss of identity can involve losses to valued social roles and to social networks which can lead to social exclusion (e.g. Sayce, 2001; Perkins & Repper, 1996). Furthermore, individuals may be labelled with a mental health-related identity, the effects of which are discussed below.

The emergence of mental health-related labels and social identities.

Feminist social constructionists argue that identity is created out of cultural, political, historical and social contexts (e.g. Reynolds & Wetherell, 2003). Therefore, identity is not perceived to be a singular, essential and static property of the individual, but contextual, multiple, fluid and intersecting with other identities (Hall, 1996; Kowitz, 2010). The issue of social identity for people experiencing mental health problems has been traced back as far as the fifteenth century, where those labelled as a 'lunatic' (or 'insane') were categorised as “earthly agents of the devil” (Leigh, 1957, p. 238) and subjected to persecution (Leigh, 1957). Hence, it has been argued that a social identity (such as 'lunatic') can become the dominant identity for people across a range of contexts and other identities, that can marginalise more socially valued ones (e.g. Tajfel, 1981). Nonetheless, some marginalised groups have used 'identity politics' to re-claim and positively reframe their devalued identities using a collective approach to subvert the dominant discourses and power relations (e.g. the Black is Beautiful movement; Miller, 1983 and Mad Pride movement; Reaume, 2008).

Whilst Rose, Thornicroft, Pinfold, and Kassam (2007) identified approximately 250 labels that are used in contemporary society to describe people with mental health problems, there are some that are used more commonly or have more negative connotations attached to them than others (Mental Health Foundation, 2013). For instance, there has been some debate over the extent to which using psychiatric diagnoses outweighs the negative connotations that can be attached to them (e.g. Callard, Bracken, David, & Sartorius, 2013). Walker (2006) argues that clinicians should not ignore the impact of psychiatric labelling (such as “schizophrenia”) on an individual. When clinicians use such labels they are “unwittingly bringing forth the entire context, the hierarchical and paternalistic role relationship together with the sticky morass of pathological and deficit-based perspectives” (Walker, 2006, p. 75).

'Mental patient' identity.

An interesting label to consider is 'mental patient'. This was, for many years, widely acceptable terminology to describe a person who was admitted to a psychiatric hospital (e.g. Hooks & Levin, 1986). Problems arose when research started to demonstrate that former 'mental patients' were experiencing social rejection (e.g. Link, Cullen, Frank, & Wozniak, 1987) and the commonalities in the negative social identity created for those who were affected by this rejection (e.g. Shaver & Scheibe, 1967). Additionally, it has been argued that this label reflected the dominant value system in mental health services at the time, namely the medical model and the professional as the 'expert' (e.g. Mental Health Foundation, 2013).

It has been widely evidenced that the 'mental patient' identity has a very negative connotation in contemporary society and is now commonly used more as an insult

than as mental health terminology (“Is mental ‘illness’ socially constructed?”, 2013). Recently, these negative perceptions have come to public media attention with the withdrawal of 'mental patient' Halloween costumes from two prominent supermarket chains (Simpson, 2013). One commentator, Sue Baker from the mental health charity Time To Change, argued that the costumes reinforced outdated assumptions about people with mental health problems being dangerous or “knife-wielding maniacs” (cited in Simpson, 2013).

Service user identity.

In contemporary society, the term service user is the most frequently used term to describe the people who use mental health services. It is particularly popular with service providers (Mental Health Foundation, 2013). The label represents a move away from the era of the institutionalisation of people in psychiatric hospitals into the “consumerist tradition of the 1990s and the democratic tradition of developing participation to ensure the suitability of services” (McLaughlin, 2009, p. 1106).

Additionally, the term is deeply entrenched in the identity (and name) of the 'service user / survivor movement' which is described as “numerous individuals who speak out for their own rights and those of others, and local groups and national organisations set up to provide mutual support or to promote the rights of current and former mental health service users to have a voice” (Wallcraft, Read, & Sweeney, 2003, p. 3).

However, the term service user has been criticised for implying that people who experience mental health problems are a homogeneous group and denying the complexity and diversity present among those who access services (Pugh, 1996).

McLaughlin (2009) argued that the label privileges one aspect of a person’s identity,

prescribing to that person a status dependent on their use of mental health services which neglects their other possible social identities (such as woman, mother, Muslim or badminton player). However, it is argued that whatever terminology is used, it will inevitably represent a “mobilisation of bias” (Lukes, 1974) in that some aspects of identity are mobilised for consideration in society and others are mobilised out.

Mental health-related labels and stigma.

There has been much debate about the possible negative consequences of having a mental health-related label or identity. Leete (1989) suggests that “your label is a reality that gradually shapes an identity that is hard to shed” (p. 199) and that through this process of shaping, individuals may lose the freedom to pursue dreams and aspirations as their identity becomes synonymous with that of a mental health-related identity such as 'mental patient' (Cooke, 2008). Similar to SIT, Modified Learning Theory (Link, Cullen, Struening, Shrout, & Dohrenwend, 1989) suggests that being diagnosed with a severe mental health problem leads to a ‘spoilt identity’ (Goffman, 1963) and lowered self-esteem which is associated with negative social, employment and economic outcomes (Wright, Gronfein, & Owens, 2000). Negative outcomes are not a direct consequence of experiencing mental health problems but a consequence of the stigmatisation which results from being labelled with this identity (Link, Streuning, Rahav, Phelan, & Nuttbrock, 1997). Furthermore, Lally (1989) argues that when internalised, this stigmatised identity can engulf or usurp previous notions of identity.

There is a plethora of literature exploring the nature and impact of the stigmatisation of people experiencing mental health problems. Research has frequently evidenced the

stigmatising attitudes held by the public towards this group (e.g. Byrne, 2001; Jorm, Jacomb & Christensen, 1999; Crisp & Gelder, 2000) and the negative stereotypes associated with mental ill health (e.g. Philo, 1996; Byrne, 1997) that may contribute towards a negative social identity and act as a barrier to recovery.

Identity: a process in personal recovery.

The literature suggests that one of the primary tasks in recovery from mental health problems is to (re)construct a positive sense of self (e.g. Young & Ensing, 1999; Slade, 2009). Leamy, Bird, Le Boutillier, Williams, and Slade (2011) developed a conceptual framework for personal recovery and found that one of the important processes involved was identity. The 'Identity' category encompassed three sub-categories named "dimensions of identity", "rebuilding/redefining positive sense of identity" and "overcoming stigma". Similarly, Andresen, Oades, and Caputi (2003, p. 588) suggest that recovery is "the establishment of a fulfilling, meaningful life and a positive sense of identity founded on hopefulness and self-determination".

Rationale for Review

There is considerable evidence demonstrating that identity is an important issue for many people experiencing psychological distress (Barnes & Shardlow, 2006) and the (re)construction of a positive sense of identity has been identified as an important process in personal recovery (e.g. Stickley & Wright, 2011; Repper, 2006). The concept of social identity, including Social Identity Theory (SIT, Tajfel, 1982; Tajfel & Turner, 1979), is a useful framework to explore those aspects of a person's identity that are related to membership of social minority groups. Additionally, it is argued that investigating the social identity of people experiencing mental health problems

could lead to useful developments of the theory itself (Jackson, Tudway, Giles, & Smith, 2009).

Literature Review: The Social Identity of Individuals Diagnosed with Mental Health Problems

Aim of Review

The review will critically evaluate the literature that explores the social identity of adults diagnosed with mental health problems. Specifically, the review aims to address two questions. Firstly, under what circumstances can a mental health-related social identity become salient? Secondly, how might espousing this identity or being seen to have this identity, impact on the process of recovery from mental health problems? For this review, the term ‘salient’ pertains to “group membership which is most prominent and significant in defining an individual’s social identity at a given time” (Jackson, Tudway, Giles, & Smith, 2009, p.167). The literature search strategy is outlined below, before the results of this search are presented.

Literature Search Strategy

The methodology adopted involved searching eight electronic indexes (see Appendix A for summary of the search methodology and results). Stage one of the literature search methodology involved a general literature search of the term “social identity” which yielded a total of 3885 articles or books. Stage two involved a more focussed search of the literature identified in stage one, which aimed to identify the empirical papers that related to the two review aims outlined above. Only peer-reviewed papers were included in the current review; in order to allow sufficient space for this

literature to be considered in sufficient depth, 'grey' or non peer-reviewed literature was excluded. Stickley and Wright (2011) suggest that the different types of literature relating to identity and recovery should each be separately synthesised and considered in depth. In total, seven peer-reviewed empirical studies were selected, all of which used qualitative methodology (see Appendix B for a table overview of included studies). These papers were critically reviewed using the framework recommended by Caldwell, Henshaw, and Taylor (2005; see Appendix A).

Literature Review

Mental health in-patient settings: an important context?

Mental health in-patient settings are complex social environments for the exploration of social identity, because those concerned are by definition in a different context to those contexts within which their social identity is usually maintained (Jackson, Tudway, Giles, & Smith, 2009). Such environments are seen to provide protective spaces, away from the visibility of the majority group (i.e. non-mental health service users), but they are also perceived as providing contexts where 'mental patient' identities can be significantly developed as a result of the symbolic interactions that are inherent in the organisational structure of psychiatric hospitals (Goffman, 1961).

Two studies explored the salient social identities of people admitted to in-patient units. Hooks and Levin (1986) explored the concepts that 40 male in-patients diagnosed with schizophrenia used to describe themselves. The taxonomy used was derived through a two-stage procedure: (1) categories were elicited by observing the patients' actions through conversations, by participating in some of the participants'

activities, and by utilising a structured interview with participants; (2) the participants were then asked to identify specific fellow in-patients who represented one or another of the social identities which had been derived. Although it was unclear how the authors carried out the data analysis, the findings indicated that thirteen social identities were found that could be grouped into three higher-order status classes. The classes identified included a 'conflict' construct (e.g. 'fighter', 'killer'), a 'sexual' construct (e.g. 'fag', 'rapist') and 'cognitive' construct (e.g. 'weirdo', 'drunk').

Participants often had three or four different identities, depending upon the setting or the interaction situation. The authors concluded that the participants' social identity was a strong determinant of their behaviour within the hospital. Specifically, participant behaviour considered by staff to be pathological was more likely "...to be institutionalised patterns of social behaviour determined by patients' conceptions of their social identities" (Hooks & Levin, 1986, p.55). Two key strengths of this study were the large number of participants included and the empirical verification strategy used. However, some caution should be exercised when interpreting these findings. Firstly, the study included a wide age range (13-50) and the authors did not consider how that the impact of admission on social identity might be different for younger participants. Secondly, although researchers were present on the unit for eight months, no attempts were reported to 'bracket' (Tufford & Newman, 2010) researcher biases, assumptions or other possible influences on the data.

Jackson, Tudway, Giles, and Smith (2009) used a cross-case qualitative approach, including semi-structured interviews, to investigate the salient social identities of eight individuals in a mental health in-patient setting. Although it was unclear what type of qualitative data analysis was used, the results suggested that identification as

an “in-patient mental health service user” often began at the first admission into hospital. Acceptance of the in-patient group membership involved repeated comparison of oneself with other group members. For some participants, this led to a constant shift in identification with this group. The degree to which this in-patient group membership was internalised also appeared to be dependent on a number of factors pertinent to the individual. These factors included: phase of in-patient stay, self-protection from institutionalisation, psychological well being, mood and interaction with other in-patients.

Some participants saw in-patient group membership as an identity that remained with the person forever, even when they were not in contact with services, whilst for others, it was a literal term and did not have any other meanings attached to it. Despite the authors incorporating a triangulation strategy in the analysis, they acknowledged that no firm conclusions could be drawn, due to the number of important limitations, i.e. limited sample, time point (the participants interviewed were preparing to leave the ward), and the effect of the researcher on the data.

Shifts in perspective on mental health-related social identities.

Tajfel and Turner (2001) argue that social identity can differ among individuals according to their evaluation of the social group to which they belong. Two research studies illustrate how the evaluation of mental health-related social identities can change over time (Forrester-Jones & Barnes, 2008; Ison & Kent, 2010). Ison and Kent (2010) explored the social identity of individuals diagnosed with an eating disorder. This study used qualitative methodology, i.e. semi-structured interviews, which were analysed using Interpretative Phenomenological Analysis (IPA; Smith, Jarman, &

Osborne, 1999). Eight participants with a range of eating disorder diagnoses (bulimia nervosa, anorexia nervosa and EDNOS) were recruited from out-patient eating disorder services. No further information was given regarding the context of these services.

The participants attributed a number of positive aspects to the initial stages of internalising their eating disorder identity. It enabled participants to feel in control, more confident, and it acted as a form of protection from the outside world. However, the participants highlighted that (with time) perceptions of their eating disorder identity changed as the negative aspects (which were related to negative physical health problems and psychological consequences) became more pronounced.

The authors suggested that a further negative influence described by the participants might have been related to the perceived stigma attached to having a mental health problem (i.e. eating disorder). The study made use of credibility checks, such as an independent analysis of data, and the authors considered the impact of their own experiences, biases and assumptions on the findings. However, one limitation was the small sample of participants used.

Forrester-Jones and Barnes (2008) used a qualitative framework (Glaser & Strauss, 1967) to examine how 17 people diagnosed with a severe mental health problem used social support to manage their 'sick identity' (i.e. mental health-related identity). Two key strengths of this study were the wide range of sources used to collect data, and the purposive sampling strategy used to capture different 'principal' sources of social support. The results showed that all participants acknowledged the salience of a 'sick identity' which included passivity, feelings of demotivation, inability to work, low

self-esteem and hopelessness. Additionally, participants identified various social interactions that had influenced the construction of their 'sick identity'. For example, individuals found that professional care was often “delivered in a way which undermined their sense of self-esteem” (p.158).

In some cases the 'sick identity' had become (or remained) salient as a result of what the authors identified as ‘secondary gains’: receiving benefits and the financial advantages of hospitalisation, abdication of responsibility and the alleviation of loneliness through in-patient admissions. However, one potential ethical issue (and potential bias influencing the data) that was identified but not fully explored by the authors was the friendships that they forged with some of the participants over the several years that the study spanned.

Strategies used to manage mental health-related identities.

SIT postulates that individuals frequently endeavour to achieve and maintain positive social identity. Four studies (Jackson, Tudway, Giles, & Smith, 2009; Forrester-Jones & Barnes, 2008; Hall & Cheston; 2002; Barnes & Shardlow, 1996) highlighted the strategies used by participants to manage their mental health-related identity so that a positive social identity could be achieved. Forrester-Jones and Barnes (2008) described a fluid model of social support to explain how individuals developed a more 'acceptable' identity, which “enabled some degree of social integration into mainstream life” (p. 153). Participants moved from “support from mental health professionals” to “support from other each other/mental health service users” to “support from communities of interest rather than diagnosis” (i.e. people not involved in mental health services). The authors suggested that the model was fluid because

some participants progressed from one stage to another, whilst others moved around less often.

Jackson, Tudway, Giles, and Smith (2009) found that participants used a strategy called “remoooring” (calling on a stronger social identity when identity is threatened by context, Ethier & Deaux, 1994) to cope with having an in-patient social identity. For example, the participants spoke about the uniqueness of their experiences and the groups (such as 'educated' or 'family') to which they belonged outside of the mental health system.

Two studies (Barnes & Shardlow, 1996; Hall & Cheston; 2002) explored how individuals used peer support groups to manage their social identity. Hall and Cheston (2002) used grounded theory (Strauss & Corbin, 1990) to investigate social identity maintenance strategies employed by individuals who attended a voluntary sector mental health drop-in centre. The study provided a comprehensive description of the context of the drop-in centre, data collection (participant observation and semi-structured interviews) and incorporated sufficient sampling methodology (purposive sample for gender, frequency of attendance and use of other services). Another strength found in this study was the use of respondent validation and the measures taken to ensure that researchers were not influenced by pre-conceived variables.

Results suggested that many participants used the drop-in centre as a way of coping with the stigma and rejection they experienced in everyday life. Most participants had accepted their membership of a low status stigmatised minority group and represented themselves and other group members in terms of negative and undesirable characteristics. The authors suggested that individuals could only continue to use the

drop-in centre, despite possible threats to their identity, if they adopted differing approaches to structure their group membership within a more positive framework (an SIT process called 'positive distinctiveness'). One SIT strategy to achieve positive distinctiveness called 'social creativity' was identified which was related to viewing other drop-in members as 'kindred spirits' and perceiving the outside world as condemnatory.

Additionally, participants used a number of strategies that served to reject the label which placed them within the devalued group, for example, using a SIT strategy named 'social mobility' where participants selectively revealed or concealed their history of mental health problems, depending on who they were interacting with.

Barnes and Shardlow (1996) investigated how social (and personal) identity influenced the nature of the peer support groups that people with mental health problems participated in. The study interviewed individuals involved in three diverse groups.

A significant issue with this study was the lack of information given regarding the context of the three groups, the selection of participants used, the sampling method used, the method of data collection and the method of data analysis used. However, the authors suggest that the groups vary in the ways that they provide 'safe environments' in which fragile identities could be supported by people with similar experiences. The groups often provided a space where skills and confidence could be developed, which then could be applied outside the group when individuals felt safe to do so.

Involvement in these groups meant that participants had, to some degree, accepted

their mental health-related identity. However, working with others who had had similar experiences enabled participants not only to support each other but to find a valued sense of themselves. The authors suggested that an implication of their findings is that individuals formerly perceived as passive recipients of mental health services can be active 'agents' in their lives, contributing to shaping mental health services and broader social objectives. However, it is hard to draw firm conclusions from this study, given the limitations outlined above.

A possible relationship between recovery and social identity.

Five of the seven studies reviewed suggested that there was a relationship between mental health-related social identity and the process of recovery (Jackson, Tudway, Giles, & Smith, 2009; Hall & Cheston, 2002; Forrester-Jones & Barnes, 2008; Ison & Kent, 2010; Saavedra, 2009). Ison and Kent (2010) found that having a negative 'eating disorder' social identity was strongly related to the motivation to seek help and engage in the process of recovery. Saavedra (2009) conducted interviews to explore the changes in personal narratives of ten individuals diagnosed with paranoid schizophrenia who were receiving recovery treatment in special care homes. His social positioning analysis (e.g. Bamberg, 1997) showed that the care homes provided a new social network that contributed towards important emotional support needed by the participants.

The author argued that one important indication of recovery was the participant's ability to describe themselves in ways other than the "label of the psychiatric patient" (p.180) and with some degree of capacity for agency. Although it is unclear from the study what the 'active ingredients' were in the social network that facilitated the

changes. Additionally, no reported attempts were made to 'bracket' (Tufford & Newman, 2010) researcher bias and assumptions in relation to the care home, a particularly significant omission since the researcher was a former staff member. It is unclear how this may have influenced the results.

Jackson, Tudway, Giles, and Smith (2009) found that moving away from identification with the 'mental health service-user' group occurred along a continuum which correlated with the use of mental health services. The continuum started with moving through various levels of observation as an in-patient, through to being a day hospital patient, then attending community mental health services and eventually returning to work. This continuum view was supported by a small group of participants in Hall and Cheston's study (2002) who described eventually adopting a 'survivor' identity. This was perceived by some participants as an active role and at the opposite end of the continuum to the 'mental health in-patient' position.

Forrester-Jones and Barnes (2008) also invoked the concept of a continuum. They found that social identity tended to shift from 'sick' to 'stigmatised' to 'recovery' to 'acceptable'. Participants felt that an identity of 'recovery' was characterised by a socially valued identity and the ability to reciprocate social support. The study found that the 'sick identity' became salient for all participants in two different ways. Firstly, half of the participants sought excitement and made themselves vulnerable to stigmatisation, stress and rejection from others which led to the 'sick identity'. And secondly, the other half of the participants found that the threat of stigma led them to live quite reclusively, which led them to experience boredom, loneliness and depression which led (again) to the 'sick' identity.

Discussion

Summary of Findings

Despite the wide recognition that identity is an important issue for people experiencing mental health problems, there is limited research that explores the salience and effects of mental health-related social identities in this group.

Notwithstanding the different methodology used and the limitations presented, the studies (Hooks & Levin, 1986; Jackson, Tudway, Giles, & Smith, 2009) that explored social identity in mental health in-patient settings provided some evidence that regardless of the context, mental health-related social identities are fluid and the degree to which 'in-patient' identities are internalised is dependent on a number of factors significant to the individual.

Whilst the majority of studies suggested that mental health-related identities are perceived as negative (Hall & Cheston, 2002; Barnes & Shardlow, 1996; Ison & Kent, 2010; Saavedra, 2009; Forrester-Jones & Barnes, 2008), this was not always the case. For example, eating disorders might be considered a more positive social identity. This is because of the positive value society places on thinness and self-control regarding eating (e.g. Brownell, 1991). However, an eating disorder that was perceived as negative was strongly related to the motivation to seek help and engage in the process of recovery (Ison & Kent, 2010). It should be noted, however, that these conclusions were based on interviews with individuals who were actively engaged with out-patient services and others might have felt differently. Additionally, mental health-related identities were evaluated as positive and maintained so that individuals could benefit from the secondary gains (e.g. financial) of having that identity (Forrester-Jones & Barnes, 2008).

Despite the limitations of the studies considered, the current review has found some evidence that people are active agents in their own lives and manage their identities via various social strategies (Ison & Kent, 2010; Forrester-Jones & Barnes, 2008; Barnes & Shardlow, 1996; Saavedra, 2009). These findings have two important implications for the facilitation of recovery: the important role of having some degree of capacity for agency in one's life and that mental health-related identity could be managed via social strategies.

Clinical Implications

These findings have important implications for clinicians. Firstly, clinicians should be exploring social identity issues with their clients. It is argued that social identity issues need to be part of individual formulation and treatment interventions (Ison & Kent, 2010), particularly because of the links between social identity and self-esteem and other important psychological characteristics. The literature identifies a way of integrating social identity into clinical practice by using the identity salience model proposed by Yakushko, Davidson, and Williams (2009). This model provides a framework of how multiple identities can be considered and how the salience of certain identities can be recognized and examined within the psychotherapy context. And secondly, clinicians should explore social strategies with their clients (where social support can be reciprocated) so that mental health-related identities can be managed and do not become (or remain) salient.

Research Implications

It is important that the results of this review should be substantiated by findings from the non peer-reviewed literature. Therefore, it is recommended that future research

should review this body of literature. Additionally, Hall and Cheston (2002) argue that there is a need for mental health voluntary services (such as groups) to establish the “empowering process which facilitates recovery” (p. 41). However, little is known about how such services or groups (with their different functions) contribute towards recovery and positive social identity. It is therefore recommended that future research should explore how participation in the different types of service user groups (such as campaigning groups or those involved in education and training, Wallcroft & Bryant, 2003) might contribute towards the achievement and maintenance of a positive social identity.

Conclusion

Social identity, including Social Identity Theory (SIT, Tajfel, 1982; Tajfel & Turner, 1979), is a useful framework to explore identity in people who experience mental health problems. A small body of research has investigated the saliency of mental health-related social identities for this group. The literature suggests that such identities are perceived to be most salient when an individual experiences significant mental health problems or as a result of such problems is admitted into mental health in-patient settings. Individuals use a number of different strategies to manage their mental health-related identity so that a positive identity could be enabled. The review highlights the possible role of peer support (or service user) groups for the transformations of such identities. However, there was limited information on how the different types of service user groups might contribute towards recovery and positive social identity. Future research needs to explore how participation in the different types of service user groups might contribute towards this.

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EXPLORING SOCIAL IDENTITY IN MEMBERS OF SERVICE USER
GROUPS THAT TRAIN MENTAL HEALTH PROFESSIONALS: A
GROUNDED THEORY ANALYSIS

Section B: Empirical Paper

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Contents Section B: Empirical Paper

| | |
|---|----|
| Abstract..... | 43 |
| Introduction..... | 43 |
| Social Identity & Mental Health..... | 43 |
| Social Identity, Mental Health & Peer Support Groups..... | 45 |
| Involvement by Mental Health Service User Groups in Professional Training..... | 46 |
| Rationale for the Current Study..... | 47 |
| Aim of the Study..... | 57 |
| Method..... | 48 |
| Participants..... | 48 |
| Ethical Considerations..... | 50 |
| Design..... | 50 |
| Procedure..... | 50 |
| Analysis..... | 52 |
| Quality Assurance..... | 52 |
| Results..... | 53 |
| Categories..... | 53 |
| Model Summary..... | 54 |
| Impact of Receiving Psychiatric Diagnosis / Mental Illness..... | 58 |
| Loss of old/former self & relationships | 58 |
| Stigma..... | 60 |
| Self-stigma..... | 61 |
| Service providers' low expectations..... | 61 |
| Societal negative reactions..... | 62 |
| Participating in SUG-TR..... | 62 |
| Supportive network..... | 63 |
| Different norms & values..... | 63 |
| Personal growth & recovery..... | 64 |
| Contributing to Positive Social Identity..... | 65 |
| Helping others..... | 65 |
| Improving services..... | 66 |

| | |
|--|----|
| Self-identity..... | 66 |
| Bridging gaps with professionals..... | 69 |
| Members of staff teams..... | 70 |
| New group roles & opportunities..... | 70 |
| Challenges to Participating in SUG-TR..... | 71 |
| On-going mental health problems..... | 71 |
| Negative & ambivalent training experiences..... | 72 |
| Too much focus on group member identity..... | 73 |
| Discussion..... | 74 |
| Summary of Findings..... | 74 |
| SIT strategies..... | 74 |
| Self-identities that facilitated positive social identity..... | 76 |
| Towards new perspectives on identity and recovery..... | 77 |
| Limitations..... | 78 |
| Clinical Implications..... | 78 |
| Future Research..... | 79 |
| Conclusion..... | 80 |
| References..... | 81 |

Abstract

Aim: The aim of this grounded theory study was to explore the social identity of members of service user groups that train mental health professionals (SUG-TR). Additionally, the study aimed to construct an explanatory model of how participating in such groups contributes towards the achievement and maintenance of positive social identity.

Method: Semi-structured interviews were conducted with eight members of SUG-TR. Grounded theory was used to build a preliminary model, which contained 5 main categories: 'Impact of mental illness/ impact of receiving a psychiatric diagnosis'; 'The experience of stigma'; 'Participating in SUG-TR'; 'Contributing to positive identity'; and 'Challenges to participating'.

Results: The constructed theory suggests that participation in such groups can contribute towards the achievement and maintenance of a positive social identity and that participants adopted specific strategies to achieve positive distinctiveness (i.e. an individual striving for positive self-concept) in the SUG-TR meetings and training environments.

Conclusion: The constructed theory extends current research and suggests that SUG-TRs provide unique opportunities for the development of socially valued roles. The limitations and clinical implications of the research are explored and suggestions for further research are presented.

Key words: education; group membership; mental health; social identity theory; service user involvement; training

Introduction

It has been argued that identity is created out of cultural, political, historical and social contexts (e.g. Reynolds & Wetherell, 2003). The concept of social identity is frequently used to understand how an individual makes sense of who they are, based on their perceptions of their salient social groups and its impact on their participation in social life (Jenkins, 2008). This concept was developed further into Social Identity Theory (SIT, Tajfel, 1982; Tajfel & Turner, 1979) which postulates that individuals often belong to predetermined social groups that structure society, and that membership of a certain group predicts intergroup behaviours. Individuals commonly strive to achieve and maintain a positive social identity through seeking out others from their designated social group ('in-group') in order to satisfy a desire for self-determination and self-esteem. The 'out-group' is the collective group to which the in-group compare themselves (positively or negatively).

Social Identity & Mental Health

Applying the social identity framework to mental health, it is argued that people identified or labelled as having a mental health problem belong to a low status minority group (Ison & Kent, 2010). This social group is considered to possess characteristics that are negatively perceived by the rest of society (Jackson, Tudway, Giles, & Smith, 2009; Hall & Cheston, 2002) and as a result can experience discrimination and stigmatisation (e.g. Crisp, Gelder, Rix, Meltzer, & Rowlands, 2000; Overton & Medina, 2008). This low status makes it difficult for members of this group to derive a positive social identity from their membership. Research investigating membership of low status minority groups has identified negative

consequences, such as an increased risk for low self-esteem and depression (Tajfel & Turner, 1979; Katz, Joiner Jr., & Kwon, 2002). As a result of these negative consequences, individuals often seek social support from each other through peer support groups (Forrester-Jones & Barnes, 2008; Barnes & Shardlow, 1996).

Social Identity, Mental Health & Peer Support Groups

Few studies have applied the social identity framework to examine issues in social identity for people attending health-related peer support groups. Within the health field, Wakefield, Bickley, and Sani (2013) found that identification with a support group for Multiple Sclerosis was significantly linked to lower depression, lower anxiety and higher satisfaction with life. Within the mental health field, two studies have attempted to explore how individuals experiencing mental health problems used peer support groups to manage their social identity.

Barnes and Shardlow (1996) investigated the personal and social identity of people who have experienced mental health problems and how this influenced the nature of three diverse support groups in which they participated. Results suggested that groups varied in the ways that they provided 'safe environments' in which fragile identities could be validated by people with similar experiences and skills and thereby confidence could be developed. However, a significant issue with this study is the lack of information given regarding the methodology used. Therefore, no firm conclusions regarding possible contributions to positive social identity could be drawn.

Hall and Cheston (2002) investigated social identity maintenance strategies employed by 14 individuals who attended a voluntary sector drop-in centre for people with mental health problems. Many participants identified their membership within a low

status stigmatised minority group (i.e. ‘mental health service user’ group). The authors found that individuals could only continue to use the drop-in centre if they adopted differing approaches to structure their group membership within a more positive framework. One SIT approach related to viewing other drop-in members as ‘kindred spirits’ and perceiving the outside world as condemnatory. The participants also used a number of strategies that helped them to reject the identity which placed them within the devalued group, for example, a SIT strategy named ‘social mobility’ where drop-in users selectively revealed or concealed their history of mental health problems to others.

Involvement by Mental Health Service User Groups in Professional Training

In recent years, mental health services in the UK has embedded service user involvement as a key principle and guiding framework (Forbat, 2008). The National Service Framework for Mental Health (DoH, 1999) and Health & Care Professions Council standards (2012) stipulate that service users and carers should be involved in providing, planning and evaluating training for all health care professionals. There is increasing recognition that service users can contribute to teaching in an active role, as ‘experts’ in their mental health problem and on the experience of using services (McLaughlin, 2009). However, there has been some debate over the likely costs and benefits for service users who become involved in health and social care education. For example, Fox (2011) asserted that one potential benefit might be the opportunity to develop a socially value role and she related the potential costs to emotional wellbeing (such as stress). Additionally, one of the barriers to the involvement in teaching, identified by Basset, Campbell and Anderson (2006), is the lack of support for service user trainers. A possible reaction to this might be the increasing number of

mental health user groups as opposed to individuals that are involved in education and training (Wallcraft & Bryant, 2003). However, there has been a paucity of research that explores the experiences of service user trainers (with the exception of Holttum, Lea, Morris, Riley, & Byrne, 2011).

Rationale for the Current Study

Little is known about mental health user groups that are involved in education and training mental health professionals. These groups are unique in that they provide their members with the potential benefits of involvement in training. These benefits have been identified as increased confidence, sense of achievement, a socially valued role, financial income and new learning skills (Fox, 2011; Ramon, 2003; Castillo, 2003). Additionally, these groups can provide its' members with the potential benefits of involvement in peer support groups, such as, improved self-esteem and increased resistance to the psychosocial effects of experiencing mental health problems (Crabtree, Haslam, Postmes, & Haslam, 2010). It is also argued that participating in such groups can provide service user trainers with a useful way of coping with the emotional costs of involvement in education, such as, feeling misunderstood by professionals and colleagues, anxiety and the fear of becoming unwell (Fox, 2011).

Aims of the Study

The aims of the current grounded theory study were therefore to:

- explore the social identity of members of service user groups that train mental health professionals (SUG-TR).

- identify the factors which contribute to the achievement and maintenance of positive identity and those which might potentially pose threats to identity when participating in SUG-TR.
- develop an explanatory model of the process of how participating in such groups impacts social identity.

Method

Participants

The participants were individuals who had experienced mental health problems and had also been members of service user groups that participated in training mental health professionals (SUG-TR) for a minimum of six months. In total, the participant group was comprised of eight individuals with two to fifteen years of SUG-TR group membership. Six participants were female and two were male. The mean length of time that they had been involved in training was approximately 6 years (range 2-10 years). All participants were White British. Table 1 below contains information regarding participant characteristics. Individuals were recruited from two SUG-TRs:

Table 1

Participant Demographics

| Participant number | Gender | Ethnicity | Number of years of experience training |
|---------------------------|---------------|------------------|---|
| 1 | Male | White British | 4 |
| 2 | Male | White British | 2 |
| 3 | Female | White British | 3 |
| 4 | Female | White British | 14 |
| 5 | Female | White British | 6 |
| 6 | Female | White British | 6 |
| 7 | Female | White British | 6 |
| 8 | Female | White British | 7 |

SUG-TR 1 was a group that was part of a large, long-established voluntary sector organisation. In total, approximately 18 members (out of a total of 50) regularly attended the monthly peer support meetings. Ten of the regular attendees were involved in training. These individuals regularly taught at three local universities which provide qualification training programmes for social workers and community psychiatric nurses. They also co-facilitated short training courses which were attended by workers from all clinical groups within the local NHS Trust.

SUG-TR 2 was a small group comprised of four core members who had experienced mental health problems. The group was affiliated to an academic institute that provided a clinical psychology training programme. The group was involved in the planning and delivering of teaching sessions, in consultations regarding possible research projects embarked on by trainee clinical psychologists, and in the recruitment of new trainee cohorts. The group met approximately nine times during each academic year.

Ethical Considerations

Ethical approval for the study was obtained from an NHS research ethics committee (see Appendix K). The study adhered to the British Psychological Society's (BPS) and the Health & Care Professions Councils (HCPC) code of ethics and conduct (BPS, 2006; HCPC, 2008).

Design

The study used a non-experimental, qualitative design which included a semi-structured interview schedule (See Appendix E). A grounded theory approach was used given the paucity of research in the area and it was felt that data analysis should not be restricted by a specific theoretical perspective (i.e. SIT; Social Identity Theory). The choice of this methodological approach was confirmed during the initial stages of data analysis, which involved what Strauss and Corbin (1990) described as isolating the 'story line'. The emerging theory had a clear relationship with SIT but also went beyond this theory as it related to wider social perspectives on identity. The open-ended questions associated with this interview method allowed for the generation of the rich data needed for a grounded theory study (GT, Charmaz, 2006).

Procedure

There were different approaches to recruitment from each group. For SUG-TR 1, potential participants who were deemed suitable were approached by the CEO or deputy CEO of the organisation, who briefly described the study and provided the participant information sheet (see Appendix C). Interested participants gave consent for the organisers to pass on their contact details to the researcher. The researcher

waited at least 48 hours before approaching the potential participants by phone to discuss the project and seek informed written consent. For SUG-TR 2, the members of the group had already given consent to being contacted regarding potential participation in research projects at the academic institute in which they were involved. The researcher obtained contact details from the institute and contacted potential participants by phone. The study was described and the information sheet provided. The researcher waited at least 48 hours before contacting the participants to seek informed written consent. Informed consent was obtained from each participant before the interview took place (example consent form see Appendix D).

Data was collected through semi-structured interviews which were audio-taped and lasted between 40 and 90 minutes. The researcher followed standard semi-structured interview practice when asking the key questions from the interview schedule (see Appendix E). Additionally, following standard grounded theory (GT) practice, the data was analysed after the first 4 participants were interviewed and questions were altered if necessary (Willig, 2008).

Consistent with the GT-approach, the participation of members of SUG-TRs who met the inclusion criteria was indicated by theoretical sampling. Theoretical sampling (Charmaz, 2006) involves sampling on the basis of emerging categories and aims to explore the dimensions and conditions of each category (Strauss & Corbin, 1998). It was hoped that interviewing participants with varied experiences, both positive and negative, would generate rich data and expand the potential theoretical understanding of participating in SUG-TRs. Theoretical sufficiency (i.e. no new categories were established from data, Dey, 1999) appeared to be achieved after the eighth interview was analysed.

Analysis

Due to the exploratory nature of the research and the aim of developing a preliminary explanatory model, grounded theory (GT) was used to analyse the data (Denscombe, 2007). Coding is a crucial technique in GT because it connects raw data with theory generation. This technique consists of three main stages:

1. Line-by-line or incident-by-incident coding. The transcript of the first interview was coded using line-by-line open coding to ensure understanding and allow immersion into the data (example Appendix F).
2. Focussed coding. The most salient codes identified from the previous stage were placed into broader codes. The data and codes were explored using the constant comparison method to ensure the coding was correct (example Appendix F).
3. Theoretical coding. The broader codes were placed into categories (or themes) which were then related to each other so that a theory could be developed. Memos and journals (Appendix G) were used to document the thinking underlying the theory's development and record the properties and dimensions (sub-categories) of the emergent categories. Axial coding, another possible stage in GT analysis (Strauss & Corbin, 1998), was not used as it was felt that it might constrain the constructed model (Charmaz, 2006).

Quality Assurance

The credibility of the analysis was enhanced by the use of extensive quotations from the interview transcripts (William & Morrow, 2008). Brackets were used to indicate

that identifiable or personal material has been omitted and numbers (Participant 1-8) identified quotations from individual participants.

The research supervisors were consulted at each stage of coding; they cross-checked the coding and the constructed model. The researcher periodically reviewed potential biases in the emerging model through the use of 'bracketing interviews' (Tufford & Newman, 2010) which enhanced the researcher's reflexivity. A reflective diary (Appendix H) was kept so the researcher could maintain an awareness of her experiences (particularly as a trainee mental health professional with service user trainers) that might influence assumptions or potential biases about social identification and groups. An independent audit of the coding (Elliott, Fischer, & Rennie, 1999) was undertaken by a colleague of the researcher, who coded a section of one of the initial interview transcripts. Only minor discrepancies were found. Yardley's (2000) guidelines were used to evaluate the credibility of the findings.

Results

Initial coding generated 212 codes, which were refined into 53 focussed codes. These were then refined and collated into 17 sub-categories and finally into five categories.

Categories

The five categories generated were: impact of mental illness/psychiatric labelling, the experience of stigma, participating in SUG-TR, contributing to positive identity and challenges to participating in SUG-TR. The five categories encompassed more subtle processes which were captured as sub-categories (see Table 2). A summary of the

model will now be presented, followed by descriptions of the categories in detail.

Model Summary

The data suggested that the processes of achieving and maintaining positive social identity for members of SUG-TRs could be conceptualised and understood with reference to five categories or processes. Two cross-referenced processes appeared to be involved, one related to identity and the other to well-being/functioning. The experience of mental ill-health and receiving a psychiatric diagnosis led individuals to experience multiple losses of (personal and social) identity and social roles or relationships. They also received a service user label.

As a result, individuals perceived themselves as part of a devalued low status social group (Impact of mental illness/psychiatric diagnosis). Having this label involved a catastrophic re-definition of identity and individuals experienced its stigmatising effects (The experience of stigma). Over time, however, individuals began to perceive their mental health problems as increasingly manageable and explored ways to cope with the psychosocial effects (e.g. stigma and loss of identity) of the label and perceived membership of the devalued group.

Table 2

Categories and sub-categories

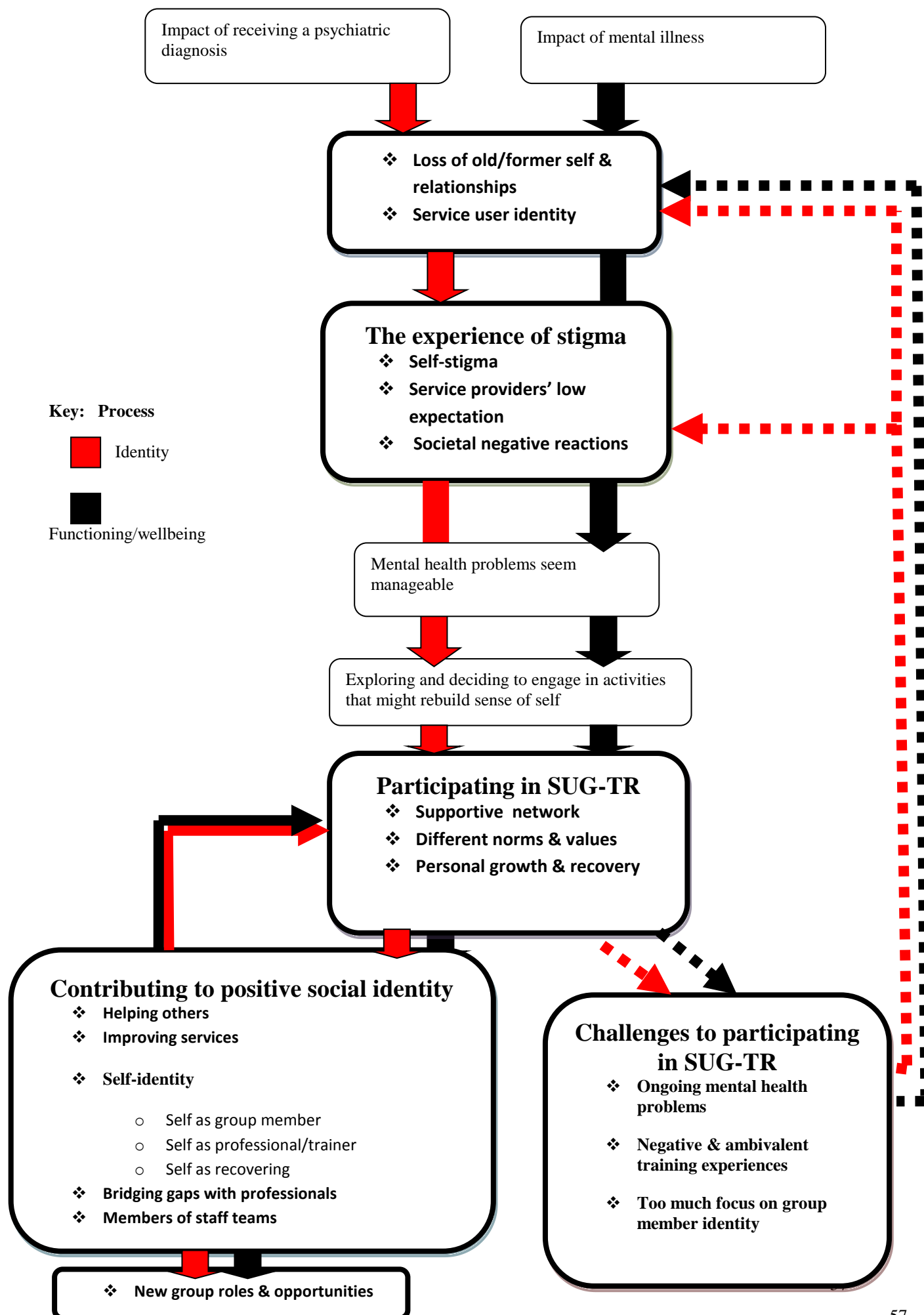
| Category | Sub-category |
|--|--|
| Impact of mental illness /psychiatric labelling | Experiencing the loss of old/former self Experiencing the loss of relationships Being labelled with the service user identity |
| The experience of stigma | Experiencing self-stigma Experiencing service providers' low expectations Experiencing societal negative reactions |
| Benefits of participating for wellbeing/functioning | Experiencing different norms and values within the group Group providing a supportive network Facilitating personal growth and recovery through training opportunities |
| Contributing to positive social identity | Emerging self-identity Helping others Improving mental health services Opportunities that involved bridging gaps with professionals Feeling part of staff teams Experiences leading to new group roles and opportunities |
| Challenges to participating in SUG-TR | Experiencing on-going mental health problems Having negative and ambivalent training experiences Too much focus on group member identity |

Joining a SUG-TR appeared to fulfil functions, one related to wellbeing and one to identity. In terms of well-being, membership of SUG-TR provided a supportive environment where individuals began to take part in activities that promoted personal growth and well-being (Participating in SUG-TR). In terms of identity, participation in the group enabled individuals to create new discursive strategies which contributed towards the achievement and maintenance of a positive social identity (Contributing to positive social identity). However, participation in the groups was also associated with challenges, such as functioning as a trainer whilst managing ongoing mental health problems or having negative/ambivalent experiences of training (Challenges to participating in SUG-TR). Such threats involved more subtle processes, and the individuals unable to manage these threats found themselves again working through issues of identity and experiences of stigma.

Relapses of mental health problems (On-going mental health problems) were often associated with the service user identity becoming temporarily dominant and (once again) threatening the loss of self and relationships. Additionally, having ambivalent and negative training experiences sometimes reinforced experiences of stigma.

Individuals found that too much focus on group member identity led to an over-identification with the service user identity (see Figure 1). In the diagram presented below (Figure 1), individuals start at the top of the model and progress to the bottom. The arrows represent processes over time and the broken lined arrows in the upwards direction indicate that some people experience challenges to participating in SUG-TR but continue to train without stepping back into stigma or loss.

Figure 1
Theoretical model



Impact of Receiving Psychiatric Diagnosis/Mental Illness

The participants attributed their decision to join the SUG-TR mainly to the significant impact of mental illness and of receiving a diagnosis. Together, these experiences had often led to a loss of their former self and relationships, and to a feeling of being stigmatised. The participants gave rich descriptions of a rejection from dominant society through multiple losses and the process of receiving a label which placed them within a devalued low status group.

Loss of old/former self and relationships.

Loss of self.

Participants described having experienced significant and sometimes multiple losses of social roles which impacted on their sense of self. Losses included work/profession, relationships (such as husband/wife) and social roles (such as band member). For some, these losses had precipitated their first significant episode of mental illness while other individuals described losses occurring as a result of their distress. Additionally, the participants spoke of the destruction of an internal sense of self and sense of personal direction in their lives. As a result, many had not engaged in social activities for several years after the onset of their illness. Overall, the losses described were frequently associated with feelings of sadness and frustration.

I think mental health episode sort of strikes at you at a sort of consciousness and I am not an expert but it sort of strikes at something inside you ... because *I don't think you can ever go back to being the person you were before.*

(Participant 2, 1, 3-6)

Loss of relationships.

Participants also described having lost important relationships, feeling isolated from friends, family, society, and loss of social status. For example, one individual had suddenly found himself unable to relate to, and discuss problems with previously close friends and family. Participants also spoke of the need to withdraw from others because of their ill-health but found that this intensified feelings of isolation which paradoxically had a negative effect on their mental health.

*I'd recently separated from my (partner)*¹ of 10 years, and had left my children, and was living in a bedroom in my (relative*)'s house out in the middle of nowhere. It wasn't particularly conducive to my mental health. I was getting very depressed. I had attempted suicide whilst staying there. And being so isolated wasn't particularly helpful.* (Participant 1, 4, 132-35)

Service user identity.

Being labelled or perceived as a service user appeared to constitute a negative re-definition of identity for most participants. The majority indicated that they were unable to maintain their previous sense of self and they saw themselves as passive and

¹ * means identifiable or personal material has been omitted

apathetic. Individuals gave rich, although differing descriptions of what the service user identity meant to them: an individual who passively used mental health services; a “crazy” type; and an apathetic individual who used mental illness as an excuse to be exonerated from the stresses of life.

... a patient up at the *Hospital who used to strip off naked, crush crystal glass ashtrays in her hand, run up and down the road naked. I mean the real sort of crazy type sort of label. (Participant 1, 12, 541-543)

You don't have to bother with the problems of the world - if anything stressful comes up you say I am mentally ill, I can't cope, I have to go into hospital and everything is ok, or I cannot do that, I am mentally ill. (Participant 2, 6, 192-194)

Some individuals also spoke about the negative emotions associated with this identity. For example, one individual described feelings of emptiness as a result of their difficulties which had lasted a long time.

... really part of me was really unfulfilled by the experience of having just to look after myself and be off sick for such a long time. (Participant 7, 9, 160-161)

Stigma

Perceiving oneself or being perceived by others as having a service user identity was experienced as deeply stigmatising. Participants appeared to experience two main types of stigma: self-stigma and stigmatisation by others.

Self-stigma.

Participants had struggled to resist their own prejudices about mental health problems. The service user identity, symptoms associated with psychological distress and life circumstances all reinforced perceived differences between participants and ‘normal society’. For example, one participant had believed that people with mental health problems were abnormal and should not mix with other people. Many participants questioned whether they had anything to offer society.

I own that previously I was prejudiced about myself. I have had to fight my own prejudices about mental ill health and having a significant health issue and so the battle is not only with what you see in the services or in society it is also with my own feelings about... Is it really possible for us, me and us to be valued useful members of society? (Participant 7, 24, 1157-1160)

Additionally, some of the participants described the negative feelings (such as guilt, anger and shame) associated with their self-perceptions.

I was deeply ashamed of becoming ill and of having a mental health problem, primarily, I suppose, because of the background I came from, from the work background I came from. But I felt guilty, I felt ashamed. (Participant 3, 3, 114-118)

Service providers’ low expectations.

The interviews suggested that there was a desire to challenge and exceed the low expectations of mental health service providers. Some participants were considered ‘revolving door’ patients due to the high number of times they had been admitted to a

psychiatric hospital. Some mental health professionals expected that they would repeat this pattern throughout the rest of their lives.

I was sort of told by a very well-meaning mental health professional that I was unemployable, always would be, and that was alright, I could just go and sit in my corner and be ill for the rest of my life. (Participant 4, 2, 42-45)

Over time, the pessimism from services had triggered anger but this had eventually given way to a more optimistic outlook and to a determination that individuals could achieve their goals in the future.

... may be stuck at this particular moment perhaps but that journey can go forward and people can achieve things way, way more than the expectation of services. (Participant 7, 10, 456-459)

Societal negative reactions.

Participants perceived society as reacting negatively to them as a result of their mental ill-health, for example with fear, disdain and a view that participants were different. The participants saw these reactions as unjustified and rejecting.

And as soon as people *mention mental health then they're like 'pfff', you know, scary. And it's not.* (Participant 3, 12, 545-546)

Participating in SUG-TR

Once mental health problems seemed reasonably manageable, the individuals explored ways to cope with stigma and rebuild their sense of self. This had led to participation in SUG-TR. Participants varied in the amount of time it had taken before they had internalised membership; for some this had happened at the first meeting,

whereas for others it had taken up to six months. There appeared to be three main ways in which group membership benefited the well-being or functioning of its members: different norms and values, supportive network, and personal growth and recovery. These are described below.

Different norms and values.

Firstly, group meetings provided an alternative social environment, with differing norms and values to those of society as a whole. Participants particularly mentioned the friendly environment, acceptance, tolerance, confidentiality, equality, encouragement and understanding. For example, one individual appreciated that mental health problems could be discussed without fear of rejection.

And it is a very accepting environment, and that's the most important thing. Somebody will decide the way they're feeling at the moment they want to turn up in a clown wig and affairs, and that's ok, nobody's going to bat an eyelid or laugh or point fingers. (Participant 4, 2, 52-55)

Supportive network.

Secondly, membership of the group usually involved a reciprocal exchange of support. Relationships with other members were characterised by companionship, community, a sense of being colleagues and acquaintances and a sense of family. The participants varied widely in the way that they related to other members; some perceived other members as colleagues, while others perceived them as family. The level of perceived closeness was strongly associated with the level of responsibility taken up within the group.

... but I don't actually see them on a friendship level. They are colleagues or

they are acquaintances that I have known from there... (Participant 6, 2, 73-75)

Reciprocity and a sense of belonging developed over time. Most participants had initially kept quiet in the group, trying to gain an understanding of its functions and values before deciding to engage fully with people. The meetings had often been the first social opportunity to meet with people with similar experiences and on equal terms.

And it was very difficult to participate because it wasn't something I'd ever really had the opportunity to speak out about how I was feeling, especially not with people that had an understanding of where I was at and how I was feeling as well. (Participant 1, 5, 177-180)

Personal growth and recovery.

Thirdly, all interviewees felt that they had grown and developed. These were often in multiple ways, including: increased confidence, increased self-esteem, finding a voice, increased self-worth and feeling useful, together with feelings of determination, achievement and empowerment. Some participants described their experiences as life-changing. Participating in SUG-TR was described as part of the journey of developing positive personal attributes and meaning in life. One participant spoke about 'borrowing' confidence from the group in initial training sessions until their confidence had developed. Many described the experience of training mental health professionals as the right type of challenge (i.e. a balance between having too much to cope with and inactivity).

It was just a part of a journey, and that was part of the journey. And it made

me confident again and a feeling of self-worth again, so it enabled me then to go to teach (health professionals). (Participant 3, 7, 546-548)

The group also provided support for some who were coming to terms with mental illness. The participants were able to draw on each other's experiences and compare strategies for coping with symptoms.

... the way I look at it now is perhaps it's no different to somebody having a heart problem, you know, it's just a different problem... but it's sort of coming to terms with it and sort of – it (SUG-TR) helps you to make sense of it. (Participant 3, 8, 601-604)

Contributing to a Positive Social Identity

The previous section outlined the ways in which group membership benefited the participants' well-being and functioning. Group membership also appeared to contribute to the development and maintenance of a positive sense of identity. This was achieved in various ways within the enabling environments provided by SUG-TR group and training: helping others, improving services, developing positive self-identities, bridging gaps with professionals, becoming members of staff teams and developing new roles/making use of new opportunities. These are described below.

Helping others.

All of the participants described achieving some fulfilment through helping others, including other group members, other people experiencing psychological distress, health professionals whom they taught and health/academic staff with whom they co-facilitated sessions.

It's helped me to help other people, and that gives you quite a kick as well to be able to be out there helping other people, not just people that are sufferers but also people that are trying to care for them as well. (Participant 5, 10, 809-811)

Improving services.

Participation in SUG-TR appeared to be motivated in part by a desire to improve mental health services. Participants felt that helping to bring about small changes in clinical practice could make a difference and this could be achieved through describing experiences of psychological distress and of using mental health services.

It's basically, the influence for me is them (health professionals) knowing what it's like. If I can make it real for them, when they practice those small things that I bring out, to make a difference. And there's nothing more powerful than getting a testimonial, is there? (Participant 8, 23, 1570-1573)

Self-identity.

Involvement in training mental health professionals allowed participants to create a new discursive framework, which enabled a positive social identity to emerge. This new self-identity was not only a result of developing more positive connotations to the mental health related aspects of their identity, but often included aspects of their former sense of self. There appeared to be three main sub-types of positive self-identity: self as a group member, self as professional/ trainer and self as recovering. These are described below.

Self as group member.

Membership of SUG-TR involved being associated with a group that the participants perceived as positive, proactive and influential. Although members felt that the group was cohesive in that it comprised people with a similar lived experience, positive social identity was achieved and maintained by the SUG-TR in providing a protective space which acknowledged and valued differences between members. Such differences included diagnoses, experiences with mental health services, personality, stage of personal growth and beliefs.

I think (the group) recognises very well that everybody is an individual and everybody is coming from different areas and also that some people might not necessarily say what is wrong but you know they might need encouragement to, you know, say how they feel.... (Participant 6, 20, 881-885)

Additionally, some individuals felt that participation in the group had allowed them to develop diverse roles and identities:

And I sort of found I can be a protestor, a rebel, or whatever. So all of these other sorts of roles or identities, in a way, have come out as well. (Participant 5, 11, 450-451)

There appeared to be variation in the extent to which identification with SUG-TR was internalised. Internalisation was strongly dependent on the person's views about their stage of recovery, the usefulness of the group and the responsibility that they held within the group. For example, some individuals described SUG-TR membership as temporary and useful whilst recovering from mental health problems. Individuals who held more responsibility, for example, organising the meetings, tended to perceive

their membership as a longer-term commitment.

I definitely see it (SUG-TR group membership) as something, as a temporary, it is like when I was in the mental health system all I wanted to do is get out of it and never go back again. (Participant 2, 5, 223-225)

Holding more responsibility within the group was strongly associated with representing the views of the SUG-TR rather than personal perspectives in training sessions.

Sometimes I'm sure I slip and say something that is very strong for me personally that may be not everybody would endorse, but I try to walk that line of presenting the group views rather than my own. (Participant 4, 21, 924-926)

Self as professional/trainer.

Whilst some individuals perceived themselves as training professionals, all described developing at least one or more of the skills associated with the training role.

Examples included: listening, writing, public speaking, flexibility, availability, preparing training materials, time-keeping and thinking on one's feet. Some individuals described reconnecting with aspects of a professional identity (such as teacher or social worker) that they had prior to the impact of mental ill health.

... because I originally was a teacher so it is sort of vaguely coming back to how things had been long ago. (Participant 6, 7, 310-311)

Self as recovering.

Many participants felt that it was important to present themselves within the training environment as recovering (rather than recovered) from the experience of mental health problems. Some of the participants had found the training sessions to be useful opportunities to process some important aspects of their difficult experiences.

I found it a very positive experience. It helps you to reflect on it (being sectioned), *and it helps you move forward with it, but it's also good because its helping them* (health professionals) understand how somebody might feel, and get them questioning things, which is what they did, you know, when they did a bit of work afterwards. (Participant 3, 25, 1112-1116)

Bridging gaps with professionals.

Training opportunities potentially bridged the gaps in power dynamics observed in traditional health professional and patient dyads. Some participants described positive experiences of co-facilitating sessions with health professionals, in that, they perceived themselves as having equal status as their co-facilitator. Additionally, the participants felt that the positive impact of groups of receptive clinicians listening to their views counteracted the negative feelings associated with membership of a devalued social group.

....a group of professionals can take the time and are prepared to listen to you and listen to your views and just listen to you, you know, and treat you like a fellow human being of the same status. (Participant 2, 10, 441-443)

Members of staff teams.

Some participants had built positive relationships with an educational institution

which had led to paid employment. For some, being a part of the staff team evoked a strong sense of belonging.

I got involved in delivering the (qualification)* which is a.... level qualification at that time and gave me a sense of community. (Participant 7, 14, 616-617)

New group roles and opportunities.

The experiences facilitated by SUG-TR provided opportunities to find new roles and ways of expressing oneself. Such experiences helped to develop confidence, which progressed to the desire to explore other potential activities. Such activities included involvement in peer support; writing groups; service improvement; social groups; national service user networks; outdoor groups; craft and campaigning.

(SUG-TR group) has given me the confidence to try more things but there are still some things which I would not even attempt to do. (Participant 6, 20, 881-882)

The participants felt that involvement in such activities promoted social inclusion. Some individuals were involved in other groups comprised of people with mental health problems only, whilst others attended activities that included people from the wider society. Additionally, some participants described the impact of taking up lead roles in their activities.

Yeah. I'm not scared to actually take groups myself now and also to speak up in groups, where before I really, really was... I was a mouse. (Participant 5, 10, 447-448)

Challenges to Participating in SUG-TR

The participants also described challenges to participating in SUG-TR and ways in which it posed potential threats to positive social identity. These challenges included fluctuations in functioning/well-being and threats to self-identity. There appeared to be three types of potential threats to participating: on-going mental health problems, negative and ambivalent training experiences, and an over-focus on group member identity.

On-going mental health problems.

The majority of participants described experiencing on-going episodes of mental health problems. At times, the episodes felt unmanageable and the individuals temporarily stopped participating in SUG-TR.

I still have difficulties, mental health difficulties. That's not gone – it's got to a level where sometimes it isn't manageable, but half the times it is...

(Participant 3, 11, 448-449)

Some participants described the impact of having the boundaries of two identities (patient and professional) crossed. As a result, many did not feel comfortable using mental health services in the same area where they were training and often received mental health services from in another area, in order to avoid seeing clinicians they had trained or worked with.

And so I have to go out of area. You know, if I'm admitted to hospital then they try and put me at (outside catchment area). (Participant 1, 12, 528-529)

On-going mental health problems were often associated with the service user identity

becoming temporarily dominant, which (once again) threatened individuals to experience a further loss of self and/or relationships.

Negative and ambivalent training experiences.

Some participants had been affected by negative and ambivalent training experiences. For example, they described encountering ‘know-it-all’ professionals, disorganised co-facilitators and organisers, disrespectful interactions during teaching, overwhelming feelings triggered during teaching, unresponsive groups, critical groups and limited feedback. Experiences of ambiguity or ambivalence were more common than negative ones. The participants had often been left wondering how professionals had experienced the training. Some were disappointed that more questions were not asked during sessions and others would have welcomed more constructive criticism.

But that (organiser) that had organised that wasn't even on that campus that day, so I couldn't sort of call round afterwards and say 'look,... was it me, was it the group, or what?'. And you sort of go off feeling not sure whether you've gaffed or whether.... (Participant 4, 8, 467-468)

Participants pointed out that ‘know-it-all’ professionals and groups who had been critical often reinforced their experiences of stigma, in that they felt unheard and stereotyped.

And you'd get some who were like 'well we work with service users all the time. We know what they think, like you'd ever tell the person who's involved with your care exactly what you think about their service. (Participant 4, 3, 86-88)

Such experiences left some individuals ruminating and fed into their low self-

perceptions. One participant described an extreme case where a SUG-TR member was sectioned on the journey home from training.

And if you have sort of lowish self-esteem, which again a lot of us struggle with self-esteem issues, it (ambivalent or negative experience) can be magnified and fester. (Participant 4, 8, 391-393)

The participants described the importance of having a designated staff member or SUG-TR contactable member with which to debrief, if needed, stressing that such availability greatly reduced the potential injury to identity. Individuals who were more experienced in training identified the importance of finding some 'middle ground' between what was relevant for the service user and what was relevant for the training group.

It is always about what is relevant to the audience rather than just I want to *speak but I think a lot of people who start off in training... think but I want to speak*, how I have to find my voice first and then I can start. (Participant 7, 15, 660-662)

Too much focus on group member identity.

Some of the participants felt that spending too much time with people who were focussed on mental ill health could have a negative impact on one's sense of self, for example, over-identification with the service user identity.

(group) is not the be all and end all of everything; I have lots of other things in my life and that is the part that reflects this illness and this difficulty and all the other things in my life reflect lots of other aspects of me, my creative side

or that I am a parent or whatever else. (Participant 7, 13, 572-575)

Discussion

Summary of Findings

A preliminary model of the changes to social identity of eight group members who participated in service user groups that train mental health professionals (SUG-TRs) has been presented. GT analysis generated five main processes that influenced social identity and the results will now be considered in relation to the relevant literature.

SIT strategies.

The results suggest that participants adopted strategies related to SIT (Tajfel & Turner, 1979) in two main ways. Firstly, participants used two SIT strategies to achieve positive distinctiveness (or identity). Tajfel and Turner (1979) argued that positive distinctiveness is achieved through social creativity by comparing and changing the values assigned to the attributes of the 'in-group'. Members of the SUG-TR used the social creativity strategy by establishing an alternative social environment with perceived differing norms and values from the wider society ('out-group') and a protective space against the psychosocial effects of having a mental health problem.

This environment also provided a space related to another strategy named social change where members' differences could be recognised and valued i.e. "equal but different" (Tajfel, 1979). This was similar to the social environment created by users of a mental health drop in centre (Hall & Cheston, 2002). And secondly, participants varied in the extent to which membership of SUG-TR was internalised which was

related to their stage of recovery, the usefulness of the group and the responsibility that they held within the group. Tajfel (1981) highlighted that in some social groups, the feeling of cohesiveness may only develop over time as a response to out-group pressure rather than an innate feeling of belongingness, and this aspect had a particular resonance for some participants.

However, it should be highlighted that these findings were generated from two SUG-TRs with differing primary purposes. Whilst both groups provided peer support through attending meetings, the SUG-TR 1 was part of a wider support network for service users and SUG-TR 2 was purposefully set up for the benefit of supporting training professionals. For members of SUG-TR 2, it is possible that the benefits of participating in the group (e.g. supportive network and social environment) were only accessible once the primary task of engaging positively in training (and the training role) was achieved. Conversely, a member of SUG-TR 2 may only feel able to access peer support when they feel actively able to fulfil the training role compared to members of SUG-TR 1 where support was widely accessible regardless of a member's capacity to engage in training. These findings suggest that there might be differences in perceived wellbeing/functioning when individuals participate in the two different SUG-TRs, but also, in the level of support that these two types of groups can offer.

Self-identities that facilitated positive social identity.

The model suggests that there are fluid, yet dynamic, cyclical processes involved in achieving positive identity, for example, participating in a SUG-TR increases wellbeing and positive social identity which (in turn) increases the likelihood of participating further in the SUG-TR which (in turn) contributes further to a positive identity. The model presented is consistent with Forrester-Jones and Barnes (2008)

who found that identity tended to move from 'sick' and 'stigmatised' to 'in recovery' whilst individuals made "attempts towards establishing another identity for themselves, more acceptable to wider society" (p168). The process of positive social identity facilitated through participating in SUG-TR involved presenting oneself within the training environments as 'recovering' (rather than recovered) from mental health problems. This was found even when participants had not experienced difficulties with their mental health or used mental health services in some time.

The 'recovering' self-identity might be understood in a number of ways. Firstly, for some individuals it might represent positive shifts in their social identity, mental health problems and relation to the wider devalued group to which they feel they belong (Tajfel & Turner, 2001). This is arguably similar to the 'recovery' social identity associated with addiction constructed within therapy groups or AA meetings (Buckingham, Frings, & Albery, 2013; Oakes, 1987). Secondly, it is possible that speaking from a 'recovering' rather than a 'recovered' identity enables some individuals to use the training environment therapeutically in order to process experiences of psychological distress. Thirdly, the flexibility of a 'recovering' identity might enable those who had not experienced mental ill health in some time to continue to participate in their SUG-TR.

The model suggests that the process of positive social identity was also facilitated through the development (or reconnection) of a training professional identity that could become salient within the training contexts. Most of the participants described themselves as skilled or even professional trainers. Additionally, some participants reconnected with aspects of the professional identity they had prior to the impact of

mental ill health. The training professional has been increasingly seen as a socially valued, 'acceptable' and work-related identity (e.g. Fox, 2011; Ramon, 2003). This identity is particularly relevant for recovery as it has been argued that accessing opportunities to work, as well as, engaging in meaningful and socially valued roles (that focus on strengths, wellbeing and 'doing') are essential for developing a sense of identity beyond symptoms, illness and disability (Shepherd, Boardman, Slade, 2009).

Towards new perspectives on identity and recovery.

Consistent with the social constructionist perspectives (e.g. Hall, 1996; Kowitz, 2010; Mishler, 1999), the results imply that people can have multiple identities that are often intersecting. The study suggests that SUG-TRs can offer a way for two apparently contradictory identities (service user and training professional) to coexist. This is relevant to social theories on identity as it demonstrates that multiple identities can rub along together, albeit sometimes in a state of tension, and that negative social identities do not have to predominate. The tension between two (sometimes) contradictory identities was also captured by Fegan and Cook (2012) who explored how people with serious mental health problems perceived the experience of volunteering for the health care organisation in which they had received a service. However, it should be noted that membership of SUG-TR was seen by some participants as an intermediate part of their journey of recovery. Unfortunately, the model does not capture the latter part of this journey and how SUG-TRs might help people to move beyond devalued identities.

Limitations

‘Analytic generalisability’ (or transferability; Firestone, 1993) is a useful concept in qualitative research where researchers generalise from particulars to broader constructs or theories. Whilst the current research is not generalisable in the statistical sense of population representativeness, the rich and in-depth analysis does enable some analytical and theoretical generalisations about the processes illuminated within the emergent model. However, it is acknowledged that the study presented is a preliminary model and would need to demonstrate that it is transferable to other members of SUG-TRs, such as ethnic minorities where issues with social identity might be more complex.

The results could have been strengthened by implementing a triangulation strategy into the methodology. Mays and Pope (2000) argued that triangulation compares the results from two or more data sources or different methods of data collection. This could be achieved by attending (and conducting participant observation) at a number of SUG-TR meetings or interviewing staff members who co-facilitated sessions with SUG-TR members. The results also could have been strengthened by implementing a respondent validation strategy by determining whether participants felt the preliminary model accurately represented their experiences (Mays & Pope, 2000). A summary of the preliminary model and categories could have been sent to participants for feedback during the data analysis stage.

Additionally, the data may have been potentially influenced or biased by the position of the researcher who was affiliated with one of academic institutions the members of one of the SUG-TR taught at. Whilst bracketing interviews were used to enhance the

researcher's reflexivity, it is possible that this position may still have influenced the responses given by some of the participants.

Clinical Implications

The findings have a number of clinical implications. Firstly, mental health services and mental health training programmes need to promote and utilise SUG-TRs as they can enable socially valued identities to develop and co-exist with mental health-related identities so that negative social identities do not remain or become dominant. However, before recommending SUG-TRs clinicians should consider the support needs of their clients. SUG-TRs primarily set up for the benefit of training professionals differ from other peer support groups that are primarily set up to support people with a lived experience of mental health problems. Specifically, in such SUG-TRs, peer support might only become accessible once an individual is able to engage positively in training (and the training role). And secondly, the study highlights the importance of psychological services also providing narrative approaches to psychological distress. This is because of its focus on building 'preferred identities' which White (2001) argues is a central theme when working with devalued groups.

Future Research

Future research could usefully replicate this study with diverse participants in other SUG-TRs, and could also further explore categories within the emergent theory. In particular, the challenges to participating in SUG-TRs and the possible repeated processes of working through issues of identity. Whilst, this model demonstrated the ways in which participating in SUG-TRs can contribute towards the achievement and maintenance of positive social identity, it is unclear what the long-term or continuing

value of SUG-TR in helping people move beyond devalued identities. A longitudinal perspective would be interesting to research. It is recommended that further research could specifically investigate whether there are any positive identity exit opportunities from SUG- TRs.

Conclusion

The study provides a preliminary model of how participating in SUG-TRs can contribute towards the achievement and maintenance of positive social identity. The results suggest that participants adopted various strategies to achieve positive distinctiveness (i.e. an individual's strive for positive self-concept) in the SUG-TR meetings and training environments. Additionally, the results suggested that the SUG-TR offered a way for two apparently contradictory identities (service user and training professional) to coexist. However, it is unclear what the long-term or continuing value of SUG-TR in helping people move beyond devalued identities. It is recommended that future research should investigate the longitudinal effects of participating.

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Section C: Critical Appraisal

Word Count: 1997

A thesis submitted in partial fulfilment of the requirements of
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SALOMONS
CANTERBURY CHRIST CHURCH UNIVERSITY

1. What have you learned and what research abilities have you developed from undertaking this project and what do you think you need to learn further?

As I had not previously carried out a qualitative project I feel that I have learnt a great deal about the whole process; from constructing a research proposal to writing the first draft of this project. My research abilities have been mostly developed in three main areas which are described below.

Interview skills

I believe that I have improved my interviewing skills. During the first interviews I felt quite anxious and allowed the participants to continue talking which meant they often went off topic. At the time I did not want to appear disinterested or offend them. But I often found myself “lost” in the dialogue and scrambled around looking through my interview schedule for questions to re-focus the interview. Additionally, during the first interview I realised that some of the questions were quite repetitive and so I modified them for subsequent interviews. During the data collection period I developed an interview agenda which listed the pertinent research objectives/information that I wanted to gain from each participant. I determined that having this agenda was helpful to refer back to during the latter interviews and it ensured that all the main research points were covered. This is consistent with a recommendation suggested by Willig (2001) who asserted that “a carefully constructed interview agenda can go some way towards ensuring that the interview does not lose sight of the original research question” (p. 22).

Grounded theory techniques

My research skills related to the grounded theory approach (GT, Charmaz, 2006) has been enhanced. I discovered that the process of coding (line-by-line, focused, etc.) took a long time and it was helpful to break down the process into manageable steps with regular breaks from analysing the data. My experience of using memo-writing (a technique used in GT) was consistent with Charmaz (2006) when she wrote that “memo-writing is the pivotal intermediate step between data collection and writing drafts of papers” (P.73). In particular, I came across the technique of clustering (a strategy where you write down your central idea/category, then circle it and connect with smaller circles to show relationships or defining properties. It helped me to organise my data and to develop the final constructed model presented in section B. However, I still consider myself a novice in using GT and I, therefore, feel the need to further develop skills in employing this type of analysis. In the future, if the data allows, I would like to utilise other GT techniques (such as axial coding; Strauss & Corbin, 1998).

Project write-up

I realised that conceptualising the model and then translating it into a coherent interesting empirical paper was taking a long time and I (sometimes) struggled to find the right words to express my ideas within the 8000 word restriction. My supervisors really helped me to articulate my thoughts and they were fairly good at prompting me to explain my assertions more explicitly in early drafts of section B. Subsequently, I did feel the need to develop competencies in transcribing large amounts of data into small concise journal articles.

2. If you were able to do this project again, what would you do differently and why?

There are three specific areas, indicated below, that I would do differently if I were to conduct this type of research again.

Ethics approval

After some discussions with my supervisors and the MRP review panel, it was decided that I should apply for NHS ethics approval. However, I ascertained that seeking NHS ethical approval was an extremely confusing and challenging experience. I had not used the IRAS system previously and navigating through it i.e. the forms and procedures (with limited support) was quite daunting. Once I had received a favourable opinion from the ethics committee, I was informed that I needed to gain permission from each host organisation where I would be conducting the research. I therefore contacted to the NHS R&D departments which covered the local areas where the service user groups met. However, both departments informed me that if I was not conducting research at one of their sites then I did not need to gain their permission. Upon reflection I believe it would have been more appropriate to seek approval through the university ethics panel because some of the interviews took place at one of the university's campus.

Service user group samples

I would give more consideration to which samples of service user groups that were used in the project. This is because I believe my position as trainee clinical psychologist may have negatively impacted on the responses given by some of the

participants. This issue is related to the concept of reflexivity in qualitative research, which means “... sensitivity to the ways in which the researcher and the research process have shaped the collected data” (Mays & Pope, 2000, p.50). One of the service user groups used in this project was affiliated with the university and the campus where I attended lectures. During some of the interviews I was struck by my own strong reactions to some of the participants’ responses, for example, when one participant spoke about a controversial cohort of trainees I worried whether they might be talking about my cohort. Additionally, I noticed that during some of the interviews with members of this service user group it felt difficult (for both participant and myself) to explore possible negative or ambivalent experiences they had. On another occasion, another participant from this group replied, “Oh no, I don’t think I’m allowed to talk about that with you,” which seemed to stop the flow of the conversation. I think that if I was to interview participants from this particular service user group again, I would have spent more time thinking about how I might address this issue. Perhaps, by exploring confidentiality at the beginning of the interviews so the participant feels comfortable to talk with trainees about difficult memories of experiences.

Measure of validity – triangulation and respondent validation

The project would have benefitted from improving the credibility checks (Caldwell, Henshaw & Taylor, 2005). I would improve this by implementing a triangulation strategy into the methodology. Mays & Pope (2000) argued that triangulation compares the results from two or more data sources or different methods of data collection. By doing this, ‘...the researcher looks for patterns of convergence to develop or corroborate an overall interpretation (Mays & Pope, 2000, p. 51). My

project could have been greatly enhanced by conducting participant observation at (minimum of two) SUG-TRs meetings in addition to carrying out interviews with trainee health professionals who had experienced the training sessions facilitated by participants and/or those academic staff who co-facilitate with participants and/or those who organise training sessions. The project could have also incorporated a respondent validation strategy which could have enhanced the accuracy, validity and transferability of the results (e.g. Barbour, 2001). Respondent validation is when feedback is obtained from participants regarding the accuracy of data given and the researcher's interpretation of that data (Mays & Pope, 2000). However, I gave each participant the option of reviewing their transcript but no one wished to do so.

Theoretical sampling

Charmaz (2006, p. 100) wrote that “the purpose of theoretical sampling is to obtain data to help you explicate your categories. When your categories are full, they reflect qualities of your respondents’ experiences and provide a useful analytic handle for understanding them”. Due to the time constraints of the project, it was unclear whether theoretical sampling was fully achieved or whether achieving it might have improved the model constructed. Therefore, I would have tried to achieve theoretical saturation by including more participants with perhaps different experiences, such as, members of SUG-TRs who are involved with training medical doctors and psychiatrists. However, the data appeared to achieve theoretical sufficiency where no new categories were established (Dey, 1999) after the eighth interview was analysed.

3. As a consequence of doing this study, would you do anything differently in regard to making clinical recommendations or changing clinical practice, and why?

The findings of this study suggest four main clinical recommendations. Firstly, I believe that clinicians should be exploring social identity issues as part of individual formulation and treatment interventions (Ison & Kent, 2010), particularly, because of its links with self-esteem and other important psychological characteristics. The literature identified a way of integrating social identity into clinical practice by using the identity salience model proposed by Yakushko, Davidson & Williams (2009). This model provides a framework of how multiple identities can be considered and how the salience of certain identities can be recognized and examined within the psychotherapy context.

Secondly, the study highlighted the importance of psychological services also providing narrative approaches to psychological distress. This is because of its focus on building ‘preferred identities’ which (White, 2001) argues is a central theme when working with devalued groups. Thirdly, the benefits of participating in SUG-TRs found in this study suggest that statutory services should be directing individuals towards alternative sources of support e.g. peer support groups. Mental health services and mental health training programmes also need to promote and utilise SUG-TRs as they can provide social support. It would enable socially valued identities to develop and co-exist with mental health-related identities so that negative social identities do not remain or become dominant.

And lastly, the findings also suggested that negative and ambivalent training experiences can pose significant threats to an individual's positive identity. Therefore, further consideration needs to be given regarding how best to involve service users and carers in mental health training. For example, Nickeas (2007) suggests that it is important to find out what actions service user trainers would like training organisers to take if they experience overwhelming emotions or have difficulty concentrating. I would recommend that training organisers (or a designated person) should be available to service users and carers during the training process (i.e. preparation period, during and after training session). Some time should also be spent in negotiating content and expectations from both parties prior to training sessions. Academic institutes and NHS Trusts should develop guidelines or policies for implementing training professionals into training programmes. Although it is acknowledged that there are some published useful practical guidelines for service user and carer involvement in education (e.g. Lea, 2010).

4. If you were to undertake further research in this area what would that research project seek to answer and how would you go about doing it?

There are two avenues, in which, I would continue research in this area and these are discussed below. Firstly, the current findings provided a substantive theory based upon the experiences of members of two SUG-TRs in England. Before findings can be reliably applied to SUG-TRs in general, it will be important for future studies posing the same research questions to be conducted in different SUG –TRs and with diverse samples. The model would need to demonstrate that it is transferable to other members of SUG-TRs, such as ethnic minorities where issues with social identity

might be more complex. Future studies might incorporate the social identity complexity framework proposed by Roccas & Brewer (2002) which is useful when investigating the perceived salience and inter-group relationships between the multiple social groups to which an individual might belong.

Secondly, whilst this model demonstrated the ways in which participating in SUG-TRs can contribute towards the achievement and maintenance of positive social identity; it is unclear what the long-term or continuing value of SUG -TRs in helping people move beyond devalued identities. It is recommended that further research could specifically investigate whether there are any positive identity exit opportunities from SUG- TRs. Given that there has been limited research in this area, qualitative methodology (such as GT) would enable the conceptual and theoretical development (Charmaz, 2006) of the model presented. Future studies would need to include appropriate measures of triangulation (such as interviewing both current and ex-members of SUG-TRs) and respondent validation.

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Section D: Appendices

**SALOMONS
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Appendix A:

Literature Search Methodology

The literature search took place between October 2012 and October 2013. The methodology is presented below:

| Stage 1 | |
|--------------------|--|
| Search engine | ASSIA (1900-2013), Google Scholar (1900-2013), IngentaConnect (1900-2013), PscINFO (1900-2013), SAGE Journals Online (1900-2013), ScienceDirect (1900-2013), EBSCOHost (1900-2013), Web of Knowledge (1900-2013), Cochrane Library (1900-2013), Google Books (1900-2013) |
| Search terms | The initial search related to the general literature and involved the following key search term “social identity” |
| Inclusion criteria | <ul style="list-style-type: none"> Articles or books focussing the identity of people experiencing mental health problems |
| Exclusion criteria | <ul style="list-style-type: none"> Articles or books in a language other than English |
| Results | <ul style="list-style-type: none"> Relevant articles or books were selected after scrutinising contents of abstracts and references cited within selected articles or books 3885 articles or books were found |
| Stage 2 | |
| Search engine | ASSIA (1900-2013), Google Scholar (1900-2013), IngentaConnect (1900-2013), PscINFO (1900-2013), ProjectMuse (1900-2013), SAGE Journals Online (1900-2013), ScienceDirect (1900-2013), EBSCOHost (1900-2013), Web of Knowledge (1900-2013), Google Books (1900-2013) |
| Search terms | The secondary search related to the literature on the social identity of people experiencing mental health problems “social identity” AND “recover(\$)” OR “”mental health” OR “mental illness” OR “schizophrenia” OR “anxiety” OR “depression” OR “psychosis” OR “personality disorder” |
| Inclusion criteria | <ul style="list-style-type: none"> Articles or books focussing on saliency of the social identity of people experiencing mental health problems |
| Exclusion criteria | <ul style="list-style-type: none"> Articles or books in a language other than English Articles or books that focus on social identity of people under the age of 18 years old. |
| Results | <ul style="list-style-type: none"> Relevant articles or books were selected after scrutinising contents of abstracts and references cited within selected articles or books 7 articles were found that related to mental health |

Appendix A:

These papers were critically reviewed using the following framework recommended by Caldwell, Henshaw & Taylor (2005):

(1) Consideration of the setting and sample of the studies allowed a judgement to be made concerning whether the findings were transferable to other settings.

(2) A concise account of the study elements enabled an understanding of how interpretations were made and the description of the setting was necessary to understand the context of the research.

(3) Evaluation of the data collection and analysis enabled the consideration of potential biases and limitations of the data presented and the conclusions drawn from them.

(4) The quality of the studies was also assessed by considering the quality control measures used.

Appendix B: Table overview of reviewed studies

| Author(s) | Methodology | Participants | Analysis/method | Results/Themes |
|----------------------|--|---|--|---|
| Hooks & Levin (1986) | <p>Data gathered by (1) written on notepads visible to participants (2) covertly recorded on tape (3) transcribed from memory</p> <p>Selected group observed over 8-month period</p> | 40 males in-patients diagnosed with schizophrenia | <p>A two-stage procedure was used (1) categories were elicited by observing patients' actions through conversations, by participating in some of the patients' activities, and by utilising a structured interview with patients (2) Participants were then asked to identify specific fellow patients who represented one or another of the social identities which had been derived.</p> | <p>Thirteen social identities were grouped into three higher-order status classes. The classes identified included a 'conflict' construct (e.g. 'fighter', 'killer'), a 'sexual' construct (e.g. 'fag', 'rapist') and 'cognitive' construct (e.g. 'weirdo', 'drunk', 'nut').</p> <p>Participant's behaviour considered to be pathological was more likely to be institutionalised patterns of social behaviour determined by participants' conceptions of their social identities</p> |

Appendix B:

| | | | | |
|--|-----------------------------------|---|--|---|
| <p>Jackson, Tudway, Giles & Smith (2009)</p> | <p>Semi-structured interviews</p> | <p>Eight individuals in a mental health in-patient setting</p> | <p>Cross-case analysis Triangulation used</p> | <p>Some participants showed a constant shift in identification with “in-patient mental health service user” group. The degree to which the in-patient group membership was internalised was also found to be dependent on a number of factors pertinent to the individual.</p> |
| <p>Ison & Kent (2010)</p> | <p>Semi-structured interviews</p> | <p>Eight participants with a range of eating disorder diagnoses (i.e. bulimia nervosa, anorexia nervosa and EDNOS) were recruited from outpatient eating disorder services.</p> | <p>Interpretative Phenomenological Analysis (IPA; Smith, Jarman, & Osborne, 1999) Researcher was independent from treatment services and carried out “credibility checks” Mentioned awareness of influences on data, such as, SIT and contextual influence of media interest</p> | <p>Results showed that perceptions of social identity changed over time. Eating disorder identity was internalised by time participants approached services for help. Negative eating disorder social identity was related to motivation to seek help and engage in process of recovery.</p> |

Appendix B:

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| <p>Forrester-Jones & Barnes (2008)</p> | <p>Ethnographic approach was used. Data was collected using a wide range of sources; reflective fieldwork notes, personal narratives, individual unstructured interviews, focus groups, participant observations of interactions in various group settings (pressure group meeting and acute wards) and naturalistic conversations.</p> <p>Purposeful sampling strategy; participants had been part of larger research cohort</p> | <p>17 people diagnosed with a severe mental health problem</p> | <p>A latent thematic analysis was carried out and then comparative methods (Glaser, 1992) were used to develop framework (Glaser & Strauss, 1967).</p> | <p>The results showed that all participants acknowledged the salience of a “sick identity” and described the facets of this identity as including passivity, feelings of de-motivation, inability to work, low self-esteem and hopelessness.</p> <p>The “sick identity” became (or remained) salient for some participants so that secondary gains could be achieved.</p> |
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Appendix B:

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| <p>Hall & Cheston (2002)</p> | <p>Data was collected through participant observation (attending 14 sessions) and by conducting semi-structured interviews</p> | <p>14 users of mental health drop-in centre.</p> | <p>Grounded theory (Strauss & Corbin, 1990)</p> | <p>The authors suggested that individuals could only continue to use the drop-in centre if they adopt differing approaches to structure their group membership within a more positive framework. One approach relates to viewing other drop-in members as ‘kindred spirits’ and perceiving the outside world as condemnatory. Participants used a number of strategies that served to reject the label which placed them within the devalued group, for example, a SIT strategy named social mobility where drop-in users selectively revealed and concealed their history of mental health problems to others.</p> |
| <p>Barnes & Shardlow (1996)</p> | <p>Not stated</p> | <p>Individuals involved in three diverse groups: a long established mental health organisation which was an umbrella group for a number of other groups, a small campaigning group of users and ex-users who worked within the local MIND organisation and an informal drop-in service run democratically by service users.</p> | <p>Not stated</p> | <p>Results showed that individuals formerly perceived as passive recipients of mental health services could be active agents in their lives, contributing to shaping mental health services and broader social objectives</p> |

Appendix B:

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| <p>Saavedra (2009)</p> | <p>13 narrative interviews</p> | <p>Ten individuals diagnosed with paranoid schizophrenia who were receiving recovery treatment in special care homes.</p> | <p>Five participants (Group 1) interviewed had lived at the homes for three months and five participants (Group 2) had been there for 61.4 months.</p> <p>Three participants from Group 1 were interviewed two years after their initial interview.</p> <p>Social positioning analysis was used.</p> | <p>Results showed that the care homes provided a new social network that contributed towards important emotional support needed by the participants.</p> <p>One important indication of recovery was that participants' (from Group 2) ability to describe themselves in their narratives in alternative categories than the "label of the psychiatric patient" (p.180) and with some degree of agency capacity.</p> |
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Participant Information Sheet

Title of project: Exploring the effects on identity of membership of a service-user group providing training to health professionals.

As you are aware my name is Monique Malwah and I am a trainee clinical psychologist completing my doctorate in clinical psychology at Canterbury Christ Church University. I am conducting this study as part of my training and I am asking service users to take part. This research is a study into the experiences of current and former service users who participate in groups that train mental health professionals.

I am therefore recruiting individuals who:

- consider themselves to have/had a mental health problem
- are core members that participate in a service-user group that trains health professionals
- have been a member of the group for at least six months

I have enclosed an information sheet with this letter which informs you of the study in more detail and may answer any questions that you have about participating in this study. It would really be appreciated if you could read through this information and consider whether you would like to take part. If you agree to take part, please email me on mm357@canterbury.ac.uk or phone on 01892 507 673. If you are not interested in taking part then please discard this information.

If you have any concerns or queries regarding this project or anything in this letter then please do not hesitate to contact me.

Many thanks for your time,

Monique Malwah
Trainee Clinical Psychologist

Title: Exploring the effects on identity of membership of a service-user group providing training to health professionals.

Many thanks for taking the time to read this information sheet.

I would like to invite you to participate in a research project about the experiences of service users who participate in groups that train health professionals. Before you decide whether to take part in the project I would like to give you some more detailed information on it. Talk to others about the study if you wish. If you still have any unanswered questions after reading the information then please do not hesitate to contact me.

Who is carrying out the research?

My name is Monique Malwah. I am a trainee clinical psychologist at Salomons, Canterbury Christ Church University. I am carrying out research as part of my doctoral course in clinical psychology. In carrying out research, I am being supervised by two clinical psychologists: Dr Anne Cooke and Dr Fabian Davis. The study has been reviewed by the University and a NHS ethics committee.

What is the research about?

This study aims to look at the experiences and the impact on current and former service users who participate in groups that train health professionals. The research hopes to gain an understanding of how getting involved in these groups affects the way in which members feel and think about themselves and how it may support their recovery from mental illness.

Who can take part in this research?

You can take part in this research if:

- You are over 18 years old
- You have been or are currently in receipt of mental health services
- You are a core member of a service user group that train health professionals
- You have been a member of this group for at least 6 months

What will I have to do if I take part in this research?

The research will involve participating in a one hour interview. During the interview, you will be asked to think about your experiences of joining and being part of the group. There will be questions on how the group has affected the way that you think and feel about yourself and how participation has affected your confidence and mental health. You will NOT be asked to recall any personal experiences of mental health problems or any experiences of personal traumas. The interview will be recorded.

There will also be an optional follow up meeting to look over the transcript of the conversations and the analysis. You will be able to ask any questions about the research and say whether you think the analysis is accurate. This conversation will not be recorded.

What happens if I become distressed during the interview?

You can terminate the interview at any point without having to give a reason. During the interview, you can take a break or even come back to a question a little later. You may also decide not to answer any question that you do not want to. The information you provide will be kept confidential. However, confidentiality will be broken if the researcher is concerned that harm is being caused to you or those around you.

Do I have to take part?

You are under no obligation to take part in this research. Your participation is entirely voluntary and you may withdraw from the study at any point. This will not affect your rights, your role in your group or access to services in any way. Neither participation nor withdrawal from the study will affect will affect your current or future care.

What will happen with the recordings of my conversations?

Your conversations will be typed up and entered onto a computer. Your name will be changed to a false name and any other identifying information, such as times and places, will be changed so you could not be recognised in any way. All of the transcripts of the conversation will then be looked by the researcher for themes and quotes that show these themes. Any report of this research will use false names so that you cannot be identified in any way. You can also have a copy of the transcripts of the conversation.

What are the possible disadvantages of taking part?

It is possible that talking about some of your experiences may bring up difficult thoughts and feelings for you. The interview will be conducted sensitively with this in mind. If this does happen, let the researcher know and you will be asked if you are happy to carry on with the research. If you would like, your care co-ordinator (if you have one) can be told that you have been distressed and they may be able offer some extra support.

What are the possible benefits of taking part?

It is hoped that the people taking part in the research will enjoy the experience. Thinking and talking about your experiences in the group may help you to process some of those experiences.

Can I have access to the results once completed?

If you would like a copy of the overall results once the research is completed then you are welcome to have a copy. You can do this by using the details below.



Salomons Campus at Tunbridge Wells
Department of Applied Psychology
Faculty of Social and Applied Sciences

Appendix C:

What should I do if I am happy to take part?

If you have read this information sheet, have any further queries or are satisfied that all of your questions have been answered then please email me on mm357@canterbury.ac.uk or phone/text me on 01892 507 673.

Many thanks for taking the time to read this information sheet and consider this research,

Yours Sincerely

Monique Malwah
Trainee Clinical Psychologist

My contact details should you have any questions:

Monique Malwah: mm357@canterbury.ac.uk

Tel: 01892 507 673 (Monday – Friday 9-5pm)

14.10.2012 version 3

Appendix D:

Participant Consent Form

Title of project:

Exploring effects on identity in service-user groups involved in education and training.

Name of Researcher:

Miss Monique Malwah

Please read the information below and initial the box where you give your consent:

1. I confirm that I have read and understood the information sheet entitled ‘Participant Information sheet for the study entitled above. I have been able to consider the information, and have any questions answered satisfactorily.

2. I understand that my participation in this research is entirely voluntary and that I am free to withdraw at any time without giving any reason.

3. **All data will be anonymised.** I understand that anonymous sections of my data collected during the study may be looked at by two examiners from Canterbury Christ Church University Clinical psychology programme and from regulatory authorities where it is relevant to the research. The chief investigator (Monique Malwah), Lead supervisor (Dr Anne Cooke, Canterbury Christ Church University) and Clinical Supervisor (Dr Fabian Davies) will have access to the anonymised transcript and the final write-up will contain short anonymous quotes which will be seen by a wider audience. I give permission for these individuals to access this data.

4. I have been made aware that direct quotes may be used in the write up of the research. These quotes will be anonymised. I agree to the use of direct quotes.

5. I agree to my interview being digitally recorded. I understand that this recording will be destroyed once it has been transcribed.

Name of Participant

Date

Signature

Monique Malwah

Date

Signature

Appendix E:

Interview Schedule

Joining the group

What led you to join the group?

What was it like when you first joined?

When did you feel you belonged to the group?

How would you say it has affected your life, if at all?

In what ways (if any), did your life changed when you became a member of the group?

PROMPT: How did you know that your life had changed?
How do you think this has come about?

What sort of things stayed the same when you became a member of this group?

Being in the group

What is the group about?

What is your role in the group?

PROMPT – What activities are you involved in, as part of being a member of the group?

What's your experience of training health professionals been like?

Do you feel the group has supported you in your role as a trainer?

If so, how?

What could be done differently (if anything)?

How often did/do you participate in the group?

What do you personally get from being a member of this group?

Do you think that all members get the same thing from the group?

How do you think others outside of the group see the group?

PROMPT: Your friends and family

The health professionals you train

Other professionals

Are there particular positives or negatives from your relationships with other group members?

Are there any ways that being a member of the group has been challenging for you?
PROMPT – Could you describe a difficult time when you were in the group?

Identity

Are there any ways that being a member of the group has changed the way you think/feel about yourself?

PROMPT – How do you think this has come about?

Do you think that being part of the group has changed the way the members may think/feel about themselves?

PROMPT – How do you think this has come about?

Are there any ways that being a member of the group has changed the way you think/feel about mental health problems?

PROMPT – How do you think this has come about?

Do you think that there are ways that the group members share or differ in the way they think about mental health problems?

PROMPT – How do you think this has come about?

Apart from being a member of this group, are there other influences/groups you are involved with that have changed the way you think/feel about yourself?

PROMPT – How do you think this has come about?

Do you think that being part of the group has impacted on your mental health?
If so, in what ways has it been helpful or unhelpful?

Has being a member of the group affected the way in which you see the future?

Do you think that participating in the group has had affect on your confidence?

Thank you for taking part

Interview agenda

Objectives

1. What are the perceived costs and benefits by group members?
2. Why is this group unique compared to other groups involved in (i.e. training group)?
3. How does the group support individuals in their training roles?
4. Has the view of themselves changed as being a member of this group?
5. What are the effects on their wellbeing?
6. What are the effects on their confidence?

Appendix F:

Extracts of transcript showing initial and focused coding

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Appendix G:

Extracts of memos kept during data analysis

Finding a voice

MM: Ok. I'm going to ask a bit about what it's like being in the group, involved in xxx. And I was wondering what you thought the group was about, what you thought xxx was about.

Participant 3: It's about having a voice locally and nationally. It's about making sure that we have the best mental health service that we've got that we can have, you know, given the restraints financially. And it's about being able to influence the decisions made by the people that make the decisions regarding budgets and how things are going to change to fit those budget restraints. And it's having, as I say, having a voice. It's being able to represent the views of service users, so it's like, you know, and actually being respected for it, you know, you're not just the token person, you know, you're not just the token service user, it's actually 'we really do want to know what you think'.

I'm struck by how passionate ** and ** are. There seems to be some conflict within them as to whether they should be representing themselves or the SUG-TR group when they are teaching. I'm really struck by just how much they really want to make a difference and not be a 'tick box exercise'. But also, they wanted to convey how much they wanted be heard and respected for it.

Rebuilding a new identity

MM: Okay, good. So I am just going to talk about (group) and I wondered what is the group about? What do you think the group is about?

Participant 2: I think helping people find their own self worth after they've been through a hard time, finding a new identity. I think mental health episode sort of strikes at you in a sort of

Appendix G:

consciousness and I am not an expert but it sort of strikes at something inside you and afterwards you have got to try and rebuilt something new out of what is left because I don't think you can ever go back to being the person you were before. So I think xxx just gives you the opportunity to find a new role, a new, new ways of expressing yourself.

** spoke about his journey of identity in quite a timely way. Its making me think that there is definitely a time element....a process of evolving. Perhaps, initially starting with the impact of mental illness destroying parts of the self and ** mentioned growth... rebuilding something from what was left. He thought that (group) helped with some of this.

Negative experiences of training

MM: And have you had any particularly bad experiences? I mean maybe not you, but been involved in or heard about some bad experiences of training?

Participant 4: Yeah. The person had – I mean I'd talked to them the day before and they weren't too good, and I had sort of suggested to them that maybe it wasn't a good idea that they did it and that we could have covered it, but she was very determined that she'd be fine. And somebody asked a question that triggered something, and she wasn't fine. It meant that evening nobody could get hold – and a couple of people from the university were with her for some time sort of trying to calm her down. In the end she went on the train home and somewhere on the train home she got sectioned under 136 of the Mental Health Act, which is sort of the/

MM: Oh, my gosh.

Participant 4: Yeah, and ended up in hospital which obviously was a really bad outcome all round

Appendix G:

I was really surprised by this bad experience. Although, this one case was very extreme, I had no idea of the impact that negative experiences of training can have on the members. All have spoken about it. These negative experiences have impact of their well-being but also confidence/self-esteem. However, it seems as though they draw some support from each other and offload (if need be) about it.

Appendix H:

Abridged version of research diary

November 2010 MRP idea

Some service users came to talk to us today about their experiences using mental health services but also their experience training mental health professionals. I'm really impressed at how articulate and passionate they are about what they do. I wonder whether there has been much research into service user and carer involvement in mental health training. They seem to all support each other by attending a group, I'm curious about how they use that space when they meet? This might be an interesting avenue for research; I need to research this more.

January 2011 Research fair

A person from ResearchNET came to talk to us about getting involved with research that is mostly conducted by service users. *** seemed so articulate and empowered. I'm wondering how being a part of that group of peers and role as research has helped him (if at all) in recovery from mental illness. Perhaps, I could conduct research comparing different service user groups and how members might see themselves. I will need to look into how much research has been done in this field. I also don't want to 'step on toes' of ResearchNET as they might be doing research about themselves... I will investigate.

February 2011

Things are starting to happen. I completed a research proposal to Anne and she (luckily) agreed to be my internal supervisor. She wanted me to 'flesh out' my proposal to make sure that no one else has done similar research before. She thinks that it might be difficult to compare two different types of service user groups so thinks I should concentrate on one type. Anne was curious as to why I was interested in groups. I explained that my MSc was related to cultural comparisons and I

Appendix H:

was always very interested in social groups. My dissertation looked at ethnic identity and I have always been interested in whether identification with the groups people find themselves in is positive or negative (or both). Social identity has always been of interest, coming from an ethnic minority myself and trying to navigate between two cultures.

April 2011

Fabian decided to be my external supervisor which is great news. He is very interested in the area and he has some good ideas / contacts that I can use to take the project forward. We explored what type of service user group that I could research and it was decided that I could get a more diverse range of participants by looking into service user groups that train mental health professionals. Fabian was very interested in how the group might perceive themselves; for example, do they see training as an avenue back to work? He suggested some research papers to help me to think about what the literature suggests about the identity of people with mental health problems.

I've discussed methodology with Anne and Fabian and we can't decide between IPA or grounded theory. Fabian has used IPA before but Anne thinks that it might be useful if I could produce a theory from the project.

November 2011

I had my MRP review today. The panel thought my idea was good but too ambiguous. It was feedback that the concept of identity was too broad and I needed to be clear as to what aspect of the identity of service users that I was investigating. Both reviewers felt that I had not been clear about the number of participants that I aimed to interview. It was felt that I needed to clarify the number of participants and produce a rationale for that number. The panel felt that grounded theory would be most appropriate for project then IPA but I would need to give a brief description

Appendix H:

of the project's sampling strategies. I need to spend more time refining the details of the project and respond to their minor conditions before the project would be fully approved.

Jan 2012

I spent some time with Anne and Fabian discussing avenues of recruitment and possible people to discuss the project with. These were the Buddy Scheme in xxxx and xxxxx. It was also suggested that I approach xxxx while I'm still in the consultation stage as xxx members context was different but the process for them was likely to be the same as my future participants. We have now decided to definitely use the grounded theory approach. I've been research the area of social identity and mental health and there does not seem to be much research that specifically explores social identity. I'm hopeful that my project will make a useful contribution to the literature.

July 2012

I had my ethic committee review today. It was really daunting talking about my project to so many people but they were nice so I hope that they will approve my project. In the meantime, Fabian suggests that I try a pilot interview. I think he has a xxxxx in mind who has had previous experience using mental health services sometime ago. I can't believe how quickly this project is moving forward. I'm excited but nervous as I've not done much qualitative research.

September 2012

I met with Anne for bracketing interview. She asked me what my theoretical positioning/assumptions might be and what experiences contributed to me choosing such a topic area. It made me think about my experiences coming from an ethnic minority. I have struggled with my identity in the past and my preconceived assumption is that connecting with people from your own social group can be very beneficial for positive social identity and to protect oneself

Appendix H:

against discrimination/prejudice. But when I start interviewing I need to put those assumptions aside and think about the data objectively (well as objectively as I can be).

December 2012

I have transcribed the first four interviews and am in the process of doing the initial coding. It seems that participants are getting a lot out of attending their groups. I was really struck by the way in which they spoke about other members as family and a community. It sounds as if they were quite isolated before joining the group and the meetings can be a protective space where they feel understood. I'm jealous. I wonder whether the other service user group will say the same thing? Some have said some very negative things about the impact that clinicians have had on their sense of self, particularly, when they were unwell. I was told by my placement supervisor that I am only a small part of my client's life, i.e. one hour a week. But, perhaps, for some clients their clinicians perception of them is important and influential. Maybe clinicians' perceptions are more important when isolated or unwell?

March 2013

I've finished interviews and transcribing. I've looked through all the interviews and made notes. There is so much information and ideas. I need to start putting categories in a model. Luckily, Anne thinks the categories are good and she advised me that I should try to stay 'close' to the data.

May 2013

I had a consultation with Anne on the phone to discuss the preliminary model I sent her. We explored the process of constructing the model and we decided that it should be a linear model that portrayed the element of time. I wonder how I can show that some of the challenges of

Appendix H:

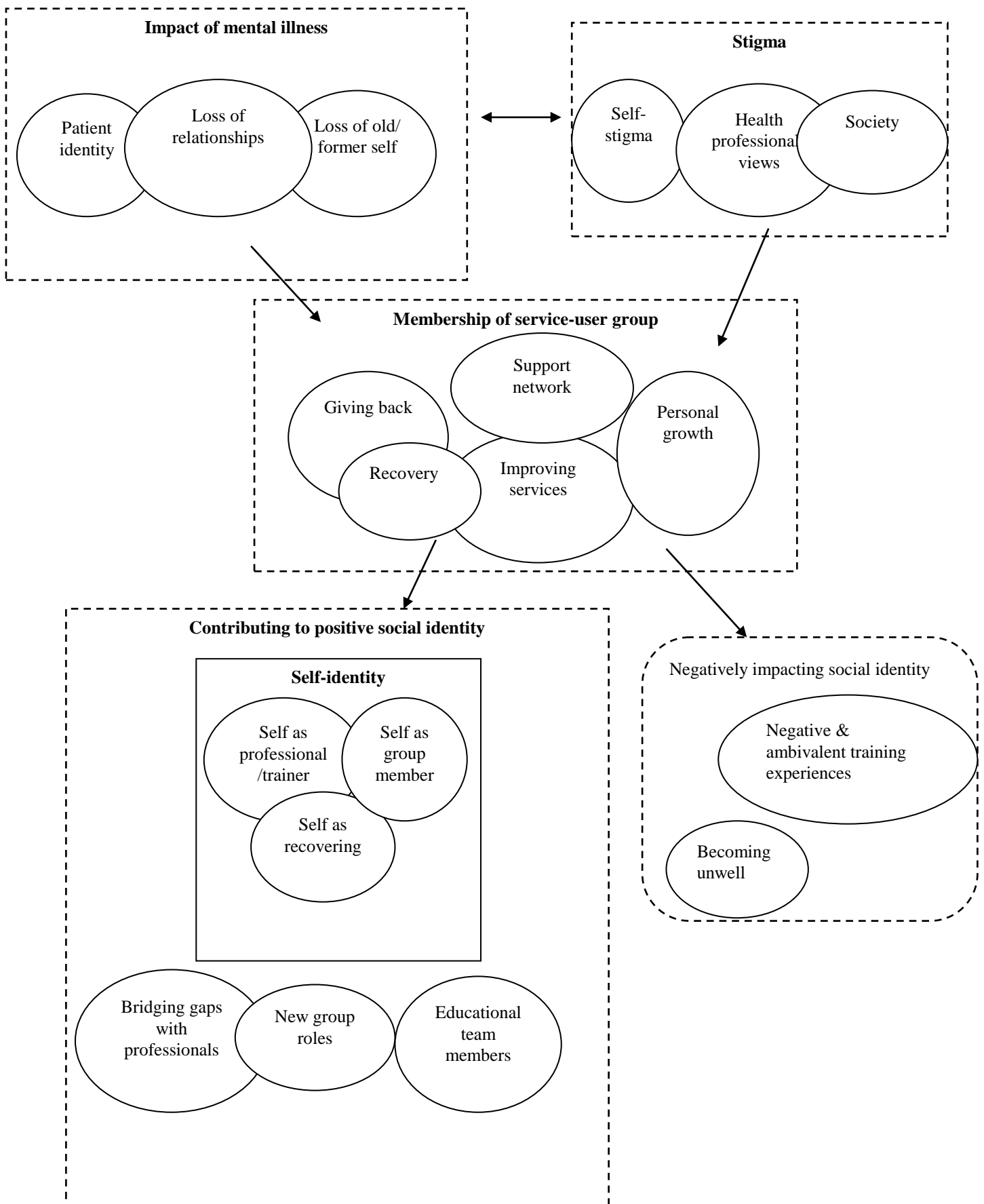
participating to SUG-TR can lead to previous stages in model. Anne also thinks that I described two processes in our conversation and should separate the process of identity from that of well-being/functioning. It's going to be a challenge to portray this in a simplistic/clear diagram but I'm really pleased with the results/categories (so far).

June 2013

This has been a very busy period as it is the write-up stage of the project. Anne liked the final constructed model but I'm struggling to find clear and concise words to describe my findings. This has slowed down this stage of the project and I'm getting frustrated with it. Additionally, I keep changing the quotations as I'm trying to find the 'right' ones that convey the essence of categories and sub-categories. I have to stay focussed and positive that I will get there....eventually!

Appendix I:

Early diagrammatic model: diagram highlighting early 'clustering' of sub-categories and preliminary relationship between categories



Appendix J: Summary of codes from constructed model

| Quotes | Sub-categories | Categories |
|---|--|--|
| <p>So it is absolutely significant because you cannot return to a normal life whatever that is when I say normal life I mean you have a house, you have an income, you have useful things that you do during the day like voluntary work or a job, you can be a parent or a brother or a sister or a husband or a wife so you cannot return to those normal things if the opportunities have gone.</p> <p>I think mental health episode sort of strikes at you at a sort of consciousness and I am not an expert but it sort of strikes at something <i>inside you ... because I don't think you can ever go back to being the person you were before.</i></p> <p><i>I'd recently separated from my (partner)* of 10 years, and had left my children, and was living in a bedroom in my (relative*)'s house out in the middle of nowhere. Because it was in the middle of nowhere it wasn't particularly conducive to my mental health. I was getting very depressed. I had attempted suicide whilst staying there. And being so isolated wasn't particularly helpful.</i></p> <p>I did not have work because it was voluntary to start with but I actually had opportunities to go and do something useful with my day and I had had years of doing nothing and being completely frustrated.</p> | <p>Loss of former self & relationships</p> | <p>The impact of psychiatric diagnosis</p> |

Appendix J:

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| <p>...what (group) was doing so instead of just somebody who used mental health services.</p> <p>...a patient up at the *Hospital who used to strip off naked, crush crystal glass ashtrays in her hand, run up and down the road naked. I mean the real sort of crazy type sort of label.</p> <p><i>You don't have to bother with the problems of the world</i> - if anything stressful comes up you say <i>I am mentally ill, I can't cope, I have to go into hospital and everything is ok</i> or <i>I cannot do that I am mentally ill.</i></p> <p>... really part of me was really unfulfilled by the experience of having just to look after myself and be off sick for such a long time.</p> | <p>Mental patient identity</p> | |
| <p>I think a lot of discrimination is like self-discrimination.</p> <p>I was deeply ashamed of becoming ill and of having a mental health problem, primarily, I suppose, because of the background I came from, from the work background I came from. But I felt guilty, I felt ashamed.</p> <p>I own that previously I was prejudiced about myself. I have had to fight my own prejudices about mental ill health and having a significant health issue and so the battle is not only with what you see in the services or in society it is also with my own feelings about... Is it really possible for us, me and us to be valued useful members of society?</p> | <p>Self-stigma</p> | <p>The experience of stigma</p> |

Appendix J:

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| <p>... may be stuck at this particular moment perhaps but that journey can go forward and people can achieve things way, way more than the expectation of services.</p> <p>I was sort of told by a very well-meaning mental health professional that I was unemployable, always would be, and that was alright, I could just go and sit in my corner and be ill for the rest of my life.</p> | <p>Service providers' low expectation</p> | |
| <p><i>And as soon as people mention mental health then they're like 'pfff', you know, scary. And it's not.</i></p> | <p>Societal negative reactions</p> | |
| <p>I think it gives everybody a form of confidence and everybody a form of belonging and family, because everybody looks out for everybody else.</p> <p>So the only sort of real contact with the outside world I had was with (SUG-TR). But the first time it was very daunting for me to actually break the sort of cycle of being by myself and on my own, and it was <i>very difficult to participate because it wasn't something I'd ever really had the opportunity to speak out about how I was feeling, especially not with people that had an understanding of where I was at and how I was feeling as well.</i></p> <p><i>... but I don't actually see them on a friendship level. They are colleagues or they are acquaintances that I have known from there...</i></p> <p>When I think you feel a member as soon as you joined but one of the great things about (group) is its highly inclusive.</p> | <p>Supportive network</p> | <p>Participating in SUG-TR</p> |

Appendix J:

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| <p><i>The way I look at it now is perhaps it's no different to somebody having a heart problem, you know, it's just a different problem. I mean there's no such thing as a normal person, and everybody, you know, everybody can have bad days.</i></p> <p><i>it makes you more tolerant of people. Whereas I wasn't that particularly tolerant of people that had different...</i></p> <p><i>One of our core belief is you know nothing about me without me, but you can sort of anonymise somebody and say 'well actually we have people that have experienced this problem'.</i></p> <p><i>You can be gay, straight, black, white, sky blue pink, and it doesn't matter. It really doesn't.</i></p> <p><i>there's not one sort of Capitol philosophy of mental illness. There's as many different viewpoints on it as there are members. And that's as it should be because everybody's experience of mental illness is individual.</i></p> | <p>Different norms & values</p> | |
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Appendix J:

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| <p>And while it was a very slow process you were able to borrow a large amount of confidence from the group if you were going out and doing something.</p> <p>but it was completely life-changing as far as I was concerned. Some of the people who came and talked to us started suggesting that <i>we didn't</i> have to be these sort of disempowered little mice who just took what <i>was given to us without challenging...</i></p> <p><i>but it's sort of coming to terms with it and sort of – it helps you to make sense of it...</i></p> <p><i>when I was in ** that I thought 'oh, actually, you know, it's not as much of an issue as I think it is'.</i></p> <p><i>and so that's why I joined Capitol. So it was really just because I wanted to have a voice.</i></p> <p>It certainly gave me more confidence and self-esteem taking part.</p> | <p>Personal growth & recovery</p> | |
| <p><i>it's helped me to help other people, and that gives you quite a kick as well to be able to be out there helping other people, not just people that are sufferers but also people that are trying to care for them as well.</i></p> <p><i>Well I think it's helped me quite a lot actually, so it's affected my life in knowing that I'm needed and I've got something to do and to be helpful.</i></p> | <p>Helping others</p> | <p>Contributing to positive social identity</p> |

Appendix J:

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| <p><i>It's basically, the influence for me is them (health professionals) knowing what it's like. If I can make it real for them, when they practice those small things that I bring out, to make a difference. And there's nothing more powerful than getting a testimonial, is there?</i></p> | <p>Improving services</p> | |
| <p>I definitely see it as something, as a temporary, it is like when I was in the mental health system all I wanted to do is get out of it and never go back again.</p> <p>And I sort of found I can be a protestor, a rebel, or whatever (laugh).</p> <p>So all of these other sort of roles or identities, in a way, have come out as well.</p> <p><i>Sometimes I'm sure I slip and say something that is very strong for me personally that may be not everybody would endorse, but I try to walk that line of presenting the group views rather than my own.</i></p> <p>I think (group) recognises very well that everybody is an individual and everybody is coming from different areas and also that some people might not necessarily say what is wrong but you know they might need encouragement to, you know, say how they feel....</p> <p>because I originally was a teacher so it is sort of vaguely <i>coming back to how things have been long ago...</i></p> <p>I suppose the whole thing that, you know, getting up to be there on time and preparing things beforehand and though even that writing down exactly what I want to say are all skills I would have found</p> <p>I found it a very positive experience. It helps you to reflect on it (<i>being sectioned</i>), and it helps you move forward with it, but it's also good because its helping them (health professionals) understand how somebody might feel, and get them questioning things, which is what they did, you know, when they did a bit of work afterwards.</p> | <p>Self identity</p> <p>Self as group member</p> <p>Self as professional/trainer</p> <p>Self as recovering</p> | |

Appendix J:

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| <p>Straight away. The very first time I felt that I belonged, you know, because like I say I was isolating myself so I used it as a therapy at the beginning.</p> | | |
| <p><i>But the fact that they're the people potentially that you sort of look up to, you know, to try and help you out, but being on a sort of level footing with them and saying 'well, no, you know. What about this?</i></p> <p>They try to get people that have experienced the difficulties to help train alongside the professionals so that you get a balanced view of <i>what's going on.</i></p> <p><i>'it has been treated as a person of valued ideas</i> rather than just somebody who is a patient or whatever.</p> | <p>Bridging gaps with professionals</p> | |
| <p>I got involved in delivering the (qualification)* which is a.... level qualification at that time and gave me a sense of community.</p> <p>So I was offered a part-time post teaching care planning.....</p> | <p>Members of staff teams</p> | |
| <p><i>Yeah. I'm not scared to actually take groups myself now and also to speak up in groups, where before I really really was ...I was a mouse.</i></p> <p>(SUG-TR group) has given me the confidence to try more things but there are still some things which I would not even attempt to do.</p> | <p>New group roles & opportunities</p> | |
| <p><i>And so I have to go out of area. You know, if I'm admitted to hospital then they try and put me at (outside catchment area).</i></p> <p>I still have <i>difficulties, mental health difficulties. That's not gone – it's got to a level where sometimes it isn't manageable, but half the times it is...</i></p> | <p>On-going mental health problems</p> | <p>Challenges to participating in SUG-TR</p> |

Appendix J:

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| <p><i>The person I was working with would say ‘can you talk a bit about x?’, and then I’d get there on the day and ‘oh, I’ve had a big re-think. Could you do a bit about y?’</i></p> <p>And if you have sort of lowish self-esteem, which again a lot of us struggle with self-esteem issues, it (ambivalent or negative experience) can be magnified and fester.</p> <p><i>And you’d get some who were like ‘well we work with service users all the time. We know what they think’, like you’d ever tell the person who’s involved with your care exactly what you think about their service.</i></p> <p>The person had – <i>I mean I’d talked to them the day before and they weren’t too good, and I had sort of suggested to them that maybe it wasn’t a good idea that they did it and that we could have covered it, but she was very determined that she’d be fine. And somebody asked a question that triggered something, and she wasn’t fine. It meant that evening nobody could get hold – and a couple of people from the university were with her for some time sort of trying to calm her down. In the end she went on the train home and somewhere on the train home she got sectioned under 136 of the Mental Health Act and ended up in hospital which obviously was a really bad outcome all round.</i></p> | <p>Negative & ambivalent training experiences</p> | |
| <p><i>Well, it’s a case of you’re dealing constantly with issues that you perhaps sometimes don’t want to be involved, you know, that are just sort of a bad reminder, you know, of who you were.</i></p> <p>(group) is not the be all and end all of everything I have lots of other things in my life and that is the part that reflects this illness and this difficulty and all the other things in my life reflect lots of other aspects of me, my creative side or that I am a parent or whatever else.</p> | <p>Too much focus on group member identity</p> | |

Appendix K:

NHS Ethics approval

This has been removed from the electronic copy

Appendix L:

End of study declaration letter to REC

[Chair of REC]
Address

Dear [Chair of REC],

Study title: Exploring the effects on identity of membership of a service-user group providing training to health professionals

REC reference: 12/LO/1250

I am writing to inform you that this study is now completed and the dissertation will shortly be submitted. I have enclosed a brief summary of the findings. If you would like any further information, please do not hesitate to contact me.

Yours sincerely,

Monique Malwah
Trainee clinical psychologist
Department of Applied Psychology
Canterbury Christ Church University
Runcie Court
Salomons Campus
Broomhill Road
Tunbridge Wells, Kent TN3 0TG

Exploring the effects on identity of membership of a service-user group providing training to health professionals

Aim: The aim of this grounded theory study was to explore the social identity of members of service user groups that train mental health professionals (SUG-TR). Additionally, the study aimed to construct an explanatory model of how participating in such groups contributes to the achievement and maintenance of positive social identity.

Method: Semi-structured interviews were conducted with eight members of SUG-TR and analysed using Charmaz's version of grounded theory (Charmaz, 2006). Grounded theory was used to build a preliminary model, which contained 5 main categories:

- impact of mental illness/ impact of receiving a psychiatric diagnosis,
- the experience of stigma,
- participating in SUG-TR,
- contributing to positive identity and
- challenges to participating.

Results: The constructed theory suggests that participation in such groups can contribute towards the achievement and maintenance of positive social identity. Participants achieved this through adopting a number of strategies that were enabled by the SUG-TR group and the contexts in which they provided.

Conclusion: The constructed theory extends current research and suggests that the salience of group membership for self-identity in a devalued minority social group for people experiencing mental illness might be heavily individual and context dependent. Limitations and clinical implications of the research are explored and suggestions for further research is presented.

Appendix M:

Journal guidelines



Journal of Community & Applied Social Psychology

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B. If the author is named in the text, only the year is cited .

Example: According to Irene Taylor (1990), the personalities of Charlotte. . .

C. If both the name of the author and the date are used in the text, parenthetical reference is not necessary .

Example: In a 1989 article, Gould explains Darwin's most successful. . .

D. Specific citations of pages or chapters follow the year .

Example: Emily Bronte "expressed increasing hostility for the world of human relationships, whether sexual or social" (Taylor, 1988, p. 11).

E. When the reference is to a work by two authors, cite both names each time the reference appears .

Example: Sexual-selection theory often has been used to explore patters of various insect matings (Alcock & Thornhill, 1983) . . . Alcock and Thornhill (1983) also demonstrate. . .

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Book

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Natarajan, R., & Chaturvedi, R. (1983). *Geology of the Indian Ocean*. Hartford, CT: University of Hartford Press.

Hesen, J., Carpenter, K., Moriber, H., & Milsop, A. (1983). *Computers in the business world*. Hartford, CT: Capital Press. and so on.

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